NHS
Greater Glasgow
and Clyde

NHS Greater Glasgow and Clyde	Paper No. 25/58
Meeting:	NHSGGC Board Meeting
Meeting Date:	29 April 2025
Title:	Health & Care (Staffing) (Scotland) Act 2019 (HCSSA) Annual Report to Scottish Government
Sponsoring Director:	Angela Wallace, Executive Nurse Director
Report Author:	Helena Jackson, Head of HCSSA Programme

1.   Purpose

1.1   The introduction of the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA) provides the statutory basis for the provision of appropriate staffing in health and social care services, enabling safe and high-quality care and improved outcomes for staff as well as service users.

1.2   The purpose of the attached paper is to provide the first of the legislated annual reports on the Health and Care (Staffing) (Scotland) Act 2019.

2.   Executive Summary

2.1   The Act aims to enable high quality care and improved outcomes for people using services in both health and care by helping to ensure appropriate staffing. The Act places duties on health boards, care service providers, NHS Healthcare Improvement Scotland, the Care Inspectorate & Scottish Ministers.

2.2   As such, NHSGGC remobilised a HCSSA whole system programme to deliver against the legislation, ensuring this covered all aspects of the Act with a multi-disciplinary approach in partnership.

2.3   Pre-enactment, NHSGGC agreed to test all duties and guiding principles of the draft legislative guidance alongside Scottish Government, NHS Health Improvement Scotland and the Care Inspectorate. We established 4 clusters of Short Life Working Groups, with over 30 multi professional and service management representatives and supported by our partnership colleagues. In completing this, we provided valuable input to Scottish Government, Health Improvement Scotland and Care Inspectorate to aid finalisation of the Statutory guidance and supporting resources.

2.4   A few of the Guiding Principles of Health and Care Staffing: -
- Improving standards and outcomes for patients / service users
- Ensuring wellbeing of staff and being open with staff and patients / service users about
- decisions on staffing
- Make the best use of available individuals, facilities and resources

2.5   These principles reflect and aid NHSGGC's ambition, values and aims, to:
- drive improvements and quality
- making the patients & service users the core of everything we do
- by ensuring our workforce, who as our most important asset, are at the heart of making our staffing models safe to provide excellence in care and quality for our patients & service users

2.6   Under the legislation, health boards, local authorities and integration authorities are to submit annual reports to Scottish Ministers on their compliance with the Act, high-cost agency use and any severe and recurrent risks. This paper and attached report are for Healthcare reporting, with Care reporting due later, in June 2025.

2.7   The report attached is in the format provided by Scottish Government as identified in statutory guidance and as legislated by the Act. Health and Care (Staffing) (Scotland) Act 2019.

2.8   The purpose of the annual reporting requirement is to:

- enable impact monitoring of the legislation on quality of care and staff wellbeing;
- identify areas of good practice that can be shared;
- identify challenges relevant organisations are facing in meeting requirements in the Act and what steps they have taken / are taking to address these;
- identify any improvement support required; and
- inform Scottish Government policy on workforce planning and staffing in the health service, alongside other sources of information and data.

2.9   Scottish Ministers will report on compliance and offer recommendations to Parliament. The data from these reports will help inform local and national workforce planning, along with health and social care policies.

2.10   The Patient Safety Commissioner for Scotland Act 2023 places a further requirement on organisations to share details of the Annual Report with them; with that post currently unfilled, Health Workforce Directorate in Scottish Government have confirmed that no action is required for 2024/25 year.

2.11   For NHSGGC, the SG Annual Report has been developed by the HCSSA Programme and reviewed by its Board on 23 January, chaired by the Executive Nurse Director. It was subsequently reviewed and approved by the Boards Corporate Management Team and Staff Governance Committee in February 2025.

2.12   The assessment for the overall level of assurance of NHSGGC's compliance with the Act is **Reasonable Assurance**.

2.13   The report commissioned in legislation is intended to be an annual report for the period of April 2024 – March 2025 inclusive. As the report was required to be drafted in January 2025, to ensure review and approval through the Boards agreed governance groups and committees, including the Board of NHSGGC, in time for submission and publication by 30 April, the timing did not allow for the full 12 months to be included.

2.14   As such we have given an indication of assurance projected at end of March / Quarter 4, alongside assessed assurance as at the end of quarter 3 (31st December 2024). Scottish Government and NHS Healthcare Improvement Scotland are aware of this approach and are content, noting this is a position similar to that of other health boards. A summary of the detailed reports components of assurance is provided in **Annexe A** at the end of the report.

2.15   The detailed report attached to this summary report gives required information and shows the progress made across what is a complex and wide-ranging piece of legislation, that has been successfully assessed for the organisation to understand how it relates to the services we deliver, for our patients, service users and staff. This achievement was through in-depth planning and the support of many professional leads, and stakeholders across the board and delivery partners, including our partnership colleagues.

3.   Recommendations

3.1   The NHS Board is asked to note the progress achieved, the assurance level at the end of quarter three and the projected assurance for the end of quarter four as Reasonable.

3.2   The Board is asked to approve the first annual report and onward submission to Scottish Government by 30 April 2025.

4.   Response Required

4.1   This paper is presented for **approval**.

5.   Impact Assessment

5.1   The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- **Better Health**   **Positive** impact
- **Better Care**   **Positive** impact
- **Better Value**   **Positive** impact
- **Better Workplace**   **Positive** impact
- **Equality & Diversity**   **Neutral** impact
- **Environment**   **Neutral** impact

6.   Engagement & Communications

6.1   From the remobilisation of the programme post-pandemic, in June 2023, stakeholder engagement across professional leaders, operational leaders and other key stakeholders across the Board and its delivery Partners, forming an inclusive whole system programme.

6.2   From the initial planning, testing the acts duties and guiding principles, into implementation has been in partnership, with over 30 multi professional and service management representatives.

6.3   This summary report does not reflect the immense effort and achievement from all involved, on delivering what is required to meet what is a complex piece of legislation. One of the most challenging aspects was translation the legislation to something meaningful for professional and operational leaders, along with each member of staff who it applies to.

6.4   The overall programme has a Corporate Communications Plan, supported by the Corporate communications Team, using the current best practice and methodology, which supported the programme activities for staff awareness, engagement, and widely accessible information to all staff (web page, core brief Team Talk, social media Vlogs and workshop / drop-in sessions). Subgroups for HSCP Oversight are in place within each HSCP and Awareness Sessions for Acute Services Sectors / Directorates have been delivered.

7.   Governance Route

7.1   The Report, and its incremental iterations developed each quarter throughout 24-25, have been presented to the HCSSA Programme Board, who have approved its assurance position, and narrative for onwards submission to the Corporate Management Team. The Corporate Management Team approved the report as attached, on 6 February for onwards submission to the Staff Governance Committee, who approved 18 February to move to submission to the NHS Board on 29 April 2025.

8.   Date Prepared & Issued

8.1   This paper was prepared on 11 April 2025.
8.2   This paper was issued on 17 April 2025.

Appendices (attached)

Appendix 1 – Scottish Government 2024-25 Annual Report.

Annexe A

Projection of Assurance
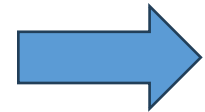
Duty#	Duty Name	Qtr 3 23-24->	Qtr1 24-25->	Qtr2 24-25 ->	Qtr3 24-25	Projected Qtr4
12IA	Guiding Principles	Limited Assurance	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Substantial Assurance
12IC	Real Time Staffing Assessments	Limited Assurance	Limited Assurance	Limited Assurance	Limited Assurance	Reasonable Assurance*
12ID	Risk Escalation is in Place	Limited Assurance	Limited Assurance	Limited Assurance	Limited Assurance	Reasonable Assurance*
12IE	Arrangements to Address Severe & Recurrent Risks	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance*
12IF	Duty to seek Clinical Advice on Staffing	Limited Assurance	Limited Assurance	Limited Assurance	Limited Assurance	Reasonable Assurance*
12IH	Adequate Time Given to Clinical Leaders	Limited Assurance	Limited Assurance	Limited Assurance	Limited Assurance	Reasonable Assurance*
12II	Ensure Appropriate Staffing	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance
12IJ	Common Staffing Method	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Substantial Assurance
12IL	CSM Ensure Training & Consultation of staff	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Reasonable Assurance	Substantial Assurance
Part 1 & 2	Planning and Securing Services	No Assurance	Limited Assurance	Limited Assurance	Reasonable Assurance	Substantial Assurance

* Subject to Due Diligence and adoption and response of Transitional Assurance reporting

Health and Care (Staffing) (Scotland) Act 2019 Annual Report / Quarterly Return

This is the annual reporting template which organisations will be required to use once the Act is in force. We are testing this out for the quarterly returns submitted prior to commencement, to increase organisation's familiarity with the template and to see if any changes are required. There are differences to requirements for the quarterly returns and the annual reporting, e.g. the quarterly returns are not required to be published; where there are differences these are explained in blue text.

1	Section 12IM of the National Health Service (Scotland) Act 1978 ("the 1978 Act") as inserted by section 4 of the Health and Care (Staffing) (Scotland) Act 2019 ("the 2019 Act") requires all Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), to publish, and submit to Scottish Ministers, an annual report setting out how they have carried out their duties under sections 12IA (including how the relevant organisation has had regard to the guiding principles in section 2 of the Act), 12IC, 12D, 12E, 12F, 12IH, 12II, 12IJ and 12IL of the 1978 Act (all inserted by section 4 of the 2019 Act).
2	Section 2(1) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when carrying out the section 12IA duty to ensure appropriate staffing, to have regard to the guiding principles for health and care staffing in section 1 of the Act. Section 2(3) of the Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this and how these steps have improved outcomes for service users.
3	Section 2(2) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS24, the Scottish Ambulance Service Board, the State Hospitals Board and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when planning or securing the provision of health care from a third party under the National Health Service (Scotland) Act 1978 to consider both the guiding principles for health and care staffing in section 1 of the Act and the need for the third party to have appropriate staffing arrangements in place. Section 2(3) of the Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this and how these steps have improved outcomes for service users.
4	Reporting for section 12IB (duty to ensure appropriate staffing: agency workers) is within a separate quarterly report and not included in this template.
5	Guidance on completing the template can be found below. Completed reports must be returned to {email} by 30 April 2025. If you require further assistance or have any queries, please contact {email}. Quarterly returns are to be returned as previously advised.

Report approval

6	This tab should be completed by the person signing off the report. An electronic signature is acceptable.
7	The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found. This does not apply to quarterly returns.

Summary

8	This tab asks for an overall summary of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act (see https://www.gov.scot/publications/health-and-care-staffing-scotland-act-2019-overview/pages/roles-in-scope-of-the-act/ for more details of which staff groups are covered under the Act).
9	Following receipt of the reports from relevant organisations, the Scottish Ministers must collate these and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be taken into account in policies for staffing of the health service. To enable this process, the information provided by relevant organisations must be comprehensive and pertinent to the staffing of the health service. Please complete these questions in detail, setting out the key achievements, outcomes, learning and risks and how this information has been used to inform workforce planning at the local level. For the quarterly returns the information will not be collated and put before the Scottish Parliament. However please still complete this in sufficient detail .
10	The tab then asks for an overall level of assurance of the relevant organisation's compliance with the Act, using the assurance categories as detailed below.

Individual duties / requirements

11	The next tabs look at specific elements within each of the individual duties / requirements of the Act, asking relevant organisations to provide an assessment of compliance against each statement, using the RAG classification below. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act, with the exception of 12IJ and 12IL which only apply to certain types of health care, in certain locations using certain employees (more information is provided in these tabs). Next to the column for the RAG status is a column entitled 'Comment'. In this column, relevant organisations should provide detail to explain the RAG status. For example, details of the organisational structures and / or processes being used, such as eRostering / SafeCare. If the RAG status is not green then explanation should be provided of the NHS functions and / or professional groups that do not have systems and processes in place or who are not using them.
12	Next, the relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future (for example, could learning in one area be applied to other areas). Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail. For the quarterly returns, relevant organisations should detail areas of success, achievement or learning related to preparation for enactment in April 2024.
13	The relevant organisation is then asked to provide details of any areas of escalation where they have been unable to achieve or maintain compliance with the particular duty or requirement or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this. Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail. For the quarterly returns, relevant organisations should detail areas of escalation / challenge / risk related to preparation for enactment in April 2024.
14	Finally, relevant organisations are asked to provide a declaration of the level of assurance they have regarding compliance with the specific section of the 1978 / 2019 Act, using the classification as below.
15	Two tabs, section 12IA and 'planning and securing services' ask additional questions. Similar to above, these should be answered in sufficient detail and more guidance is given in these two tabs.

RAG status

16	When asked to provide a RAG status, please use this key.

Green		Systems and processes are in place for, and used by, all NHS functions and all professional groups
Yellow		Systems and processes are in place for, and used by, 50% or above of NHS functions and professional groups, but not all of them
Amber		Systems and processes are in place for, and used by, under 50% of all NHS functions and professional groups
Red		No systems are in place for any NHS functions or professional groups

17	**Declaration and level of assurance**

When asked to provide declaration of the level of assurance, please use this key.

Level of assurance	System adequacy	Controls
...tantial assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
...onable assurance	There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non- compliance.
...ited assurance	Significant gaps, weaknesses or non- compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
...o assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

Name of organisation: NHSGGC

Report authorised by:
Angela Wallace
Executive Director of Nursing and SRO for HCSSA

Location where report is published: TBC when April 25 Board Papers on GGC Website

Purple Text is new or revised since the last incremental quarterly revision. **Green is adopting relevant updates adopted from the new SG Exemplar Report.** **Black text is content that has been in previous iterations and not amended.**
All text will be changed to Black post CMT / SGC review and before it goes to NHSGGC Board and published.

Summary report

Please answer the questions below, to provide an overall assessment of how the organisation has carried out its duties under section 2 of the 2019 Act, and sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the 1978 Act (inserted by section 4 of the 2019 Act).

Please advise how the information provided in this report has been used or will be used to inform workforce plans.

The processes, intelligences and reports that are in place to support the duties of the Act and in development will inform local workforce plans. The internal quarterly assessment reports are shared as part of internal governance processes so there is a shared understanding of the information available, its purpose, and for all leaders to consider how this can effectively inform and influence workforce planning. The aggregated summary report is also shared, however more work is required to produce a robust aggregated report that will allow services to be benchmarked with due diligence applied.

The Board undertake annual service reviews, which include budget setting (and agreement of budgeted staffing establishments) using a process that consider demand, capacity, activity, and quality (DCAQ) - the outputs from the different structures in place to support the Act provide important information and intelligence that is integral to this process. The Act doesn't sit in isolation and therefore it is important to consider the information related to the Act, alongside other performance and governance measures and information.

Recognising this has been the first year working under the new legislation, there has been significant learning, as well as new and emerging questions and considerations about how we deliver compliance in practice, and how the information and intelligence can be captured and used in a meaningful way.

In June 2023 NHSGGC embarked on a remobilisation of its Health and Care (Staffing) (Scotland) Act 2019 Programme (HCSSA), including a review of the Governance and its Programme Board (PB), to ensure NHSGGC have the required guidance and supportive structures in place to enable appropriate understanding, application and implementation of the HCSSA. This is also to provide assurance that the statutory guidance, and any associated resources, are in place to enable health & care services to meet the requirements of the Act, including the provision of appropriate reporting to Scottish Government and ministers.

NHSGGC self-nominated to be a pre-implementation test Board, which involved testing the effectiveness of the guidance on interpreting and implementing the Act, the preparedness of the Health Board to assess the impact of implementation and to provide regular reports to the Scottish Government Health and Care (Staffing) (Scotland) Act Testing Oversight Group. The scope of this testing was inclusive of all chapters and of all appropriate professions. The Board took a systematic testing approach, for each chapter / duty with identified professions.

The initial purpose of the HCSSA PB is to oversee NHSGGC's testing of the implementation of the Act across NHSGGC. The Programme Board is supported by Workstream sub-groups that are testing duties and guiding principles of the Act and oversee NHSGCC's readiness to implement what was required against each chapter / duty and assess the impact of implementation across required professions. Also, other Workstreams constituting Projects that are enablers or facilitate aspects of delivery such as eRostering, and others to ensure embedding in business as usual delivery. The Programme Board is responsible for ensuring a robust process of evaluation was built into the testing to ensure continuous evaluation and learning throughout the lifetime of the project, both at Board level and to Scottish Government's Health and Care (Staffing) (Scotland) Act Testing Oversight Group. This was in the form of initial SWOT / GAP analysis, Driver Diagrams, evidence bank creation and implementation action planning. The Programme Board are responsible for giving guidance in areas of challenge or where there requires escalation or any areas requiring specific attention.

The NHSGGC HCSSA PB is chaired by the Executive Nurse Director (END) and membership consists of HSCP Chief Officer (CO) Representation, HSCP Chief Social Work Officers (CSWO), Deputy Nurse Director, Deputy Medical Director, Lead Nurses Workforce and Excellence in Care / Quality Assurance, Allied Health Profession, Pharmacy, Healthcare Sciences (HCS), Psychology, Medical, Dental, Optometry, Public Health, Acute Service Directors, General Managers, Clinical Service Managers, Human Resources, Staff-side, eHealth and finance. During the pre enactment phase also included Scottish Government Testing Lead & Ass Nurse Director, Senior Programme Advisor HIS, HIS Programme Head and Care Inspectorate. Regular updates are provided on progress, risks and issues by the Head of Programme / PMO, with suitable governance agreed and reports are shared by Programme Board Members throughout professional and operational structures and any HCSSA subgroups established within our multi-faceted sub structures. There are also sub groups supporting planning and communication and Short Life Working Groups (SWLG's) formed for Implementation Action Plan delivery, where working groups could not be identified withing the Boards operational structures.

The HCSSA PB reports into various agreed Standing Committees and Groups to inform, request support, and seek approvals as appropriate. These consist of the Area Clinical Forum, Clinical and Care Governance Committee, Board Staff Governance Committee (which monitors the current Workforce Strategy Implementation Plan) which in turn will report to the Health Board, Acute Partnership Forum, Area Partnership Forum and Corporate Management Team and through the Staff Governance Committee, to the NHSGGC Board. Regular reports are also provided to a variety of governance meetings such as Informal Directors, HSCP Chief Officer Tactical Meetings, Area Nursing and Midwifery Committee and the Nursing and Midwifery Council. In addition, all 6 HSCPs have a Health and Care Staffing Oversight Group to meet and progress the HCSSA requirements. Awareness Sessions are also being embedded into Secondary Care via Senior Management Meetings and / or Workforce Planning Groups.

The information provided in this report is a combination of that identified through the testing period and into evidencing and implementation / action and form other methods of engagement and feedback. Regular reporting overall in the form of a Highlight Report and maintaining a Risk, Assumption, Issue and Decision (RAID) log, provides incremental updates during progress, identifying areas of further scrutiny, action and support, to enable compliance and appropriate reporting for the initial report in April 2025. In addition the 'Quarterly Test Reports' previously sent to SG pre enactment (this report) have been continued to be produced and used internally in NHSGGC to continue to assess assurance and progress, used as the foundation for the Boards quarterly Internal Assurance reporting and to prepare for the first annual report.

At the point of drafting the Annual Report (January 2025), the HCSSA Programme is reporting on areas of closure and completion, established policy or procedure and how this is embedded in business as usual organisational structures and where relevant, remaining transitional activities required post the programme closure scheduled for end of March 2025 (aligned to SG Funding ceasing). It is planned that continued oversight is required until processes and assurance is fully embedded, and a proposal of what will be the focus and how this will be provided is being considered.

In Addition to the above, we have included reference to this programme and work in our ADP return for Workforce Planning and will be constantly considering and reviewing these reports to contribute to workforce planning and a number of related activities.

Please summarise any key achievements and outcomes as a consequence of carrying out the duties and requirements in the Act.

Much of the Act supports objectives or activities already embedded in business as usual within the Board and recognise that many of the duties identified in the Act are related to our own 4 Corporate Aims of : -
Better Health – Improving the health & well-being of the population.
Better Care – improving individual experience of care.
Better Value – reducing the cost of delivering healthcare
Better Workplace – creating a great place to work

For Better Care - Improving individual experience of care, the HCSSA Programme is linked in with our Patent Experience Team and we have some highlights form the 2024 Quarter 4 Patient Experience Report and we will monitor this, in line with the Act. Listening to our patients, their families and carers, and hearing about their experience of care is extremely important to NHSGGC. Care Opinion is one of the feedback mechanisms that helps us do this. The feedback we receive provides us with the opportunity to learn from people that use our services on what is working well, and identify any areas of improvement. Some highlights are shown below, with staff being the most frequently used tag to describe what was good about our services. The key themes from the word cloud are our staff, with Nurses and Doctors the most mentioned staff groups, with the care and friendly professional treatment the most common themes shared.
•917 pieces of feedback about services received between 1st October 2024 - 31th December 2024. 77% of all feedback received was identified as positive.
•841 stories were posted through Care Opinion from 1st October 2024 - 31th December 2024.
From April 24 - Dec 24
· 2339 pieces of feedback about services received between 1st April 2024 - 31th December 2024. 79% of all feedback received was identified as positive.
· 2077 stories were posted through Care Opinion from 1st April 2024 - 31th December 2024.

Better Workplace - Involvement in staffing model decisions, better informed staff and enhanced training opportunities for staff development.   Delivery of good assurance of compliance to the Act is a foundation, better informed, trained & staff will deliver provide excellence in care and quality for our patients & service users.
The iMatter Staff Experience Continuous Improvement tool allows all teams, Directorates, Health and Social Care Partnerships (HSCPs), and the Board the opportunity to seek feedback on staff experience over the past 12 months, review this feedback to identify the areas of strength, along with opportunities or improvement to further support our staff going forward. In 2024 we have had a consistent response rate and employee engagement index score of 76 (Strive and Celebrate rated), with an overall experience score of 6.9 (Whilst not a formal KPI within iMatter, this score is crucial to understanding the wider experience of staff and review this across NHSGGC to help inform further discussion and engagement with staff). The Weighted Index Value for all Staff Governance Standard Strands are in the green, Strive and Celebrate category. Notably, Well Informed sits highest at 79, with Appropriately Trained and Developed at 76 and provided with a Continuously Improving & Safe Working Environment, Promoting the Health and Wellbeing of Staff, Patients and the Wider Community at 77. The component level question and responses remained similar, yet there is scope for improvement. Our 2024 results will be considered against those in 2025 and consideration on how the Acts aim and duties may have influenced this positively. Outcome have helped inform the Workforce Strategy, with key themes such as kindness and person-centred communications and engagement. In addition, through our Collaborative Conversations programme with staff groups and teams, we go beyond the questions asked in iMatter, to get to the heart of what matters to staff at work, and what drive positive experience at work. Feedback is provided anonymously to Senior teams for review and action, and, where appropriate, consistent themes from across a number of teams and service areas, are considered as part of the wider Board action planning discussion.

For Better Value - Reducing cost of delivering healthcare (minimal cost variation / use of PRA). Work that has been ongoing since testing in 23-24 on High Value Agency Usage, coupled with the focus of the Boards Sustainability & Value Programme of work, have reduced the levels of High Value Agency Use, evidenced by test reports in September 23 compared to the reports submitted to Scottish Government and published as required in the legislation.

The programme board provide regular communication to staff to maintain awareness of the Act and the structures and processes / SOPs in place to support them in their roles, ensuring staff see the relevance for them and those they care for, and to help keep people connected to the impact of these structures. Importantly, this helps to ensure staff know how to escalate risk or concerns about clinical care. Key achievements for the HCSSA Programme in 2024 were:
> Review of the Real Time Staffing resources and an options appraisal, resulting in a recommendation to proceed with SafeCare Implementation (approval for this recommendation is awaited) with Interim Organisational Level Standard Operational Procedure launched
> Staffing Level Tool process, schedule and governance approved and embarked upon. New Governance in place for the Common Staffing Method (CSM), Case Study developed and promoted and development of a CSM SOP and promotion.
> Quarter 1 Internal Assurance Report completion and submission using interim process while in Programme status. Quarter 2 completed & provided to HIS in draft until Staff Governance Committee review Feb25 (along with this Annual Report based on Quarter 3 position)
> Quarter 1,2 & 3 High-Cost Agency Report submission with Quarter 4 forecast to be on Target with some areas of improvement.
> Launch of HCSSA Communications and Staff Engagement Plan with regular Core brief updates, launch of a dedicated HCSSA Webpage for all colleagues to access as well as the public and expanding resources https://www.nhsggc.scot/health-care-staffing-scotland-act-2019/
> Operational Level SOP developed for Time to Lead launched via Core Brief. Further promoted with release of a Time to Lead local level (service) Implementation Case Study, and Vlog.
> Further Local Level SOP development and Case Study resources across the main professions the Act covers.
> Proposal for quarterly Assurance Report process post Programme with a revised assessment template.

Please summarise any key learning and risks identified as a consequence of carrying out the duties and requirements in the Act.

Key Learning: To enable appropriate assurance to the Act, clear lines of responsibility and accountability for compliance with the Act are mapped to professional groups named in the legislation within all our services. During 24-25 this was progressed via the Programme Board and its whole system and multi professional and accountable officer approach and has been frequently reviewed. Currently Transition into a 'Business-as-Usual' State is being considered.

Key Learning: When introducing Standard Operating Procedures (SOPs), There is Once at an Organisational Level that sets the scenes and key aspects, ensuring a level of consistent and standardisation to the Act and minimises differences in translation and understanding. Then local SOPs are encouraged to be developed and implemented at a department level to take into account specific resourcing establishment and skill mix, patient / service demand and service profiles.

Key Learning: Key theme of learning is that consistency of approach to process (where appropriate), communication, education and training on the Act and production of standardised practice and associated policies is beneficial to evidence compliance with the legislation is helpful. The approach was to identify where this may be required per the Duties, and monitor delivery via the Implementation Plan, establishing Short Life Working Groups (SLWGs) where appropriate or utilising other governance groups already embedded in business processes to deliver, depending on interconnectivity and resources required.

RISKs: As we continue the implementation activities identified for respective duties, we will work within the programme board members and through the various standing committees and groups to ensure assurance is clearly provided and identify risks, during the programme phase these are captured and worked through in the programme Risk Register. As we move to transition to business as usual, and residual risks at an appropriate level will be reviewed and be considered for inclusion in the Corporate Risk Register with mitigation action where possible or to tolerate should it be beyond the board's ability to remediate.

Key Risk: Time and appropriate resources to complete all activities and actions identified, especially as the Act is now enacted. Some activities required go beyond the 31st March 2024, and into future years, such as implementation of SafeCare across a large and complex organisation. Mitigations are in place to delivery a level of assurance with organisational SOPs and processes in place in the interim.

Key Risk: Cannot currently fully ensure reach and assess compliance for all professional groups and the sub roles and services underneath these, for two main reasons, a) complexity of service structures and b) clarification of certain roles, as they may not match the Staffing list provided by HIS/SG as naming convention is different.

Key Risk. Some professional groups sit across services within all directorates / sectors and Health & Social Care Partnership, meaning that accountability is complex and for some aspects of the duties, difficult to establish. This risk is being mitigated through the key learning point above and is under constant review, especially during Implementation Activities and the HSCP Sub Group and Informal MDT Planning and Communications Group, and risk and issue will be escalated through the HCSSA Programme Board for support advice and decision making.

Key Risk: External organisations requesting changes to legislated tools and resources requiring extensive related activity such as testing and change rollout that NHSGGC may not be ready to engage in, due to scale of organisation, potential resourcing required including funding.

Key Risk: In regards to the area of Care Services and interpretation of the Act, there is limited changes foreseen here by the Care Inspectorate. There has been a separate testing process with the Care Inspectorate with 2 of our 6 HSCP's participated. There is a potential that all the care services encompassed by the Act will be required to provide reporting in future, following the first tranche of reporting to SG and Ministers, such as child and family services, and HSCP's and Local Authorities should be considering this for future planning and expanded reporting.

Key Risk: Ongoing review, improvement activities and reporting may not be able to be fully transitioned from the programme and adopted into current board operational structures, which have relied on non-recurring funding for related activities and posts to end of March 2025. With the overall financial landscape in the NHS and public sector in Scotland this is unlikely to be able to facilitate mitigation locally without further financial support nationally.

Key Risk: Reporting Timeline for SG submission will not allow for a full 12 months intelligence and assessment in order to meet timetable for internal governance / Committee Reporting and progress to NHSGGC Board for end April submission to SG. Therefore the Annual Report is likely to not reflect aspects of delivery subsequently achieved within the final quarter, or reflect new risks / issues identified within the last quarter of the financial year. A change to submission to end of June would assist with mitigation and align to the deadline for Care related reporting.

We have noted the following high level / profession specific risks emerging from the Quarterly Assurance Reports / Clinical Advice and Assurance reporting : -

HealthCare Scientists are a grouping of professional roles that is fairly new, and is still being established not just in NHSGGC but across NHS Scotland. As such there are challenges around the application of aspects of the Act to this professional 'community', that need to be overcome. In some ways the Act is helping with the establishment of HealthCare Scientist as a recognised professional grouping, but also on the converse, structures and networks around this are new and in development and for some aspects of the Act, are not yet in the maturity like N&M, or AHPs as an example to embed things as easily and get full assurance.

Dental / Oral Health - Recruitment nationally in all areas of dentistry remains problematic. It presents that the lack of Dental Care Professionals and Dentists seeking new employment or to move new positions remains low. In addition to this general risk, there is a current issue that powers set out in the NHS General Dental Services (Scotland) Regulations 2010, do not give a Health Board the power to require dental practitioners to provide staffing information when they apply to be listed; (ii) whether there are any other powers available to a Board to impose such a requirement; and (iii) whether, in any event, the nature of dental practices make it practical to engage with applicants to dental lists about matters of staffing. NHS Scotland Central Legal Office (CLO) have reviewed and advised that the 2010 Regulations do not provide a statutory basis for Boards to require provision of the necessary information and are not aware of any other Regulations or Acts of Parliament which would give a Board the power to require this information. This means we are not able to provide the relevant evidence or assurance for the planning and securing of services as outlined in the Acts Guiding Principles for this independent contractor / practitioner group. The advice from CLO is being provided to SG for consideration and to agree what actions is required and by whom. At the point of drafting this report, the action lies with SG legal to consider the CLO view, which may also be similar for other Independent Contractor Groups such as Optometry and General Practice

Nursing, & Midwifery HCSW- Unpredictability of service demands and seasonal challenges as well as other non-seasonal demands on service, whilst maintaining and demonstrating quality and care alongside cost containment programmes may have impact on some aspects of the Act. NHSGGC has had a successful NQN/NQM outcome and work on recruitment and retention is continual. We are aware that staffing challenges exist in HSCP and are mindful the implementation of the act will likely highlight these issues further. Managers are currently using a range of processes and skills to mitigate against staffing risks and we will continue to do this on an ongoing basis e.g. targeted and creative recruitment, robust new staff induction and support, arrangements for cross cover of areas etc. We recognise that we have a range of duplicate staffing reporting systems that could be more effectively streamlined and also know that while the nursing profession is further ahead with their knowledge and support arrangements for enactment. There may be anticipated risks related to the act in terms of time to ensure staff attend priority training and to fulfil their full responsibilities in their clinical leadership role, however the learning from testing the full set of duties and activities and actions being addressed in the Implementation Action Plan will work towards possible mitigation. Time to Lead and Protected Learning is now part of our Nursing and Midwifery workforce plan and will be key agenda items and focused pieced of work. We are also aware that while Common Staffing Method may highlight a need for increased staffing, this could be constrained by the availability of staff to fill posts and also whether budget constraints will support recruitment. Also it may identify the need of service redesign, that is not able to be quickly established as requires careful planning, consultation and execution. Despite this NHSGGC are progressing discussions and reports at operational and board level to discuss issues identified from the CSM and to seek solutions.

For all professions - Risks around the availability and timelines for adopting suitable electronic systems which allow real-time input and output such as SafeCare which will greatly assist in meeting the requirements of the Act, are high for a Board the size of NHSGGC and

its complex structure, including Regional & National Services.

Please indicate the overall level of assurance of the organisation's compliance with the Act, reflecting the report submitted.

Reasonable Assurance

Assurance level is improving as implementation actioning is delivered and embedded organisationally

Projected Qtr 4 Assessment of Reasonable Assurance Overall

1 Guiding principles for health and care staffing
2 Guiding principles etc. in health and care staffing and planning
12IA Duty to ensure appropriate staffing

Guidance chapter link

RAG status

Section	Item	Status	Comment
12IA(1)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary (see guidance for details of professional disciplines included within the Act) are working in such numbers as are appropriate for the health, wellbeing and safety of patients; the provision of safe and high-quality health care; and in so far as it affects either of those matters, the wellbeing of staff.	Yellow	Good Evidence was identified during the testing phase for Guiding Principles, and recognised as a 'golden thread' through many of the separate duties within the wider Act. This is where we focus on specifics identified as good evidence and where further improvement may be required. Self-Assessment returns and verbal assurance to HCSSA testing leads provided assurance that processes are in place for the professional disciplines cited in the Act. It is noted that not all functions operate the same system or process at operational levels. Post programme assurance will be operationally via the quarterly Assurance assessment and report, and periodically sought from workforce planning groups and other groups as relevant that are taking forward strategy's, such as the Staff Health Strategy, the 25-30 Workforce Strategy (in conjunction with delivery of the NHSGGC 2025-28 Workforce Plan). Implementation of the new Organisational Level RTS and Escalation and Time to Lead SOP's and evidence at a local level will contribute to an assessment of Green as planned for end of quarter 4, along with other local resources developed. Also sign posting to national resources to support staff understanding of the Act, and how they can support the Board meet its legislative duties.
12IA(2)(a)	These systems and processes include having regard to the nature of the particular kind of health care provision	Yellow	Business continuity plans are service specific depending on the nature of the provision. Workforce governance discussions consider setting eg, acute pharmacy services have specific process to define staffing e.g. critical care for adults and neonates, cancer services, preparative services. For nursing and midwifery professions, this is achieved through the use of the common staffing method to determine appropriate staffing levels and for inpatient the Boards Safe to Start process (also being considered for other services and professions) to provide an establishment, and staff requirement for each shift which considers the kind of healthcare provided. Some systems and processes are tailored and some are generic. For example daily huddles will take into account workloads, patient acuity and requirements for that day, others such as iMatters are more generic. Going forward it we will ensure that developments to existing or new processes consider the type of care provision and recognised the demands and challenges this has on staffing levels and staff, and is being taken forward under 12IC&D. Turas & Learn Pro online learning and face to face training is available to all staff. Workforce processes are in place for all NHS functions and the recommended roll out of the Optima eRoster and SafeCare systems and outputs of the HCSA Programme Board will feed into further standardising these processes. This links with established annual service reviews which consider demand, capacity and quality, and an integral part to this is workforce requirements.
12IA(2)(b)	These systems and processes include having regard to the local context in which it is being provided	Yellow	Business continuity plans are specific to the local context and are in place across services Service planning is the responsibility of local managers, engaging with local teams and services to ensure local context is recognised, considered and had regard to when considering staffing requirements. The application of the Common Staffing Method (CSM) incorporates the inclusion of local context into reports and workforce plans for the relevant professions (Nursing & Midwifery and ED Medicals Staff) and reflects dynamic service review and planning. This then feeds into wider system workforce planning approaches, and will ensure local context is reflected in staffing establishments and models. Developed RTS &RE SOP in local services ahead of SafeCare deployment.
12IA(2)(c)	These systems and processes include having regard to the number of patients being provided it	Yellow	The workforce requirements reflect the activity, or number of patients being cared for by a person or a service. These are considered in real-time as part of real-time assessment to reflect variation in demand and activity, to ensure staffing meets any change in patient activity. Along with the Common Staffing Method for relevant professions and services, reflects dynamic service review and planning. Patient Experience - 1st October 2024 - 31th December 2024, 917 stories were shared about services across NHSGGC. Of feedback received 841 stories were received via Care Opinion and 76 received through other channels such as the NHSGGC website. From these stories feedback was identified and shared with services 1265 times (stories often reference multiple services). The charts below provide a breakdown of positivity of feedback, across the health board with 77% of feedback received identified as positive which is slightly less than the previous quarter. (81%)

12IA(2)(d)	These systems and processes include having regard to the needs of patients being provided it	Yellow	The analysis of the number of patients requiring the provision of service is already considered in staffing decisions and workforce planning. Some services work with approximate case load numbers or RAGG type systems to ensure needs are being met appropriately. However, further work is required to allow broader evidenced assurance of this, which is underway. On a day to day basis, real-time staffing assessment is embedded in practice and ensure that any changes to patient needs can be captured the new RTS & RE SOP outline process to identify any risk to providing appropriate staff to meet the needs of the real-time demands, mitigated or escalated for support. In addition the complete roll out of SafeCare as the Real Time Staffing tools will help move the assessment to Green with the SafeCare reporting supporting with evidence.
12IA(2)(e)	These systems and processes include having regard to appropriate clinical advice	Yellow	During the testing process, evidence of good practice and processes where identified. Further review was needed to ensure consistency and a process recommendation has been taken forward via the Clinical Assurance and Advice SLWG and linked to CSM Governance and RTS & RE. The SLWG's for Real Time Staffing and Time To Lead have concluded 'organisational level' SOPs that incorporate the requirement for appropriate clinical advice and will progress in implementation in Quarter 4, allowing this RAG Rating to improve further. In the meantime, managers and leaders are aware and supported to ensure they seek relevant clinical advice to support decision making. Current staffing assessments, such as Safe to Start in Acute Nursing and other professions, annual staffing assessment through the CSM Staffing Level Tools for relevant workforce include clinical advice.
2(1)	These systems and processes include having regard to the guiding principles when carrying out the duty imposed by section 12IA	Yellow	As Above The guiding principles for health and care underpin healthcare planning and delivery, and reflect the ways of working within the Board. These are represented with the use of the Common Staffing method specifically, and as an example used as a structure to support workforce planning processes. These are reflected in the Boards person centred practice, engagement and feedback form patients and staff, for the purposes of ensuring high quality safe healthcare with the best possible outcomes for patients, and in relation to the principles of the Act, the wellbeing of staff.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	An initial Assurance Template had been developed and distributed through Professional Leads HCSSA Programme including Sub Groups, via HCSSA SharePoint and Website along with a VLOG on how to approach use. The Clinical Advice and Assurance SLWG has subsequently reviewed this along with feedback from stakeholders. The template has been revised with examples of what is required under each section of the act and related checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has been published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures. Options for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports has been provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation. Once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable an consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non compliance.

Please provide information on the steps taken to comply with section 12IA.

These are steps taken to comply with 12IA in general. Examples could include information about workforce planning, national and international recruitment, retention, retire and return, service redesign, innovation, staff wellbeing, policies around supplementary staffing,

The Board's Workforce Plan (2022–2025) details our approach to meeting the challenges of supply, training, development and service and is also complemented by our own NHSGGC Workforce Strategy. The NHSGGC Workforce Plan 2022-25 is concluding, with the NHSGGC Workforce Plan 2025-28 in late stages of development. The NHSGGC Workforce Plan 2025-28 will be aligned to the National Workforce Strategy and will reflect the five pillars of the workforce journey:
Plan – evidence based, whole system planning to take place
Attract – explore alternative routes to recruit staff, incorporating equality and diversity, approaches to domestic and international recruitment
Train – maximise learning and education pathways, develop a digitally enabled workforce
Employ – focus on T&Cs, fair and meaningful work, professional registration
Nurture – improving culture, leadership, staff welfare, inclusion, partnership working

This will also be complemented by the four pillars of the NHSGGC Workforce Strategy 2025-30:
Safety, Health and Wellbeing
Organisational Culture and Leadership
Learning and Careers
Recruitment and Retention

NHSGGC recognise that the workforce is a major driver in ensuring sustainability of services. All workforce related activity will be delivered in line with the NHSGGC Financial Plan and Sustainability and Value Programme, this will include exploring opportunities for sustainable workforce change linked to the Moving Forward Together clinical and infrastructure plans. The Health and Care Staffing Scotland Act 2019 is also considered in Workforce strategy and planning for the appropriate professions.

NHSGGC have a Staff Health Strategy, the aim is to improve staff wellbeing, promote a caring workplace, reduce, and prevent ill-health and reduce sickness absence. It has four strategic objectives: 1. Strengthening support for mental health and wellbeing including stress; 2. Promote NHS Greater Glasgow and Clyde as a fair and healthy workplace in line with Fair Work Nation principles; 3. Address in-work poverty and promote holistic wellbeing to mitigate inequalities in health; 4. Support for managing attendance. The focus is now on delivery of the actions in the Staff Health Strategy Action Plan. There is a wide range of work ongoing to deliver on these priorities, including support around stress, mental health, bereavement, menopause, and physical activity. This includes delivery of an evidence based, high quality Occupational Health Psychology and Mental Health team and a single point of entry into the service to make it easier for staff to access the support that they require.

NHSGGC employ the NHS Scotland Attendance Management Policy to support the Board make the most of the employee attendance by reducing both short and long-term absence through promoting positive attitudes to work and effectively working in partnerships with all parties to reduce employee absence to the minimum levels as possible. This policy ensures that NHSGGC adopt a fair, consistent and supportive approach to staff with health problems, resolving long-term or on-going absences through the most appropriate means available and ensuring they provide a healthy and safe workplace. All areas of the organisation are supported with detailed reporting providing visibility of those with any periods of absence, absence reasons and volume of absences over agreed periods. This reporting is published on a daily, weekly and monthly basis, enhancing monitoring and supporting a reduction in absence.

NHSGGC are committed to the further reduction in Nursing and Midwifery agency spending in Acute Services and HSCPs. The use of Premium Rate Agency resources was eliminated by NHSGGC at the end of 2023, evidenced in our legislated quarterly reporting under the Health and Care (Staffing) (Scotland) Act 2019. The use of Standard Rate Agency resources is governed by an agreed set of monitoring and control measures, with specific documented approval processes in place for the use of any agency resource. Executive levels sign off is required for all agency resource deployment. This usage is now at minimal levels within NHSGGC. The level of prescription of one to one Mental Health care for patients within an acute setting has resulted in an ongoing resource pressure resulting in continued use of agency Registered Mental Health nurses. This accounts for 90% of all remaining agency use.

Effective recruitment activity, a focus on the recruitment pipeline and increased stability provided by a reducing annualised turnover rate has assisted in the increase of the Band 5 Registered Nursing establishment in NHSGGC over recent years. Calendar year 2025 commenced with 95% Band 5 Establishment and 96% Registered Nursing Establishment providing a solid foundation to maintain this reduction in agency use

NHSGGC operate the Medical Staff Bank for the West of Scotland and are committed to the reduction of Agency/Locum spend in all services. NHSGGC is focused on reducing the reliance upon additional doctor in residence shifts as a supplementary workforce. The use of supplementary medical shifts to close roster gaps is unfunded and the financial impact is growing as we look to backfill the gaps created by less than full-time NES funded trainees. A review is underway aligned to reducing resident doctor spend. At the beginning of 2023, agency use was greater than 280 shifts per week representing over 30% of all Medical Bank shifts. This has been reduced to circa 150 shifts per week accounting for 24% of Medical Bank shifts. The key focus on reducing this spend is to achieve Establishment position in all roles. This will be supported by continuing to recruit doctors to the NHSGGC Medical Bank and thus provide additional resources for key areas. In addition, a focus on team service planning will ensure that all job planning is complete and that job plans satisfy the agreed policy. Over 80% of workers are now coming from the bank rather than agencies. Agency workers are being replaced with bank workers where possible, with the only remaining high-cost agency workers being Consultant Psychiatrists, where hard to fill vacancies persist on a national basis.

NHSGGC has the largest Staffing Bank in Scotland and operates an efficient, adaptable model. As part of a West of Scotland procurement exercise, NHSGGC introduced a neutral vendor arrangement covering the engagement of all Nursing, Midwifery and Allied Health Professional and Healthcare Scientist resources. This agreement will increase the amount of direct engagement of agency workers and will help drive down the rates paid by influencing the supply chain

In Autumn 2023 the eRostering programme was brought into the wider Health and Care (Staffing) (Scotland) Act 2019 (HCSSA) Programme as one of the enabling workstreams, as it completed its Project Initiation, Readiness, Deployment and Adoption phases for the Early Adopter areas at Inverclyde Royal Hospital. Resources were provisioned by the Board to support the initial business change and roll out of the e-Rostering application. We have prioritised the rollout withing the funding made available in the Boards Financial Plan, noting that further resource is required to support the wider roll out due to the supplier failing to yet provide a national payroll interface alongside their roster product. Requesting existing staff who compile and update 'paper' rosters to enter data in both the eRostering solution and into SSTS for payment, was not agreed in partnership. Resource for double entry was not expected at this stage in the programme and has been modelled in line with Boards who have already demonstrated the need for such additionality.   NHSGGC Staff Bank are engaged alongside SSTS and Payroll on the configuration of key systems, including the instances of RL Datix systems already in use. This is designed to ensure optimal integration between substantive and supplementary resources as the benefits of the e-Rostering project. Subsequently, in 24-25 we have continued to rollout out Optima in Clyde Sector Nursing and Midwifery, and for Emergency Department Medical Consultants in the QEUH.

Additionally, the broader Optima product suite incorporating SafeCare from RL Datix is now becoming the new / replacement system for Staffing Level Tools (currently in legacy SSTS system) as legislated in the Act and the HCSSA Real Time Staffing Assessment and Risk Escalation (including reporting), in its SafeCare Module, part of the Optima Suite. The continued learning from the current users of eRoster in Clyde, as well as learning from other Health Boards who have, or are rolling out SafeCare as recommended by Scottish Government as their Real Time Staffing solution, has been used to inform an options paper, providing recommendations on implementation of Optima suite of systems (HealthRoster and SafeCare) by end of March 2026. The implementation of SafeCare ensures the Board can work towards improved compliance with legislation. Alongside SafeCare, the implementation of Optima is recommended to ensure NHSGGC continue to remain focused on improving rostering practice and efficiency, which subsequently allows us to work towards further reducing additional spend on temporary staffing and being able to fully realise any system benefits. Utilising the Boards provisioned budget for eRostering and proceeding with roll out of Optima and testing followed by rapid deployment of SafeCare across two integrated workstreams allows NHSGGC to continue the implementation of Optima whilst rolling out a robust Real Time Staffing solution as required by the HCSSA.   NHSGGC continues to support HIS in the testing of Staffing Level Tools in the new system as well as building a deployment plan across the resources named in the Act, requiring a Real Time Staffing solution. The lack of a product development map continues to present a challenge and requires implementation planning to be flexible. A recommendation paper to proceed has been approved by the HCSSA Programme Board for CMT consideration and approval.

Please provide information on how these systems and processes, and their application, have improved outcomes for service users

This should include, but not be limited to data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting.

This will continue to be an area of focus to bring together more closely patient quality and patient feedback and safety data, alongside staffing information. Through effective clinical governance structures there are established structures in place to review patient quality and safety information, and patient outcomes and feedback data.

NHSGGC report on a selection of the activities and interventions via the NHSGGC Clinical Governance Annual report and covers the period April 2022-March 2023 and highlights some of our achievements and key activities throughout the year, as well as outlining priority areas for the year ahead. It is illustrative rather than comprehensive and therefore important to note that there is substantially more activity at clinician, team and service level arising from the shared commitment to provide high quality of care.
https://www.nhsggc.scot/downloads/nhsggc-board-paper-23-77-clinical-governance-annual-report-2022-2023/

Under the revised Quality Strategy and its implementation, new governance and reporting has been established through the Quality Strategy Board, into the Boards standing committees and a Quality Strategy Report see https://www.nhsggc.scot/your-health/nhsggc-quality-strategy-2024-2029/
Delivering The Quality Strategy will address a number of these areas under the themes;
• Everyone Everywhere - Developing an approach that supports a culture of careful kindness, trust, respect and compassion. Leadership for quality at every level with a new structure and governance.
• Person Centred - Refresh and develop a new approach to person-centred, value-based care across the health and social care system
• Co-Production - Systematically involve people who use and work in our services to voice their views, needs, and wishes and to co-produce plans and proposals about our services Connecting our system wide approach to listening and learning from people's experience.
• Safe, Effective & Efficient - Deliver improvements in safety through relevant Scottish Patient Safety Programmes
• Learning, Listening and Improving - Further develop Quality Improvement Capability across NHSGGC supported by an ambitious programme of training and development and an impactful QI Network. Develop a learning system to accelerate improvement and good practice to improve the quality of care for the people who use our services

Other developments in the Boards Digital services, such as Digital Clinical Notes and patient centred care plan, which has been delivered into Adult inpatient services in acute, is being considered as a board wide standard for further deployment.

The Board demonstrates an ongoing commitment to listening and learning from the experience of patients/ carers and service users and seeks feedback using a range of methods. The Patient Experience Public Involvement (PEPI) Team supports clinical teams and services to implement and manage Care Opinion at a local level, working in collaboration with the Care Opinion Team. Regular reports are provided to NHSGGC's Care and Clinical Governance Committee (CCGC) on how we are using Care Opinion; what we hear from patients and families and what changes and improvements services are making as a result. All professions strive to deliver person centred care. Care planning and taking patients' view into consideration requires review. Person Centred Care Team to review how professions find out what and who matters to develop care plans that are person centred. We will aim to further Improve and strengthen patient feedback process where these may be impacted by lack of staffing resource. This will include the use of this feedback to inform staffing decisions. Services to ensure appropriate patient feedback mechanisms are in place such as Care Opinion and can evidence its use and outcomes.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, application of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level or risk.	This should describe how the success, achievement or learning could be used in the future. Continue the roll out of eRostering across the organisation, using learning from areas that have already implemented.
Delivery and ongoing enrichment of HCSSA Webpage to engage and support staff and provide information to the wider public	The Board has developed a web page that provides a range of information and resources regarding the Act, access to internal and signpost external resources to support staff for reference to support the Board meet the duties off the Act. https://www.nhsggc.scot/health-care-staffing-scotland-act-2019/	Further work to promote training resources available across all professional disciplines
Person centred care standard & planning (across professions)	There is a person-centred care standard being developed across the board, and currently covers the 5 largest professions and it is applicable to all registrants and HCSWs also. This is part of the Excellence in Care approach and the standard is a deliverable of the Quality Strategy and Implementation plan. Also included in the Nursing & Midwifery strategy, incorporating the person centred care plan was codesigned with staff and people with lived experience. This is part of the N&M Strategy, and will be delivered via the Digital Clinical Notes project, also the eHealth / Digital Strategy.	Single standard to assist with consistency across services. The Person Centred Standard is also being benchmarked with the National work to develop a core set of person centred measures
Staff Wellbeing Strategy In place	The Staff Health Strategy 2023-2025 has been fundamental in delivering support to help maintain and improve staff health. Importantly it also reflects what support staff tell us they need. A good example of this is in relation to menopause support for staff. Menopausal Women are the fastest growing demographic in the workplace with 79% of NHS GGC employees women. We know from the 2022 Staff Health Survey that menopause is a concern to a significant number of our staff. In response as part of the Staff Health Strategy we have been able to offer Virtual Engagement Events (over 700 staff attended) as well as monthly Group Consultations relating to menopause and supported by the NHS GGC Menopause specialist. Feedback has been excellent on both these initiatives.	We will review the impact of these initiatives over the winter and the chair of the Women's Staff Health Group will attend the next Staff Health Strategy Group to describe the range of work that is ongoing in relation to menopause. This will form part of a wider focus on Women's Health leading into 2025. Staff Wellbeing process or policy that are not part of the Once for Scotland
iMatter, Staff experience, Employee Engagement & Communication	Strengthen and promote staff wellbeing strategies such as staff health, peer support, speak up campaign, active health and iMatter.	The outcomes of iMatter have provided us with a wealth of information, which has informed and influenced a number of continuous improvement activities, outlined below: • working with iMatter leads across NHSGGC to support continuous improvement in both process as well as the staff experience • we would align iMatter and IIP, by feeding iMatter themes into local improvement plans • for 2025, we're developing an engagement guide for teams that have been amber / red for more than one year • informing the 3 year plan for Internal Communications and Employee Engagement action plan • 'You Said/ We Did' communications, corporately and locally to showcase the ways in which the employee voice has influenced action • We have updated the Staff Governance Committee assurance presentations to put more focus on how Directorates are using iMatter feedback to drive improvement • Board action planning partnership group reviewed the outcomes from iMatter 2024 and included Investors in People and Collaborative Conversation themes, to build a wider Staff Experience Board Action plan 2025 which draws on the wider organisational themes. A draft plan is awaiting approval, which focuses on Staff Wellbeing, Leadership Visibility, Learning & Development and Communication & Engagement. Throughout 2025, we'll continue to share updates on the improvement activities underway, as well as progress on the Board action plan, highlighting the impact of staff voices in driving positive change.
General - Policies	Testing of the Guiding principles with the multi professional SLW identified the need to ensure moving forward GGC policies, strategies, SOPs etc take into account the Guiding principles and can be evidenced within the content. The Boards Policy Development Framework Assurance Checklist and Policy Template have both been updated to include consideration on the Act in its drafting. https://www.nhsggc.scot/about-us/nhs-board/finances-publications-reports/	Most of the policies that the act cover in relation to workforce are Once for Scotland and NHSGGC will contribute to the next development phase (2.2) and will request they appropriately cover the Acts Guiding Principles and Duties. Where any Local policies still are in place, when reviewed and updated, including appropriate reference to the Act and its guiding principles and duties will be included.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge / risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with recruiting a particular staff speciality or in a remote / rural location.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in recruiting in a particular speciality or remote / rural location, the relevant organisation may have investigated retire and return schemes or upskilling and career development for existing staff. It may also have looked at how the service could be redesigned.

General	Clinical Demand versus Quality Care: Balancing Time Allocation for Staff Wellbeing, navigating patient expectation with vacancy rates and recruitment issues. Further work required with Staff Forum to address concerns and wellbeing	Delivering The Quality Strategy will address a number of these areas under the themes provided above.
General	Financial Pressures: Impact on staff wellbeing, retention, increase patient waiting times, reduction of quality outcome. Pay disparities causing dissatisfaction and retention concerns. Unintended consequence of Sustainability & Value / Financial improvement targets compounding this issue.	Business continuity plans to give regard to decisions on contingency planning, use of agency staff and mitigation of risk, linking to 12ID/E. The process must also include appropriate action if there is a circumstance where the organisational decision conflicts with the clinical advice.
General	Patient Experience & Feedback - Good evidence of patient experience mechanisms however these were impacted in some areas by staffing levels, low engagement, lack of formats, accessibility and resources. Not all areas of NHSGGC or HSCP's Delivery Partners use Care Opinion, and use other methods of feedback.	Patients: Improve and strengthen patient feedback, a review is underway with a view to standardise feedback and consistently report. . This will include the use of this feedback to inform staffing decisions. Expanding the use of service experience tools, such as Care Opinion or similar, monitoring the reporting for improvement and addressing areas of concern.
General	Constraints in staffing numbers, recruitment & retention challenges, low morale, high absenteeism and workforce instability. Lack of time for training and the nurturing of new staff in post. Lack of time for innovation: Balancing Clinical Duties and quality improvement development.	These issues are the focus for workforce planning groups and in activities and actions to deliver the boards workforce plan. The 25-30 workforce strategy will also bring focus to areas requiring improvement, some of which are listed below.
General		Work with Skills for Health to apply the 6 Step Methodology to workforce planning to profession who do not already use this for service design, such as AHP's, with the intention to transform roles , ensure right skill principles, improve recruitment and retention practice and increase transforming roles and practice, ie using AP's
General		Recruitment: Support early recruitment where workforce plans identify the need for staffing and improve communication and transparency where posts cannot be filled. Understand trends through exit interviews, such as loss of staff to private sector, early retirement, poor wellbeing etc. Improve flexibility in work patterns.
General		Continue to review, develop or revise workforce plans, service specifications, models of service delivery to ensure the right staff, right skills right place.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance	*Assurance level is improving as implementation actioning is delivered and embedded organisationally*

Projected Qtr 4 Assessment of Substantial Assurance

12IC Duty to have real-time staffing assessment in place

RAG status

Section	Item	Status	Comment
12IC(1)	Clearly defined systems and processes are in place, and utilised, for the real-time assessment of compliance with the duty to ensure appropriate staffing, in all NHS functions and professional groups.	Yellow	Good Evidence was identified during the testing phase for Real Time Staffing, with the multi-disciplinary testing team identifying several strengths, with all areas tested having a process for real time staffing in place. All areas operate dynamic risk assessment either through use of safety huddles or in response to unplanned absence/vacancy which impact staffing levels. Staff can voice concern regarding appropriate staffing in real time directly to their line manager, who can take action to mitigate any risk identified. An example of this would be bringing in additional resource from another areas, redeployment of available staff and/or a re-prioritising of workload for the staff in the area. However, focus for improvement was more consistency of practice and application and to move to a single resource or tool for RTS reporting. The adoption of SafeCare has been recommended and is awaiting review and approval at the time of writing this report.

Self-Assessment returns and verbal assurance to Health and Care (Staffing) (HCSA) testing leads provides assurance that processes are in place for the professional disciplines cited in the Act, at the high level at least. It is noted that not all functions operate the same system or process at operational levels.

The Programme Board have approved and published an Organisational Level Standard Operating Procedure for Real Time Staffing and Risk Escalation to ensure a consistent and systematic approach that will apply to all services and offer assurance that this duty is being complied with. Local operational level SOPs are being developed along with recording mechanisms that are currently in place to ensure there is oversight of risk, and a pathway to achieving standardisation and improved levels of compliance in the interim.

Clearly defined systems are in place for acute nursing and midwifery with daily safety huddles and safe to start processes in place. Every professional group understands the requirement for the clear assessment, documentation of risks, decisions, and actions and the need for this to be maintained while pending the roll out of SafeCare. Further evidence of implementation of the agreed organisational level SOP will enable this assessment to improve and pave the way for successful adoption of SafeCare should that be agreed. |
12IC(2)(a)	These systems and processes include the means for any member of staff to identify any risk caused by staffing levels to the health, well-being and safety of patients; the provision of safe and high-quality health care; or, in so far it affects either of those matters, the wellbeing of staff.	Yellow	Outcomes from the multi-disciplinary testing identified that systems and processes in place for risk identification (as opposed to incident recording) and identification of recurrent or escalated risk vary across services. Datix the NHSGGC Incident and Risk system currently in place does not have the functionality to automate and make appropriate linkages to set parameters, so requires a process to be utilised effectively. In N&M incidents that are recorded that are associated with staffing levels are reported and reviewed by senior management and acted on appropriately (which includes required escalation). However, this requires manual reporting and linkages and conversion to risk for recurrence. The aforementioned RTS & RE SOP has been developed based on the process established in Acute N&M, utilising Datix Incident reporting as the system currently available. Evidence is already coming through at the end of quarter 3 and early quarter 4 of this process being applied. Further work on ensuring local implementation plans for the SOP professionally and through organisational reporting structures will further evidence the process is being followed. Further implementation of the agreed organisational SOP at a local level will enable this assessment to move to Green, an ambition for end of quarter 4.
12IC(2)(b)	These systems and processes include the means for the initial notification / reporting of that risk to the relevant individual with lead professional responsibility.	Yellow	The aforementioned Board Wide RTS & RE SOP includes this requirement, along with organisational Datix Structures. Clinical Leadership has also been defined within the Time to Lead SOP. Further implementation of the agreed organisational SOP at a local level will enable this assessment to move to Green, an ambition for end of quarter 4.
12IC(2)(c)	These systems and processes include the means for mitigation of risk, so far as possible, by the relevant individual with lead professional responsibility, and for that individual to seek, and have regard to, appropriate clinical advice as necessary.	Yellow	The aforementioned Board Wide RTS & RE SOP includes this requirement. Clinical Leadership has also been defined within the Time to Lead SOP, depending on the team and profession, these SOPs may be consolidated. Further implementation of the agreed organisational SOP at a local level will enable this assessment to move to Green, an ambition for end of quarter 4.
12IC(2)(d)	These systems and processes include means for raising awareness among all staff of the methods for identifying risk, reporting to the individual with lead professional responsibility , mitigation, and seeking and having regard to clinical advice.	Yellow	As Above
12IC(2)(e)	These systems and processes include means for encouraging and enabling all staff to use the systems and processes available for identifying and notifying risk to the individual with lead professional responsibility.	Yellow	As Above
12IC(2)(f)	These systems and processes include the means to provide training to relevant individuals with lead professional responsibility on how to implement the arrangements in place to comply with this duty.	Yellow	We have developed and continue to develop and publish resources including case studies, with the largest of the professions each delivery this, for others to review and consider. Learning module on Datix for Managers is under Statutory / Mandatory via Learn Pro. There is a HCSSA specific web page where we are adding helpful learning resources, in conjunction with the National HCSSA Learning via TURAS promoting through the boards Core Brief and included in awareness sessions.
12IC(2)(g)	These systems and processes include means for ensuring that individuals with lead professional responsibility receive adequate time and resources to implement those systems and processes.	Amber	As Above and in conjunction with the Time to Lead Standard Operating Procedure has been approved and Case Studies developed and published, with are requirement for all teams to consider and ensure they have a SOP as required and rolled out will enable this to progress to yellow by the end of quarter 4.

| N/A | There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met) | Amber | An initial Assurance Template had been developed and distributed through Professional Leads HCSSA Programme including Sub Groups, via HCSSA SharePoint and Website along with a VLOG on how to approach use. The Clinical Advice and Assurance SLWG has subsequently reviewed this along with feedback from stakeholders. The template has been revised with examples of what is required under each section of the act and related checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has been published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures.

Options for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports has been provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation.

Once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable an consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non compliance. |
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Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, areas that have implemented and are using SafeCare are finding it easy to be able to record risks that are identified and the mitigation measures implemented and clinical advice received. Reports extracted from the system are demonstrating an auditable trail of decision-making.	This should describe how the success, achievement or learning could be used in the future. This success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation.
Delivery and ongoing enrichment of HCSSA Webpage to engage and support staff and provide information to the wider public	The Board has developed a web page that provides a range of information and resources regarding the Act, access to internal and signpost external resources to support staff for reference to support the Board meet the duties off the Act. https://www.nhsggc.scot/health-care-staffing-scotland-act-2019/

This has specific Case Studies, Posters and examples of local team level SOPS supported by Vlogs for Real Time Staffing & Risk Escalation | Further work to promote training resources available across all professional disciplines |
| SOP for Real Time Staffing and Risk Escalation | Review of the processes in place by the multi-disciplinary team identified several strengths and all areas tested had a process for real time staffing in place. Good practice has been brought into the Organisation Wide SOP Developed and published: - | The focus for improvement was ensuring that all staff members are aware of the process, that the process is consistent and recorded and what level of escalation is appropriate.

Build on these existing processes and document with Local SOP to cover any aspect not already part of process and documented, using Checklist in Organisational SOP, Implementation from Quarter4 and beyond |
	Good Use of Safe To Start / Safety Huddles	
	Robust evidence of RTS processes, although some need formally documented	
	Use of Datix for Incident recording aligned to staffing Levels in N&M and AHP	
	Prioritisation Guidelines to categorize patients if staffing is challenged or less than optimal	
	Local Risk registers available that may reference any related Risks to staffing levels	
	Contribution to Workforce Tool Runs where relevant / appropriate	
	N&M BRAVE Report	
	Out with N&M and use of rostering in SSTS, use of Rotas for managing peak workload and leave	
	Defined process / pathways to escalate rota issues, through clinical leaders or admin support	

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with encouraging and enabling certain professional groups to use the systems and processes.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in engaging certain professional groups, what measures have been put in place with regard to increasing this such as using professional networks, staff representatives etc.

Across professions	No single RTS resource / system deployed and in operation in NHSGGC for enactment.	A multiprofessional Short life working group (SLWG) was established to assess available Real Time Staffing Tools / Resources & Systems. The recommendation was not to move to any interim system due to size / complexity of GGC due to time and resource required including change fatigue for those staff in scope of the Act. The recommendation was propose the Boards adopts Safecare and this recommendation is awaiting review and approval. In the interim, to strengthen the multiple good processes already in place and in the interim release an Organisational Standard Operating Procedure (SOP) to ensure consistency and standardisation where appropriate. This was completed, socialised, approved via the established HCSSA Programme Governance, and published and promoted via corporate communications. Action for PB members to ensure the RTS & RE SOP was reviewed and plans to be established via professions and service leads to implement within local teams as appropriate. Further awareness meetings are underway, along with the development of test cases to be shared by at least one area within the main professional groups.
		Through local assessment, identify the professions/services that currently do have a RTS resource or process documented and embedded with routine procedures of recording risk escalation. Populate Evidence Bank with those in place with some due diligence they meet the Act and this duty, review and update or create as required, following the Organisational Level SOP and its checklist. Ensure all relevant professions and services have a suitable process that are recorded and accessible to all members of staff within the service and they can be easily evidenced and, in any monitoring, or compliance checks.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

<div style="background:orange">Limited assurance</div>   *This will change when Organisational level SOP is cascaded and implemented and assurance around current process being robustly recorded and standardised where appropriate.   Also again once SafeCare roll out plan is in place*

<mark>Projected Qtr 4 Assessment of Reasonable Assurance</mark>

12ID Duty to have risk escalation process in place

Section	Item	Status	Comment
12ID(1)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the escalation of any risk identified through the real-time staffing assessment processes which has not been possible to mitigate.	Yellow	Good Evidence was identified during the testing phase for Real Time Staffing, with the multi-disciplinary testing team identifying several strengths, with all areas tested having a process for real time staffing in place. All areas operate dynamic risk assessment either through use of safety huddles or in response to unplanned absence/vacancy which impact staffing levels. Staff can voice concern regarding appropriate staffing in real time directly to their line manager, who can take action to mitigate any risk identified. An example of this would be bringing in additional resource from another areas, redeployment of available staff and/or a re-prioritising of workload for the staff in the area. However, focus for improvement was more consistency of practice and application and to move to a single resource or tool for RTS reporting. The adoption of SafeCare has been recommended and is awaiting review and approval at the time of writing this report. Self-Assessment returns and verbal assurance to Health and Care (Staffing) (HCSA) testing leads provided assurance that processes are in place for the professional disciplines cited in the Act. It is noted that not all functions operate the same system or process at operational levels. Escalation is currently in the majority through processes such as telephone, email or MS Teams notification to a senior manager. The escalation of risk is often supported through the established huddles / forums with professional leadership support. Standardised recording of this and subsequent decision making is an area that needed developed, which has been delivered via the new Organisational RTS & RE SOP in SafeCare. The Programme Board have approved and published an Organisational Level Standard Operating Procedure for Real Time Staffing and Risk Escalation to ensure a consistent and systematic approach that will apply to all services and offer assurance that this duty is being complied with. Local operational level SOPs are being developed along with recording mechanisms utilising Datix are established to ensure oversight of risk, and a pathway to achieving standardisation and improved levels of compliance in the interim. While the SOP is the interim solution, we are unable to robustly capture and evidence all risk escalations, and associated action / mitigations within our current structures - evidence of compliance with this duty will require SafeCare being fully deployed (once approved). Clearly defined systems are in place for acute nursing and midwifery with daily safety huddles and safe to start processes in place. Every professional group understands the requirement for the clear assessment, documentation of risks, decisions, and actions and the need for this to be maintained pending the roll out of SafeCare. Further evidence of implementation of the agreed organisational level SOP will enable this assessment to improve and pave the way for successful adoption of SafeCare (once approved).
12ID(2)(a)	These systems and processes include the means for the lead with professional responsibility to report the risk to a more senior decision-maker.	Yellow	As above, part of processes establish across teams and included in the new Organisational RTS & Escalation SOP being implemented locally for clear documented process. We have worked closely with the Boards Chief Risk Officer to review the requirements of the Act and current Incident and Risk Processes, to ensure alignment, clarity and appropriate application. The Chief Risk Officer also participated in the GAP Analysis and drafting of the Organisational level RTS & Escalation SOP.
12ID(2)(b)	These systems and processes include the means for that senior decision-maker to seek, and have regard to, appropriate clinical advice, as necessary, when reaching a decision on a risk, including on how to mitigate it.	Yellow	As Above. Escalation of a risk is through operational lines of management or professional lines, depending on the service structure. Where it is not the case that escalation follows a 'professional' line of seniority, services have in place governance processes whereby a risk is reviewed by an appropriate professional clinician to ensure clinical advice is provided. The Organisational level RTS & Risk Escalation SOP details the need to seek appropriate clinical advice as required, and the SOP will be reviewed as a live document to keep it accurate and up to date, with local Level SOPs outlining details relevant .
12ID(2)(c)	These systems and processes include the means for the onward reporting of a risk to a more senior decision-maker in turn, and for that decision-maker to seek, and have regard to, appropriate clinical advice as necessary, when reaching a decision on a risk, including on how to mitigate it.	Yellow	As Above. The Operational RTS & RE SOP requires locally structures to be identified locally for escalation including succession / onward escalation if required. The Board has confidence in the SOP, which sets out the requirement to escalate and seek clinical advice through professional lines and this will be systematically monitored through Datix an assessment returns. Safety huddles, and clear communication lines evidenced by self assessment returns. There are existing mechanisms in place to allow rapid escalation through the relevant professional and managerial lines, with appropriate clinical advice, to respond to any urgent concerns.
12ID(2)(d)	These systems and processes include means for this onward reporting in (c) to escalate further, as necessary, in order to reach a final decision on a risk, including, as appropriate, reporting to members of the relevant organisation.	Yellow	As Above. The reporting and recording of risk on Datix has the capacity for escalation up to executive level if required to achieve awareness, mitigation or elimination of the risk. As part of the new Organisational RTS & Escalation SOP, the consistent and standardised use of Datix has been reviewed. Quarterly assessment provided by Directors and Chief Officers will give assurance that services have in place Business Continuity plans, service level risk registers and escalation of risks through appropriate governance groups up to strategic and corporate risk registers as required which are reviewed by members of the relevant organisation (Board / HSCP). However due to the interim process recording for services, we will not be in a position to move to a fully assured green position until the full deployment of SafeCare.
12ID(2)(e)	These systems and processes include means for notification of every decision made following the initial report, and the reasons for that decision, to anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice.	Yellow	As Above. Whilst there is a level of confidence about awareness and compliance with this overarching duty, being able to evidence feedback has been provided in all cases is impossible without the use of digital systems and technology to support these communications, especially if decision making and feedback span across different shift patterns. Where SafeCare is in place staff have access to feedback within the system. While DATIX has this function, all required staff communications is also reliant of informal verbal feedback which cannot be evidenced robustly at this time, and we will not be in a position to move to a fully assured green position until the full deployment of SafeCare.
12ID(2)(f)	These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to record any disagreement with any decision made following the initial identification of a risk.	Yellow	As Above, all staff have the ability to escalate concerns with a staffing decision following the processes outlined, in conjunction with the Time to Lead Organisational Standard Operating Procedure which includes clinical leader definition and responsibilities.

12ID(2)(g)	These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to request a review of the final decision made on an identified risk (except where that decision is made by members of the relevant organisation).	Yellow	As above.
12ID(2)(h)	These systems and processes include means for raising awareness amongst all staff of the arrangements stated in (a) to (g) above.	Yellow	As above.
12ID(2)(i)	These systems and processes include the means to provide training to relevant individuals with lead professional responsibility and other senior decision-makers on how to implement the arrangements in place to comply with this duty.	Yellow	As Above We have developed and continue to develop and publish resources including case studies, with professions each delivering this, for others to review and consider. Learning module on Datix for Managers is under Statutory / Mandatory via Learn Pro. There is a HCSSA specific web page where we are adding helpful learning resources, in conjunction with the National HCSSA Learning via TURAS promoting through the boards Core Brief and included in awareness sessions.
12ID(2)(j)	These systems and processes include means for ensuring that individuals with lead professional responsibility and other senior decision-makers receive adequate time and resources to implement the arrangements.	Amber	As above and in conjunction with associated with Duty 12IH Current provision to ensure adequate time built into Job Descriptions as they are refreshed. Also with the Time to Lead Standard Operating Procedure has been approved and Case Studies developed and published, with are requirement for all teams to consider and ensure they have a SOP as required and rolled out will enable this to progress to yellow by the end of quarter 4.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	An initial Assurance Template had been developed and distributed through Professional Leads HCSSA Programme including Sub Groups, via HCSSA SharePoint and Website along with a VLOG on how to approach use. The Clinical Advice and Assurance SLWG has subsequently reviewed this along with feedback from stakeholders. The template has been revised with examples of what is required under each section of the act and related checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has been published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures. Options for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports has been provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation. Once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable an consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non compliance.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, senior decision-makers in paediatric nursing were identified and chain of escalation communicated to all personnel. Individuals are now much better aware of who to contact during any particular shift in the event that a risk needs to be escalated.	This should describe how the success, achievement or learning could be used in the future. The procedures for identifying the chain of escalation that were used in paediatric nursing are now be trialled and rolled out across other areas.
General / Across Professions	Review of the processes in place by the multi-disciplinary team identified several strengths and all areas tested had a process for real time staffing in place. Good practice along with outcome of Gap Analysis of Datix Incident and Risk Management modules completed with Chief Risk Officer, included into the Organisation Wide SOP Developed and published.	The focus for improvement was ensuring that all staff members are aware of the process, that the process is consistent and recorded and what level of escalation is appropriate. Build on these existing processes and document with Local SOP to cover any aspect not already part of process and documented, using Checklist in Organisational SOP, Implementation from Quarter4 and beyond
General / Across Professions	Boards Chief Risk Officer participating in HIS Review of National Risk Matrix and working across teams in HIS to ensure this gives due consideration and consistency with that required to comply with the Act and duties	Ongoing.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating or giving clinical advice on a risk are notified of decisions made the reasons for them.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes.

Across professions	No single RTS resource / system deployed and in operation in NHSGGC for enactment.	A multiprofessional Short life working group (SLWG) was established to assess available Real Time Staffing Tools / Resources & Systems. The recommendation was not to move to any interim system due to size / complexity of GGC due to time and resource required including change fatigue for those staff in scope of the Act. The recommendation was propose the Boards adopts SafeCare and this recommendation is awaiting review and approval. In the interim, to strengthen the multiple good processes already in place and in the interim release an Organisational Standard Operating Procedure (SOP) to ensure consistency and standardisation where appropriate. This was completed, socialised, approved via the established HCSSA Programme Governance, and published and promoted via corporate communications. Action for PB members to ensure the RTS & RE SOP was reviewed and plans to be established via professions and service leads to implement within local teams as appropriate. Further awareness meetings are underway, along with the development of test cases to be shared by at least one area within the main professional groups.
		Through local assessment, identify the professions/services that currently do have a RTS resource or process documented and embedded with routine procedures of recording risk escalation. Populate Evidence Bank with those in place with some due diligence they meet the Act and this duty, review and update or create as required, following the Organisational Level SOP and its checklist. Ensure all relevant professions and services have a suitable process that are recorded and accessible to all members of staff within the service and they can be easily evidenced and, in any monitoring, or compliance checks.
		Mitigated and non-mitigated risks identified through RTS & RE SOP and related Datix Risk reporting need to be considered for determining recurrent risks as the systems mature.
Across professions	Implementation of SafeCare for Real Time Staffing recording and reporting, and or any future change of current incumbent Incident and Risk Management System	For any system changes in future, the identified project team will need to refer to the HCSSA requirements and undertake suitable GAP analysis to ensure functionality and configuration is appropriate to deliver recording and escalation reporting as per the Act. Involving the Datix Teams and key professional stakeholders with respect to the Act should help mitigate future change impact on what has been established for HCSSA.
Resourcing	Time and resources to continue to embed these resources and support practice, as new learning emerges, increased activity with compliance monitoring and reporting.	Continue to monitor as progress into a BAU delivery. Highlight risk with reduced resource next financial year when SG funding no longer available and the dedicated resources stop.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Limited assurance   *This will change when Organisational level SOP is cascaded and implemented and assurance around current process being robustly recorded and standardised where appropriate.   Also again once SafeCare roll out plan is in place*

Projected Qtr 4 Assessment of Reasonable Assurance

12IE Duty to have arrangements to address severe and recurrent risks

Section	Item	Status	Comment
12IE(1)(a)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the collation of information relating to every risk escalated to such a level as the relevant organisation considers appropriate.	Yellow	Good Evidence was identified during the testing phase for Real Time Staffing, with the multi-disciplinary testing team identifying several strengths, with all areas tested having a process for real time staffing in place. Self-Assessment returns and verbal assurance to Health and Care (Staffing) (HCSA) testing leads provides assurance that processes are in place for the professional disciplines cited in the Act. It was noted that not all functions operate the same system or process at operational levels. However, focus for improvement was more consistency of practice and application and to move to a single resource or tool for RTS reporting. The adoption of SafeCare has been recommended and is awaiting review and approval at the time of writing this report. Processes are already in place in regards to the reporting of severe risks as part of the system of internal control which based on an on-going process designed to identify, prioritise and manage principal risks. The system aims to evaluate the nature and extent of risks, and manage risks efficiently, effectively and economically. The Board has an established Audit and Risk Committee as part of the standing committees to support the NHSGGC Board. NHSGGC has continued to build on existing risk management arrangements during 2023-24. The Board agreed its updated Risk Appetite Statement in December 2023 while a Risk Management Strategy and Risk Register Policy and Guidance document was approved in December 2022. NHSGGC has established a robust framework, based on ISO 31000 for the management of risk. See more detail in the Annual report published October 2024 https://www.nhsggc.scot/downloads/annual-report-and-consolidated-accounts-2023-2024/ Currently risks raised on the Datix system are allocated a rating for impact (severity) and likelihood (anticipated likelihood of reoccurrence). All Datix submissions can be reviewed across functional groups for risk type, trends and occurrences. Reporting of risk on Datix has the capacity for escalation up to executive level if required to achieve awareness, management, mitigation or elimination. Functional groups report appropriate risks into the Health and Safety committee and/or the clinical governance committee when appropriate. Also each service area can report on risks specific to their area to provide localised and operational understanding of risk. Any future review of Board level Directorate and Corporate Risks will include consideration as appropriate in regard to recurring risks associated with the Act. The Programme Board have approved and published an Organisational Level Standard Operating Procedure for Real Time Staffing and Risk Escalation to ensure a consistent and systematic approach that will apply to all services and offer assurance that this duty is being complied with. Local operational level SOPs are being developed along with recording mechanisms that are currently in place to ensure there is oversight of risk, and a pathway to achieving standardisation and improved levels of compliance in the interim. Further evidence of implementation of the agreed organisational level SOP will enable this assessment to improve and pave the way for successful adoption of SafeCare should that be agreed.
12IE(1)(b)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to identify and address risks that are considered severe and / or liable to materialise frequently.	Yellow	As Above, the approved and published Organisational level RTS & Escalation SOP considers and references existing Risk management processes including level of risk identified and if they are appropriate, once investigated, what risks are escalated to senior organisational leaders and executive level and when and to ensure that all actions and onwards escalation are captured and can be reported, including where clinical advice is required (which can be more than one person / profession) and where there may be disagreement. Also to ensure a standardised approach to rapid escalation through the relevant professional and managerial lines, with appropriate clinical advice, to respond to any urgent concerns. It is for each area to assess severity and/ or recurring risk within their local context, using the national guidance and frameworks that exist. Each professional group/ service will determine what constitutes a severe risk to their safe service delivery within these frameworks. This has been clearly identified for all areas, as part of the development of the risk escalation SOP. Also to gain assurance that all services have in place Business Continuity plans, service level risk registers and escalation of risks through governance groups up to strategic risk registers as required which are reviewed by members of the relevant organisation (Board / HSCP).
12IE(2)(a)	These systems and processes include the means for recording risks that are considered severe and / or liable to materialise frequently.	Yellow	All identified severe and recurring risks are reported through the lines of governance. Thematic reports are available from Datix. It is for each area to assess severity and/ or recurring risk within their local context, using the National guidance and frameworks that exist. Each professional group/ service will determine what constitutes a severe risk to their safe service delivery within these frameworks. This is currently not clearly identified for all areas, this will be addressed through the review of current risk management systems and processes to clarify the duty for each function to identify what constitutes a severe risk.
12IE(2)(b)	These systems and processes include the means for reporting of a risk considered severe and / or liable to materialise frequently, as necessary, to a more senior decision-maker, including to members of the relevant organisation as appropriate	Yellow	As Above All identified severe and recurring risks are reported through the lines of organisation structures and Risk governance. Each Directorate has a Risk register. It is for each Directorate to assess severity and/ or recurring risk within their local context, using the National guidance and frameworks that exist. Each professional group / service will determine what constitutes a severe risk to their safe service delivery within these frameworks. Due to system limitations, we are currently unable to easily identify and report capture the spectrum of incidents and mitigated risks that occur frequently, in an automated way, this requires local analyses and identification to then be logged as a Recurring Risk.
12IE(2)(c)	These systems and processes include means for mitigation of any risk considered severe and / or liable to materialise frequently, so far as possible, along with a requirement to seek and have regard to appropriate clinical advice in carrying out such mitigation.	Yellow	As Above, this is also considered in the Time to Lead Organisational Standard Operating procedure, approved and published. The RTS & RE SOP requires clinical advice to be sought and record this locally, and this is to be audited through the self-assessment returns that are to be returned quarterly.
12IE(2)(d)	These systems and processes include means for identification of actions to prevent the future materialisation of such risks, so far as possible.	Yellow	As above Our embedded governance processes includes robust Adverse Event Reviews relevant to the reported severity, including significant adverse event reviews (SAER) for specific severe events to mitigate the risk of reoccurrences. These processes are well embedded in the Risk Management Framework, which lays out the process management of risk from service level to Executive strategic level risks.

N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	An initial Assurance Template had been developed and distributed through Professional Leads HCSSA Programme including Sub Groups, via HCSSA SharePoint and Website along with a VLOG on how to approach use. The Clinical Advice and Assurance SLWG has subsequently reviewed this along with feedback from stakeholders. The template has been revised with examples of what is required under each section of the act and related checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has been published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures.
			Options for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports has been provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation.
			Once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable an consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non compliance.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, a recurrent risk was identified in the capacity of one laboratory, leading to a delay in testing samples and communicating sample results. Following investigation, the process for booking in samples was streamlined and an admin coordinator was appointed. This has improved performance and the lab is now meeting its targets.	This should describe how the success, achievement or learning could be used in the future. For example, the organisation is now looking at whether the changes implemented in the one lab could be applied to other labs, to improve performance across the division.
General / Across Professions	Review of the processes in place by the multi-disciplinary team identified several strengths and all areas tested had a process for real time staffing in place. Good practice along with outcome of Gap Analysis of Datix Incident and Risk Management modules completed with Chief Risk Officer, included into the Organisation Wide SOP Developed and published.	The focus for improvement was ensuring that all staff members are aware of the process, that the process is consistent and recorded and what level of escalation is appropriate.
		Build on these existing processes and document with Local SOP to cover any aspect not already part of process and documented, using Checklist in Organisational SOP, Implementation from Quarter4 and beyond
General / Across Professions	Boards Chief Risk Officer participating in HIS Review of National Risk Matrix and working across teams in HIS to ensure this gives due consideration and consistency with that required to comply with the Act and duties	Ongoing.

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating or giving clinical advice on a risk are notified of decisions made the reasons for them.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes.
Across Professions	In the future, the Boards Incident and Risk System will be replaced. Possibly risk to adopt new system that has different functionality to what we have or require. Conflated with rollout of SafeCare & timelines which are not set and are likely to be beyond the HCSSA Programme timeline.	Working with the Datix System Team and eHealth in regards to mapping RTS, Risk Reporting and escalation and identifying any GAPS
		For any system changes in future, the identified project team will need to refer to the HCSSA requirements and undertake suitable GAP analysis to ensure functionality and configuration is appropriate to deliver recording and escalation reporting as per the Act. Involving the Datix Teams and key professional stakeholders with respect to the Act should help mitigate future change impact on what has been established for HCSSA.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance	This will change when Organisational level SOP is cascaded and implemented and assurance around current process being robustly recorded and standardised where appropriate. Also again once SafeCare roll out plan is in place

12IF Duty to seek clinical advice on staffing

Guidance chapter link

Section	Item	Status	Comment
12IF(1)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to seek and have regard to appropriate clinical advice in making decisions and putting in place arrangements relating to staffing under sections 12IA to 12IE and 12IH to 12IL and to record and explain decisions which conflict with that advice.	Yellow	Good Evidence was identified during the testing phase of our programme on this duty and a review of the processes in place by the multi-disciplinary team identified many areas exhibiting good practice in this area, such as the use of risk registers, Datix, safety huddles, contingency planning and local governance. There are different mechanisms to evidence when clinical advice has been sought, and potential is variability in the recording of that as well as explaining decisions within business as usual processes, however, not necessarily a negative. Focus for improvement varied between professions, but the generally the key theme identified was the lack of consistent process for requesting clinical advice, recording, reporting and escalating. The deployment of both the Operational RTS & Risk Escalation and Time to Lead SOPs will drive consistency were needed, whilst local implementation will allow for local context, team structures.
12IF(2)(a) (i) and (ii)	These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any risks caused by that decision are identified and mitigated so far as possible.	Amber	As Above The Board has a Clinical & Care Governance Committee which meets quarterly, supported by Divisional / Sector Governance Groups. The overall purpose of the Clinical and Care Governance Committee is to provide assurance across the whole system regarding clinical and care governance ensuring escalation to the NHS Board These groups receive reports on Clinical Risk, and Safety and Quality Programmes. The development and deployment of both the RTS & Escalation and Time to Lead SOPs has addressed this for reporting risk and also recording decision making (including disagreement), and feedback process, including conflict recording. This will continue to drive consistency were needed, whilst local implementation will allow for local context, team structures to be clearly understood. Due diligence is underway to ensure that clinical / professional leaders are appropriately included in the assessment of the internal assurance reporting, through operational structures and as we transition from a programme focus to that embedded operationally. This is being tested for the Quarter 4 assurance reporting, especially as this moves towards a business as usual process and product, handed over by the HCSSA Programme. This assessment will move to Yellow with that process deployment and due diligence reviews. We would expect there to be dialogue and discussion between the decision maker and individual providing clinical advice to inform and support the decision making, including potential risks associated with different options, however in the event that a decision is made that conflicts with the clinical advice received, any actual or potential risk will be identified and mitigated so far as possible. Whilst the organisation has confidence that this practice is followed, supported by the SOPs in place and awareness / training of decision makers, there is no single automated mechanism or process of evidencing this practice at present.
12IF(2)(a) (iii) and (iv)	These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any person who provided clinical advice on the matter is notified of the decision and the reasons for it and this person is able to record any disagreement with the decision made.	Amber	As Above. With further Due Diligence testing the Assessment feedback for Internal Quarterly Assurance Reporting with an overview of reporting using Datix, this assessment will move to Yellow.
12IF(2)(b)	These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the relevant organisation on at least a quarterly basis about the extent to which they consider the relevant organisation is complying with the duties in 12IA to 12IF and 12IH to 12IL.	Amber	An initial Assurance Template had been developed and distributed through Professional Leads HCSSA Programme including Sub Groups, via HCSSA SharePoint and Website along with a VLOG on how to approach use. The Clinical Advice and Assurance SLWG has subsequently reviewed this along with feedback from stakeholders. The template has been revised with examples of what is required under each section of the act and related checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has been published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures. Options for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports has been approved by the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation. It is anticipated that the risk Rating on this will be progressing to Yellow by end of Quarter 4.
12IF(2)(c)	These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to enable and encourage other employees to give views on the operation of section 12IF and to record those views in the reports to the members of the relevant organisation.	Yellow	As Above There are a range of ways that we collect feedback from staff, and this will be reflected in compliance monitoring of the different duties in such a report, for example, as detailed in 12IC, 12IH, 12IJ, 12IL. There are questions within iMatter regarding staff opinion on how well staff believe their views are listened to and acted upon. Professional leads also conduct their own staff engagements exercises along professional lines. The systems and processes developed by the organisation include mechanisms for individuals with lead clinical professional responsibility, to enable and encourage staff to give views on the operation of seeking clinical advice on staffing. Staff are encouraged to share and document these views to allow these to be considered in the quarterly assessments and onward reports to the Board.
12IF(2)(d)	These systems and processes include the means to raise awareness among individuals with lead clinical professional responsibility for a particular type of health care in how to implement the arrangements in this duty.	Yellow	As Above The HCSSA Programme Team have delivered internal engagement sessions with accountable managers, professional leads and across governance groups and committees. There has been information sessions and training for individuals with lead clinical professional responsibility at an executive level, and Directorate and HSCP level and also throughout the professional structures. A communication strategy is in place and is being constantly reviewed for improvement and as part of implementation activities will include arrangements anything respective to 12IF clinical advice being developed and released. A dedicated HCSSA Web Page has been developed and has resources and features SOP's and a Video featuring different professions speaking about what the Act means to them, along with other resources.
12IF(2)(e)	These systems and processes include means for ensuring that individuals with lead clinical professional responsibility for a particular type of health care receive adequate time and resources to implement the arrangements.	Amber	As Above Some of the professions have clearer roles with assigned time in their job planning or rosters for clinical leadership (especially in N&M and Medical). Healthcare Scientists and AHP Job Roles will contain clinical leadership, but specific time may not be formally set for this and is considered on an individual basis depending on the role. With the formality of SOPs and system recording, there was some concern raised that there may be additional time required to carry out the process and assessment when there are competing priorities, which will be kept under review as part of those projects and quarterly assurance assessments. These systems are monitored through operational processes to identify any reduced provision of supervision time. This will be improved by the wider roll out of eRostering. In addition and in tandem with Duty 12IC and 12ID, reviews should identify risks through risk management systems and processes and review the impact on patient outcomes where a risk is identified. With further Due Diligence testing the Assessment feedback for Internal Quarterly Assurance Reporting with an overview of reporting using Datix, this assessment will move to Yellow.

12IF(3)	These systems and processes include means for the relevant organisation to have regard to the reports received.	Amber	As Above. The organisation's systems and processes include means for the relevant organisation to have regard to the reports received, with reporting via a standing committee of the Board. The governance structure of the organisation ensures that the organisation has regard to reports created.
			A further programme of promotion and awareness is planned for Quarter 4 in preparation. It is anticipated that the assessment on this will be progressing to Yellow by end of Quarter 4.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	An initial Assurance Template had been developed and distributed through Professional Leads HCSSA Programme including Sub Groups, via HCSSA SharePoint and Website along with a VLOG on how to approach use. The Clinical Advice and Assurance SLWG has subsequently reviewed this along with feedback from stakeholders. The template has been revised with examples of what is required under each section of the act and related checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has been published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures.
			Options for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports has been provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation.
			Once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable an consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non compliance.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, the views of employees included in the reports prepared by individuals with lead clinical professional responsibility for a particular type of health care identified a potential improvement in working practices to.	This should describe how the success, achievement or learning could be used in the future. For example, the potential improvement is being trialled in the one area and if successful will be rolled out across other areas in the organisation.
Person centred care standard & planning (across professions)	Ensure measures of quality are clearly defined and understood. The quality strategy and implementation plan covers this and all of the professions named within the legislation. There is a person-centred care standard being developed across the board, and currently covers the 5 largest professions and it is applicable to all registrants and HCSWs also. This is part of the Excellence in Care approach and the standard is a deliverable of the Quality Strategy and Implementation plan. Also included in the Nursing & Midwifery strategy, incorporating the person centred care plan was codesigned with staff and people with lived experience. This is part of the N&M Strategy, and will be delivered via the Digital Clinical Notes project, also the eHealth / Digital Strategy.	Single standard to assist with consistency across services. The Person Centered Standard is also being benchmarked with the National work to develop a core set of person centered measures

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, in compiling the reports made to the members of the Health Board, there is are good mechanisms in place for the Medical Director to enable and encourage medical employees to give their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions.
Across professions	Financial Pressures: Impact on staff wellbeing, retention, increase patient waiting times, reduction of quality outcome. Pay disparities causing dissatisfaction and retention concerns. Unintended consequence of Sustainability & Value / Financial improvement targets compounding this issue. ☐	Business continuity plans to give regard to decisions on contingency planning, use of agency staff and mitigation of risk, linking to 12ID/E. The process must also include appropriate action if there is a circumstance where the organisational decision conflicts with the clinical advice.
Across professions	Reporting requirements for Clinical Leaders are developed and integrated into the Boards appropriate governance, to give assurance on compliance with duties and escalate risks where not.	Ensure reporting is in place for clinical professions to report quarterly, within existing board governance structures the extent to which they consider compliance across the duties is being achieved. This is to be collated and provided to Medical Director, Director of Public Health and Executive Nurse Director who will review and report quarterly to the Board via agreed governance groups. Work is underway to ensure that clinical / professional leaders are appropriately included in the assessment of the internal assurance reporting, through operational structures and as we transition from a programme focus to that embedded operationally. This is being tested for the Quarter 4 assurance reporting, especially as this moves towards a business as usual process and product, handed over by the HCSSA Programme. The overall assurance assessment will move to Yellow with that process deployment and due diligence reviews.
Across professions	Time and appropriate resources to complete all activities and actions identified, especially as the Act is now enacted. Some activities required go beyond the 31st March 2024, and into future years, such as implementation of SafeCare across a large and complex organisation. Mitigations are in place to delivery a level of assurance with organisational SOPs and processes in place in the interim.	Recommendation has been made to adopt SafeCare for RTS & Re and now also for Staffing Level Tools. In the Interim SOPs have been established and due diligence will be carried out to ensure embedded in local services and teams

Declaration: The relevant organization has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

| Limited assurance | *This will improve once transitional Assessment process is tested at the end of quarters 4 and due diligence completed, with any review and adjustments of process required* |

Projected Qtr 4 Assessment of Reasonable Assurance

12IH Duty to ensure adequate time given to clinical leaders

Guidance chapter link

Section	Item	Status	Comment
12IH	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties.	Yellow	Evidence across professions of planning, documenting and reviewing via Job Planning, PDP-Rs, regular meetings between senior leaders and team leads, Annual PDP/Appraisal process with 6 monthly reviews. Indicative measures for leadership activities available on TURAS via appraisal process with ability to monitor PDPs as well as eJobPlan for Medical staff and clinical handovers and supervision. Current monitoring of professions out with medical is primarily through one to one meetings throughout the appraisal year. A clinical lead is in place for all services to support or provide professional advice with real-time staffing decisions and address any risk escalation, and provide representation on workforce planning groups within their areas of responsibility . This is embedded within the Time to Lead Organisational Standard Operating Procedures (SOPs) in place, and supported through the SOP on RTS & risk escalation.
12IH	These systems and processes include time and resources for these individuals to supervise the meeting of the clinical needs of patients in their care; to manage, and support the development of, the staff for whom they are responsible; and to lead the delivery of safe, high-quality and person-centred health care.	Yellow	GGC Person Centred Care (PCC) steering group focuses on approaches to ensuring PCC is integral to ways of working and delivery of services. There is a person-centred care standard being developed across the board, and currently covers the 5 largest professions and it is applicable to all registrants and HCSWs also. This is part of the Excellence in Care approach and the standard is a deliverable of the Quality Strategy and Implementation plan. (See12IA) Through the measures outlined above, as well as line management and professional leadership support at all levels, clinical leaders will be supported to have the time and resources to undertake these roles, or seek support and highlight risks where this is not sufficient.
12IH	These systems and processes include the means to identify all roles, and therefore individuals, with lead clinical professional responsibility for a team of staff.	Yellow	As Above. Multiple systems have the means to identify all roles and individuals with lead clinical professional responsibility for a team. This includes payroll systems, Job Planning for Medical and via SSTS structures, which the majority of non-medical professional staff employ in management of payroll based activities and for N&M rostering. All roles are identified within eEES (Employee Electronic Staff System) and TURAS all are arranged through job role and titles. Staff job descriptions reflect the specific leadership responsibilities, requirements and expectations within each role, although may not be explicit over proportionality of this leadership with other job role activities. The Time to Lead Short Life Working Group (TtL SLWG) developed a definition of Clinical Leaders as part of the Organisational level SOP, which was approved, published and being promoted for local implementation through quarter4. In Line with the RTS and Risk Escalation SOP, local SOP's will be produced which will also enable identification of lead clinical professionals in a team, to ensure a consistent and systematic approach that will apply to all services and offer assurance that this duty is being complied with.
12IH	These systems and processes include the means to determine what constitutes sufficient time and resources for any particular individual.	Amber	As Above. For some professions there is Job Planning via a system and others using more manual methods as well as TURAS appraisal manager discussions and outcomes. Outcomes can be recorded within these systems and be identified and expectation within Job Description as required. These can be reviewed through appraisal and PDP, as well as lines of escalation in the event a risk to quality and safety is identified. Some of the professions have clearer roles with assigned time in their job planning or rosters for clinical leadership (especially in N&M and Medical). Healthcare Scientists and AHP Job Roles will contain clinical leadership, but specific time may not be formally set for this and is considered on an individual basis depending on the role. with the formality of SOPs and system recording, there was some concern raised that there may be additional time required to carry out the process and assessment when there are competing priorities. This will be monitored as part of the quarterly Internal Assurance assessment and reporting. Positive assessment will allow for a move to Yellow. Due to varied systems and depth of use across professions there is no one standard way to currently record that the time identified has been ringfenced for leadership activities, with clinical / service demand sometimes requiring the time set aside to be rearranged and some aspects never recovered, and there is no way of easily recording this other than manually at a person level and discussing as part of appraisal or other meeting with managers. There are some National Level Job Description updates being reviewed and where relevant GGC participates, such as Pharmacy, we will ensure this is also considered.
12IH	These systems and processes include the means for ensuring this duty has been reviewed and considered within the context of job descriptions, job planning and work plans, as appropriate.	Yellow	As above, job descriptions, job planning and work plans are assessed at appropriate time, for example, through job planning or TURAS PDP Appraisal. Job planning and Turas appraisal sign off completion rates can be monitored through respective systems. Workforce groups when developing workforce plans review staffing levels, levels of redeployment, and gives consideration to non-case holding time of certain posts when developing workforce plans. Where there be less definition and clarity in current Job descriptions, this is being reviewed moving forward as roles are reviewed withing team structures and before advert.
12IH	These systems and processes include the means to consider outputs from activities carried out to meet this duty in order to inform future workforce planning and protect the leadership time required for clinical leaders.	Yellow	As Above. Discussion time with line managers to agree levels of time and resource to discharge their responsibilities and clinical workload are a core component of annual appraisal meetings. Workforce planning in place in the relevant Professional areas, including Common Staffing Method (for relevant staff). The organisation has robust systems and processes in place including the means to consider outputs from activities carried out to meet this duty in order to inform future workforce planning and protect the leadership time required for clinical leaders. Benchmarking and the requirements of this duty are noted within workforce groups. All professional leads have access to annual appraisal, PDPs and will have access to workplan / job planning through manual or electronic systems. Discussion time with line managers to agree levels of time and resource to discharge their responsibilities and clinical workload are a core component of annual appraisal meetings. Workforce planning includes for some professions the six step methodology and Common Staffing Method, both take cognisance of outputs from staff.

N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	An initial Assurance Template had been developed and distributed through Professional Leads HCSSA Programme including Sub Groups, via HCSSA SharePoint and Website along with a VLOG on how to approach use. The Clinical Advice and Assurance SLWG has subsequently reviewed this along with feedback from stakeholders. The template has been revised with examples of what is required under each section of the act and related checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has been published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures. Options for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports has been provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation. Once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable an consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non compliance.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project was a determination of time and resources for different team leaders and feedback so far has been positive.	This should describe how the success, achievement or learning could be used in the future. This has now been extended to other AHP areas and trialled to see applicability.
General / Across Professions	Organisational Level Time to Lead Standard Operating Procedure approved, published and promoted (includes Clinical Leader definition).	Implementation Qtr4 and assurance reporting, continue to monitor through due diligence process post programme during transition period.
Delivery and ongoing enrichment of HCSSA Webpage to engage and support staff and provide information to the wider public	The Board has developed a web page that provides a range of information and resources regarding the Act, access to internal and signpost external resources to support staff for reference to support the Board meet the duties off the Act. https://www.nhsggc.scot/health-care-staffing-scotland-act-2019/ This has specific Case Studies, Posters supported by Vlogs for Time to Lead	Further work to promote training resources available across all professional disciplines

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, in compiling the reports made to the members of the Health Board, there is are good mechanisms in place for the Medical Director to enable and encourage medical employees to give their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions.
Across professions	Reporting requirements for Clinical Leaders are developed and integrated into the Boards appropriate governance, to give assurance on compliance with duties and escalate risks where not.	Ensure reporting is in place for clinical professions to report quarterly, within existing board governance structures the extent to which they consider compliance across the duties is being achieved. This is to be collated and provided to Medical Director, Director of Public Health and Executive Nurse Director who will review and report quarterly to the Board via agreed governance groups. Work is underway to ensure that clinical / professional leaders are appropriately included in the assessment of the internal assurance reporting, through operational structures and as we transition from a programme focus to that embedded operationally. This is being tested for the Quarter 4 assurance reporting, especially as this moves towards a business as usual process and product, handed over by the HCSSA Programme. The overall assurance assessment will move to Yellow with that process deployment and due diligence reviews.
Across professions	Current issues with supervisory / management capture and available reporting.	Links to eRostering / Safe Care RTS implementation recommendation and future deployment.
Across professions	Support from Once for Scotland / National groups on Definitions, JD standardisation and apportionment of leadership time and definitions.	Review career pathways and job descriptions, aligning with national directives. Continue requesting STAC support on national level definition and standardised T's & C's.
		There are some National Level Job Description updates being reviewed and where relevant GGC participates, such as Pharmacy, we will ensure this is also considered.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Limited assurance	*This will change when Organisational level SOP is cascaded and implemented and assurance around current process being robustly recorded and standardised where appropriate. Also again once SafeCare roll out plan is in place*

Projected Qtr 4 Assessment of Reasonable Assurance

12II Duty to ensure appropriate staffing: training of staff

Section	Item	Status	Comment
12II	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all employees receive such training as considered appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b) and such time and resources as considered adequate to undertake this training.	Green	NHSGGC has a Staff Governance Committee which monitors various aspects for Workforce, including staff engagement, development. This includes reporting on Statutory and Mandatory T and PDPs. These reports are made available via Board Papers quarterly and some aspects are reported in the Boards Annual Report, which sets out corporate aims, one of which being Bett Workplace. This consists of the following objectives, that in many ways mirror the intent and aims of the act and this specific duty : - □ To ensure our people are well informed. □ To ensure our people are appropriately trained and developed. □ To ensure our people are involved in decisions that affect them. NHSGGC has an Induction film welcoming new employees with the aim of highlighting our values and ambitions and to outline the ethos of patient centred care in the Board. It is key that we committed to the core NHS values of: Care and Compassion, Dignity and Respect, Openness, Honesty, Responsibility, Quality and Teamwork and we use these values to guide us in all that We are committed to equality and diversity to a zero tolerance toward racism, sexism and homophobia. We have access to some of the finest facilities and resources in the country, but it is values and attitudes we demonstrate as individuals that make the biggest difference to our patients and their families. It can also be used when our team members transfer to a different role our organisation or return after an extended period of absence such as maternity leave or secondment. An effective induction process should provide a variety of benefits and support our aim delivering high quality patient care and the efficient delivery of services. We are encouraging new employees to complete core statutory and mandatory training prior to commencement. Mar have a vital role in supporting compliance and a MicroStrategy Dashboard is available for Statutory and Mandatory Training and PDPs. There are local KPI dashboards and regular monthly r submitted to leaders on the status of their teams compliance. Learn-pro system in place to monitor compliance with mandatory and essential training for all NHS functions and professional groups. Compliance levels with mandatory and induction compl monitored. PDP completion monitored through TURAS platform along with completion of mandatory and essential training at one to one meetings between managers and staff within all pro In house education teams for professions monitor and provide extensive educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific). All em undergo induction and orientation. Training on legislation is incorporated as part of the nursing and midwifery Champions Programme and support for Staffing Level Tool runs, for staff with responsibility to implement. TURAS resources available to all staff involved in Staffing Level tool runs. Continual promotion and signposting of the Nationally developed TURAS resources occurs, encouraging update at the appr level to all staff who the Act applies to. Workforce Groups and Professional leads contributing to TURAS resources being further developed and targeting communications for skilled level as appropriate. When SafeCare is approved for adoption, rollout will include learning on the Act as part of deployment as relevant, signposting to National resources also.
12II	These systems and processes include means to determine the level of training required, and time and resource to support this, for all relevant employees.	Yellow	As Above. Training within the organisation is clearly determined along the lines of Statutory, Mandatory, and profession / subject specific requirements for role. Training is supported by prote time to complete and all training requirements, and read resources. Different professions have different set national training curriculums. These are supported through professional lines and t needs analysis, funding and expert support e.g. Practice Development Facilitators, and clinical educators. Current National programme on Protected Learning Time underway and locally led by HROD driving consistency. The assessed level will move to green with the delivery of this associated a
12II	These systems and processes include the means to deliver the agreed level of training to all relevant employees.	Green	As Above Profession led in house education teams provide educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific). PDP completion monitored th TURAS platform along with completion of mandatory and essential training at one to one meetings between managers and staff within all professions. □
12II	These systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training.	Yellow	As Above Flexible approach to staff completion of mandatory training and on line learning access to training available and where required, from devices and locations including areas out with the clinica setting. Staff can choose based on judgement and demand, when to complete e-learning. Current National programme on Protected Learning Time underway and locally led by HROD driving consistency. The assessed level will move to green with the delivery of this associated activity.□
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	Through mechanisms outlined above. Each professional lead will take learnings form the testing and re identified areas of improvement forward within their professional governance groups t a reliable, systematic and where feasible automated approach that will apply to all services and offer assurance that this duty is being complied with . Large areas of professionals have a proc recording in place. This needs to be a consistent and standardised approach were appropriate / possible, allowing for professional & role based adaptation Current National programme on Protected Learning Time underway and locally led by HROD driving consistency, this should also have delivery outcomes that support monitoring compliance assurance and risk levels. An Assurance Template had been developed, tested and reviewed with feedback from stakeholders and distributed through Professional Leads HCSSA Programme including Sub Groups, vi HCSSA SharePoint and Website and we are developing a VLOG on how to approach use . The template has been revised with examples of what is required under each section of the act an checklists, allowing assessment and provision of evidence against each of the duties for assurance and allows a level of consistency, while still allowing for local configuration. This has beer published and professional leads are promoting its immediate use, along with being promoted through relevant sub groups and existing governance and operational management structures. Commission for quarter 4 will be issued in March 2025.

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action

This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project was a determination of time and resources for different team leaders and feedback so far has been positive.	This should describe how the success, achievement or learning could be used in the future. This has now been extended to other AHP areas and trialled to see applicability.
All	Promotion of TURAS Learning resources and signposting via the HCSSA Webpage, accessible to all.	Further review and understanding and working to develop the TURAS Analytics of the National HCSSA Resources with NES
Nursing & Midwifery	The TURAS resources are promoted as part of Acute induction and essential learning.	

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, in compiling the reports made to the members of the Health Board, there is are good mechanisms in place for the Medical Director to enable and encourage medical employees to give their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions.
All AFC Professions	Current National programme on Protected Learning Time underway and locally led by HROD driving consistency. This work may identify a level of activity requiring protection time for professions that will be challenging to introduce, whilst Boards are managing reduced working week and covering staffing gaps during a period of financial challenge.	AFC time to Learn, needs to consider the legislation and its definitions in its delivery. Risk of creating separate definitions and not contributing to monitoring compliance and assurance and risk levels. NMAHP representatives on the AFC Time To Learn project board, raising requirements from the Act.
Medical Doctors in Residence	Mandating any of the TURAS resources is difficult across professions, and especially for new doctors as their mandatory Learnpro modules and the induction programme is already very extensive.	Continue to signpost the TURAS HCSSA Learning resources and encourage people to look at then, especially informed. Work with NES & HIS on the planned review of the learning resources, suggest a further cut back basic entry level TURAS, removing some of the detail not that relevant for entry level staff.
All professions	Mandating any of the TURAS resources is difficult across all professions. Only some professions have adopted mandating as part of professionally agreed training, such as Psychology	Consider stipulating completion of informed level and skilled level for staff as appropriate to their role with evidence as we implement SafeCare
All professions	Low TURAS Analytic evidence on completed training - relies on users completing voluntary questionnaire for Informed.	Targets communications from professional leads and in workforce groups to promote learning uptake (including completion of questionnaire) Work with NES & HIS on the planned review of the learning resources, improving way of confirmation of achievement across all levels.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance

Assurance level is improving as implementation actioning is delivered and embedded organisationally, movement to green is dependent on the AFC Protected Learning work ongoing.

12IJ Duty to follow the common staffing method
(*The relevant organisation **must only** report on the types of health care, location and employees as detailed in section 12IK)

Guidance chapter link

Section	Item	Status	Comment
12IJ(1)	Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, to follow the common staffing method no less often than the frequency prescribed in Regulations.	Green	N&M Workforce Governance Sub Group for CSM is established, and links will be maintained with Medical Leads associated with ED Services. The N&M Workforce Group will be the professional group and governance route under business and usual post programme. In the interim have also reported through the HCSSA PB, to ensure oversight of the outputs and the systematic delivery to progress further assurance.

A small dedicated team was established within NMAHP Directorate for the enactment year to support duty 12IJ & 12IL. An annual schedule for delivering the CSM was agreed for all Nursing and Midwifery and Medical professionals in scope, including the ECPT tool run. A programme of support is given for preparation, education, running, reviewing, quality assuring and reporting on each tool run (meeting all aspects of CSM). The 24-25 Staffing Level Tool (SLT) run plan was approved via our Corporate Management Team and is in progress.

Baseline Run of Staffing Level Tool Runs for completed in 23-24 was compiled and submitted to the Executive Nurse Director. Ongoing meetings and further exploration of what the results mean are diarised.   A continuous quality improvement approach is in place.

HIS quality assurance checklist is utilised and recorded to assure that each SLT run is fully quality assured. Access to all available resources is provided to areas including: HIS speciality specific tools, training videos, templates, local training, as well as real time in person support from the Boards small dedicated team. A standardised reporting template is completed after each run which incorporates all aspects of CSM. Each Sector/HCSP is also asked to complete a local report which is presented at each Senior Management Team and submitted to DND to have a final CSM meeting and commission the 24-25 board report due in Spring 2025.

25-26 CSM SLT plans are underway with improved iterations to the CSM reporting template and guidance, a newly approved Standard Operating Procedure is in place, and a communications plan. As the SG provisioned funding for the Health and Care Staffing Programme ends in March 25, we are developing a self-directed learning tool kit which aligns to the HIS toolkits, whilst considering how to resource further support. |
| 12IJ(2)(a) | These systems and processes include use of the relevant speciality specific staffing level tool and professional judgement tool as prescribed in Regulations, and taking into account results from those tools. | Green | All speciality specific staffing level tools are identified and allocated as appropriate within the Board's Staffing Level Tool run schedule. This includes professional judgement and quality tools. The Lead Nurse for Nursing & Midwifery Workforce will work with HIS to ensure all relevant updates and developments are incorporated into the schedule in timely manner with expert support and advice. We also have an internal assurance system to monitor compliance. |
| 12IJ(2)(b) | These systems and processes include taking into account relevant measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H(1) of the 1978 Act by the Scottish Ministers (including any measures developed as part of a national care assurance framework). | Green | As Above.

A range of agreed quality measures are included utilised for completion of triangulation under the our CSM and reporting template. Our existing dashboards facilitate this. inputs into workforce plan(s). Work is underway within the Board to develop a new dashboard with a focus on back in balance and inclusive of all Nursing and Midwifery teams.

There is a person-centred care standard being developed across the board, and currently covers the 5 largest professions and it is applicable to all registrants and HCSWs also. This is part of the Excellence in Care approach and the standard is a deliverable of the Quality Strategy and Implementation plan. (See12IA) |
| 12IJ(2)(c)(i) | These systems and processes include taking into account current staffing levels and any vacancies | Green | The CSM reporting template includes processes that take into account staffing levels and vacancies. Relevant teams use this information when determining their improvement plans, outcomes and risks. |
| 12IJ(2)(c)(ii) | These systems and processes include taking into account the different skills and levels of experience of employees | Green | This is included in standardised reporting template and included in local training consisting of local context including consideration of skill mix and the experience of employees.

From feedback we have included a dedicated skill mix section and breakdown of all bands in the 25-26 CSM reporting template. This displays our continuous improvement journey as we make iterations to our process. |
| 12IJ(2)(c)(iii) | These systems and processes include taking into account the role and professional duties of individuals with lead clinical professional responsibility for the particular type of health care. | Green | Lead professionals with responsibility for successful delivery of the CSM including staffing level tool runs in their locality / services and triangulation activities, CSM triangulation and reporting receive pre tool run preparation support. A standardised reporting template has been implemented and the CSM SOP also includes a roles and responsibility section to support further. |

Ref	Duty description	RAG	Assessment
12IJ(2)(c)(iv)	These systems and processes include taking into account the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care (particularly those to which the common staffing method does not apply).	Yellow	As Above The CSM SOP outlines the requirement and process for local reporting and governance, which includes presentation at local senior management team meetings, submission of local report to DND, final CSM meeting and commissioning of a board report to be taken through corporate governance structures. The delivery of the CSM Board Report to END and Board Governance in Spring 2025 will revise this assessment to Green.
12IJ(2)(c)(v)	These systems and processes include taking into account the local context in which health care is provided.	Green	As Above This is included in the CSM reporting template and included in local training.
12IJ(2)(c)(vi)	These systems and processes include taking into account patient needs.	Green	As Above. Where available this includes review of Care Opinion, complaints, changing acuity, dependency and demand levels etc. The quality measures also allow teams to correlate workforce issues directly with quality and aids in developing an action plan when appropriate for improvement
12IJ(2)(c)(vii)	These systems and processes include taking into account appropriate clinical advice.	Yellow	Included in CSM reporting template and included in local training, focusing on risk assessment & prioritisation, clinical professional advice/ guidance sought where required and noting of decision making. The CSM SOP references the Organisational Level SOP developed for RTS and Risk Escalation (see 12IC/D). The governance of this process and onward reporting within NMAHP directorate and to Medical Directorate for ECPT is in review. Consideration of Clinical Advice is included inherently in the CSM process, also the quarterly assurance process will enable affirmation. The delivery of the CSM Board Report to END and Board Governance in Spring 2025 and the cross reference to quarterly assurance reporting will revise this assessment to Green.
12IJ(2)(c)(viii)	These systems and processes include taking into account any assessment by HIS, and any relevant assessment by any other person, of the quality of health care provided.	Yellow	Included in standardised reporting template and included in local training. All inspection, audits and surveys are included for review within the CSM process and the NHSGGC schedule of Staffing Level Tool runs. This duty is cross covered within quality measures and context elements of triangulation. NHSGGC are currently working through an action from a recent ED HIS inspection to develop a Nursing and Midwifery and Emergency department clinicians report for ECPT. Once available and agreed we will revise this assessment to Green.
12IJ(2)(c)(ix)	These systems and processes include taking into account experience gained from using the real-time staffing and risk escalation arrangements under 12IC, 12ID and 12IE.	Yellow	Included in the CSM reporting template and included in local training, focusing on recurring incident, risk assessment and escalation, assessment & prioritisation. This incudes use of appropriate Datix Incident recording and Risk Escalation, including Severe and recurring Risks. Early analysis from testing suggests there are some real time staffing assessment and processes in use, some electronic, but this is not wide spread or consistently applied in 'Real Time' as described by the Act and supporting guidance. SSTS is used thoroughly through N&M however, this is not always updated real time. eRostering and SafeCare is not available for rollout to all N&M at the point of reporting. See 12IC/D/E and reference to recommendation to roll out SafeCare for RTS and expanding eRostering use for N&M. In the interim the Organisational level RTS and Escalation SOP has been deployed for consistency and robustness of process. This is being reviewed for local implementation aiming for a level of standardisation for huddle templates. We have also recently developed a new Safe to Start which aligns with the guiding principles and the new NHS Scotland RAGG. The NHSGGC Area Partnership Forum has approved and development of HSCP, Acute Inpatient and Adult Outpatient SOP's are underway, with ambition to be agreed and be in live use by end of quarter 4, enabling this assessment to turn green. Testing of Safecare foe RTS & RE and Staffing Level Tools in development is also underway. Other professions are adopting this as part of their local RTS & RE where applicable.
12IJ(2)(c)(x)	These systems and processes include taking into account comments by patients and individuals who have a personal interest in their health care, which relate to the duty imposed by section 12IA.	Yellow	Included in standardised reporting template and included in local training - Quality Measures "patient complaints, patient comments" the Board uses care opinion, local feedback, patient forums to record views of service users and these are utilised in the triangulation of the CSM. Continual review of Care Opinion feedback and evidence of other methods of feedback are considered. The delivery of the CSM Board Report to END and Board Governance in Spring 2025 and the cross reference to quarterly assurance reporting will revise this assessment to Green.
12IJ(2)(c)(xi)	These systems and processes include taking into account comments by employees relating to the duty imposed by section 12IA.	Yellow	Included in standardised reporting template and included in local training as well as in "comments by staff", "iMatter, employee experience". Consultation is also considered through in person team meetings and their outcomes and/ or general annual staff survey results, and feedback during tool runs. The CSM Subgroup are working to standardise staff feedback through a feedback form. When this is finalised and deployed, with returns, this will allow the assessment to move to green.
12IJ(2)(d)	These systems and processes include means to identify and take all reasonable steps to mitigate any risks.	Yellow	Included in standardised reporting template and included in local training under risk assessment and prioritisation - Staff are asked to explain internal reporting, escalation and prioritisation process considering key factors listed: have risks been identified, have identified risks been mitigated, how are risks escalated and to whom, is clinical advice sought. This duty links with the SOPs developed for 12IC/12ID/12IE and 12IF. The CSM SOP describes identification, review, mitigation and recording of severe and recurrent risks related directly with the CSM. The assessment will move to green post testing the recommended process Internal Quarterly Assurance reports and the responses and due diligence regarding 12IC/D/E, as the programme transitions to operational reporting from.

12IJ(2)(e)	These systems and processes include means to decide what changes (if any) are needed to the staffing establishment and the way in which health care is provided as a result of following the common staffing method.	Yellow	Included in the CSM reporting template and included in local training under staff are supported to make their recommendations and next steps considering the factors listed and any others which may be relevant: is redesign or service/roster/skill mix required? Is a workforce plan required? Has professional advice been sought? How are staff consulted and informed during this process? Also considering - Is staffing appropriate to provide safe, high quality care? Does this situation require recommended actions for remedy or escalated if recurring. The CSM SOP outlines local SMT reporting and submission of reports to the Corporate Management team to consider and develop a board report to inform service redesign and workforce planning. The delivery of the CSM Board Report to END and Board Governance in Spring 2025 and the cross reference to quarterly assurance reporting will revise this assessment to Green.
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	Assessment is supported via the dedicated team within NMAHP Directorate. During Enactment reporting will be via the HCSA Programme Board in conjunction with the N&M Workforce Governance CSM Sub Group established, for BAU actioning and reporting with links to Medical for ECPT as appropriate. Post programme this will be monitored via the N&M Workforce Governance CSM Sub Group and via the recommended option for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports (provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation). The monitoring and output will allow this assessment to move to green. The relevant oversight groups (incl workforce planning), have been established where the outcomes of the reports will be considered within the wider context of service delivery inclusive of all relevant professions. The ambition is to ensure all decision making is made with oversight of all professional groups and aspects of service delivery

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, application of the common staffing method in adult inpatient provision identified some areas where the staffing establishment needed to be changed and some areas with potential for service redesign. These changes are now in progression and will be trialled to monitor the outcomes.	This should describe how the success, achievement or learning could be used in the future. For example, following completion of the trials regarding changes in staffing establishment and service redesign, decisions will be taken as the changes made. These could then be used as case studies to inform training for staff about the use of the common staffing method.
Delivery and ongoing enrichment of HCSSA Webpage to engage and support staff and provide information to the wider public	The Board has developed a web page that provides a range of information and resources regarding the Act, access to internal and signpost external resources to support staff for reference to support the Board meet the duties off the Act. https://www.nhsggc.scot/health-care-staffing-scotland-act-2019/ This has specific CSM Case Studies, Posters and resources supported by Vlogs	Further work to promote training resources available across all professional disciplines
Person centred care standard & planning (across professions)	There is a person-centred care standard being developed across the board, and currently covers the 5 largest professions and it is applicable to all registrants and HCSWs also. This is part of the Excellence in Care approach and the standard is a deliverable of the Quality Strategy and Implementation plan. Also included in the Nursing & Midwifery strategy, incorporating the person centred care plan was codesigned with staff and people with lived experience. This is part of the N&M Strategy, and will be delivered via the Digital Clinical Notes project, also the eHealth / Digital Strategy.	Single standard to assist with consistency across services. The Person Centred Standard is also being benchmarked with the National work to develop a core set of person centred measures
Nursing and Midwifery and ED medical	Active participation in National Expert Working Groups on Testing Staffing Level Tools, Testing and feedback on Mental Health and Learning Disability SLT completed	Plans to support further review of SLT's moving to SafeCare from SSTS, resourcing dependant.
Nursing and Midwifery and ED medical	Approval of new Common Staffing Method Standard Operating procedure and implementation of reporting template and guidance. Reports for Acute Inpatient and HSCP for 23/24 test tool runs completed, with good learning	Review SOP in 2 years unless significant National Changes require review sooner.
Nursing and Midwifery and ED medical	N&M HCST SharePoint developed with continual review and publicising of tool kits and new sessional resources	Continual review and update / enhance resources as required
Nursing and Midwifery and ED medical	N&M Workforce Governance CSM Sub Group established, for BAU actioning and reporting with links to Medical for ECPT as appropriate. Utilised to review, agree and embed policies including a governance and escalation process.	The process and onward reporting within NMAHP directorate and to Medical Directorate for ECPT is in review

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action

This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provision and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc.
Nursing and Midwifery and ED medical	Key areas of focus for the Implementation Action Plan (IAP) are as follows: -	Deliver Champions Programme based on a BAU model. Proposal underway for movement to Pre recorded Learning Materials due to resourcing post HCSSA Programme and funding.
Nursing and Midwifery and ED medical	Resourcing post 24-25. While we are looking at innovative and streamlined ways of delivering the Champions Programme, there is a substantial level of co-ordination, advice and support resource requirement for each areas staffing tool run and subsequent reporting collation and submission.	Resourcing post end on non-recurring HCSSA Programme funding underway to support this as a BAU process.
	As we have a triple challenge of sustainability and value, quality and workforce	Considered communication plans, ongoing discussions and deeper dives into CSM outcomes and risks. Focused areas of work. We will require to consider new developments of how deliver our services.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance   *Assurance level is improving as implementation actioning is delivered and embedded organisationally*

Projected Qtr 4 Assessment of Substantial Assurance

12IL Training and consultation of staff
(*The Health Board and Agency **must only** report on the types of healthcare, location and employees as detailed in section 12IK)

Guidance chapter link

Section	Item	Status	Comment
12IL	Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of employees.	Green	A small dedicated team was established within NMAHP Directorate for the enactment year to support duty 12IJ & 12IL. An annual schedule for delivering the CSM was agreed for all Nursing and Midwifery and Medical professionals in scope, including the ECPT tool run. A programme of support is given for preparation, education, running, reviewing, quality assuring and reporting on each tool run (meeting all aspects of CSM). The 24-25 Staffing Level Tool (SLT) run plan was approved via our Corporate Management Team and is in progress. Incorporated TURAS HCSSA training modules into Induction & Essential Learning frameworks, created a specific KSF associated, and improve the champions training Programme. Staff are already encouraged to access HIS learning resources and a review is underway to seek to improve how this is distributed to increase staff engagement and to monitor completion of TURAS resources. Staff consultation/engagement in local tool runs is recorded using a standardised template which will be completed by each area following each tool run. A SOP specific to the CSM has been developed, including a training package that supports HIS' learning resource and is mandatory for all staff in scope. Staff are required to access HIS learning via TURAS resources . Staff consultation/engagement in local tool runs is recorded using a standardised template which is completed by each area following each tool run.
12IL(a)	These systems and processes include means to encourage and support employees to give views on staffing arrangements for the types of health care described in section 12IK.	Green	Staffing Views are collated as part of Staffing Tool Run Process. The review and improvement of the champions programme considers this aspect of the Duty. Consideration on how collated views are taken account of and used in decision making through the newly established CSM Sub Group of the N&M Workforce Group, will further grow confidence that we will be in a position to evidence further and address any GAPS.
12IL(b)	These systems and processes include means for taking into account and using views received to identify best practice and areas for improvement in relation to staffing arrangements.	Green	Staff involvement encouraged and evidenced via standardised reporting template and included in local training. Consultation is acceptable through face to face team meetings and their outcomes and /or via iMatter, employee experience" and feedback during tool runs.
12IL(c)	These systems and processes include training employees (in particular those employees of a type mentioned in section 12IK) who use the common staffing method on how to use it.	Green	As above
12IL(d)	These systems and processes include ensuring that employees who use the common staffing method receive adequate time to use it.	Green	As above. As in 12H, systems and processes are in place to ensure suitable time is allocated via SSTS/local rotas; Regular meetings between senior leaders and team leads; Annual PDP/Appraisal process with 6 monthly reviews.
12IL(e)	These systems and processes include providing information to employees engaged in the types of health care mentioned in section 12IK about its use of the common staffing method, including the results from the staffing level tool and professional judgement tool; the steps taken under 12IJ(2)(b), (c) and (d) and the results of the decisions taken under 12IJ(2)(e).	Yellow	As Above, completion of standardised reporting template following tool run incorporating CSM. Services encouraged to share report with all staff following completion to allow for transparency and staff to be made aware of outcomes. This is a specific step within the preparation and education elements of the Staffing Level Tool run process. All clinical leaders with responsibility for the completion of the CSM are encouraged to hold face to face feedback sessions in keeping with line management role and responsibilities. This includes the Emergency Department staff running the EDEM Tool. The move to Green will be post first Board Report and agreed feedback planned for first quarter of 25-26
N/A	There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Green	The relevant oversight groups (incl workforce planning), have been established where the outcomes of the reports will be considered within the wider context of service delivery inclusive of all relevant professions. The ambition is to ensure all decision making is made with oversight of all professional groups and aspects of service delivery through relevant multidisciplinary workforce planning groups. The CSM Sub Group has also been approved for establishment as a sub group of the N&M Workforce Group, with agreed, defined links to Medical for ED. Post programme this will be monitored via the N&M Workforce Governance CSM Sub Group and via the recommended option for a process of commissioning, collating, assessment post programme closure, to produce the Internal Quarterly Assurance reports (provided to the HCSSA Programme Board and the recommended option will be tested for Quarter 4 reporting. A programme of promotion and awareness is planned for Quarter 4 in preparation).

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action

This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning. For example, key personnel who were very experienced in using the common staffing method were engaged to train and mentor other personnel involved in the process.	This should describe how the success, achievement or learning could be used in the future. For example, those key personnel have now decided to meet regularly in a forum to discuss shared learning and to ensure the common staffing method is used consistently across all relevant areas in the organisation.
Person centred care standard & planning (across professions)	There is a person-centred care standard being developed across the board, and currently covers the 5 largest professions and it is applicable to all registrants and HCSWs also. This is part of the Excellence in Care approach and the standard is a deliverable of the Quality Strategy and Implementation plan. Also included in the Nursing & Midwifery strategy, incorporating the person centred care plan was codesigned with staff and people with lived experience. This is part of the N&M Strategy, and will be delivered via the Digital Clinical Notes project, also the eHealth / Digital Strategy.	Single standard to assist with consistency across services. The Person Centred Standard is also being benchmarked with the National work to develop a core set of person centred measures
Nursing and Midwifery and ED medical	Incorporated TURAS Health & Care Staffing modules into Induction & Essential Learning frameworks.	
Nursing and Midwifery and ED medical	N&M KSF guidance for clinical leaders agreed with support of Learning & Education on how the Act threads through the wider KSF Framework	
Nursing and Midwifery and ED medical	N&M HCST SharePoint developed with continual review and publicising of tool kits and new sessional resources	Continual review and update / enhance resources as required
Nursing and Midwifery and ED medical	N&M Roster Policy has been reviewed and is progressing through governance approval channels	Roster policy reviewed and now progressing through approval process
Nursing and Midwifery and ED medical	N&M Workforce Governance CSM Sub Group established, for BAU actioning and reporting with links to Medical for ECPT as appropriate. Utilised to review, agree and embed policies including a governance and escalation process.	The process and onward reporting within NMAHP directorate and to Medical Directorate for ECPT is in review

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge / Risk	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provision and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc.
Nursing and Midwifery and ED medical	Conduct a staff consultation as part of CSM including reporting. ☐	Work underway to create a feedback form for the 24/25 tool runs.
Nursing and Midwifery and ED medical	Scottish Government funding that has facilitated the small dedicated team to support CSM development and related Training ends Mar2025.	Proposal for 25-26 included in the HCSSA Position and Transition Paper. Awaiting executive review and approval of fixed term Board funding.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance   *Assurance level is improving as implementation actioning is delivered and embedded organisationally*

Projected Qtr 4 Assessment of Substantial Assurance

1 Guiding principles for health and care staffing
2 Guiding principles etc. in health and care staffing and planning

Guidance chapter link

RAG status

Section Item		Status	Comment
2(2)	Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that when the Health Board is planning or securing the provision of health care from another person, it has regard to the guiding principles for health and care staffing and the need for that person from whom the provision is being secured to have appropriate staffing arrangements in place.	Yellow	We have reasonable assurance that systems and processes are now in place to ensure that when the Health Board or a delivery partner is planning or securing the provision of health care from another person or organisation or board, specifications and agreements / contracts have regard to the guiding principles for health and care staffing and describe appropriate staffing arrangements required. We are currently not able to provide the same level of assurance surrounding the Independent Contractor arrangements and remains problematic as it assessed that there are no powers to obtain assurance for Dental Practitioners, Optometrists or General Practitioners. For Independent Pharmacies, the Standard SLA has been updated with reference to the Act.

Please provide information on the steps taken to comply with section 2(2)

These are steps taken to comply with 2(2) in general. Examples could include information about procurement and commissioning processes, how the guiding principles are taking into account and what procedures are in place for obtaining information about staffing arrangements.

NHSGGC acknowledges that as an organisation with our delivery partners, a need to review the legislative requirements to have regard for the Guiding Principles and the need for appropriate staffing arrangements when planning or securing the provision of healthcare from another provider. Scoping work was undertaken to update procedures and processes to ensure specifications give regard to the duties and appropriate staffing when, planning, specifying and agreeing contracts / agreements and that we can evidence compliance.

We grouped the scoping work as follows: -
> Practitioner / Contractor Services
> Commercial Contracts & Agreements, including those for HSCPs
> Board to Board SLAs
> Board to Org contracts or agreements, including HSCPs
We have also as part of our whole system approach contributed to discussion on a broader approach for Care Services - HSCP/LA/CI
□
NHSGGC Procurement and Procurement and Contracting teams Tender Strategy Document and template has been updated to ensure proposed procurements are assessed for requirement to ensure specifications for Healthcare Services cover the Acts guiding principles and appropriate staffing, for healthcare and care services (tendering for new services or re-negotiating current services). Developing a couple of test cases are planned when opportunity allows.

In addition, the board and its delivery partners Planning Leads have been informed about the Act, and its guidance in relation to consideration of specifications being aligned with the guiding principles and appropriate staffing as per the Act when planning or commissioning of new or substantial changes to any services.

We have engaged Board Finance and Service Delivery leads on the current Board to Organisation / Board Service Level Agreements (SLA's) and to ensure everyone involved in developing an SLA or similar agreement ensure along with all other legal obligations, the delivery of the scope of service is clear on the staffing arrangements and gives regard to the Acts guiding principles. NHGGC has led on working with the NHS Central Legal Office on suitable clauses to build into SLAs, which are now available and being adopted for any new, reviewed or changed SLA's. This has been shared Nationally for consistency and in the ethos of a Once for Scotland approach.

Please provide information on how these systems and processes, and their application, have improved outcomes for service users

This should include, but not be limited to data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting.

We are not yet in a position to be able to answer this as changes made are too early for any impact assessment and this is not a retrospective activity. All specification for services and therefore subsequent delivery should underpin the themes as per the refreshed Boards Quality Strategy, ensuring the quality of care is at the heart of service delivery by whomever provides it.
□

Areas of success, achievement or learning

Please provide details of areas of success, achievement or learning associated with carrying out the requirements.

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement or learning.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in recruiting in a particular specialty or remote / rural location, the relevant organisation may have investigated retire and return schemes or upskilling and career development for existing staff. It may also have looked at how the service could be redesigned.
Board to Board SLA's	NHSGGC has been the lead board for the National HCSSA Workforce Leads Collaborative in progressing a generic clause for Board to Board SLA agreements working with CLO. NHSGGC have adopted the generic clause in all new or revised/ changes SLA's. Delivered targeted communication with Heads of Planning and Finance who work collaboratively with Service commissioners.	Tracking that the SLA's that NHSGGC Commissions have been updated with new clause covering HCSSA until complete
Commercial Contracts & Agreements	NHSGGC Procurement department have updated their Tender Strategy Document to ensure that any new tenders, including mini competitions in frameworks for services that involve healthcare services or care services that deliver via staffing roles in scope of the act, have suitable specification on appropriate staffing, has regard to the guiding principles to allow resultant responses and contracts to provide suitable assurance.

The update to the tender Strategy Document and cascade and application, will put checks and processes in place to ensure specifications are clear and identify what is required or that service and enable delivery to give assurance of compliance with the Act. In addition, the identified process will be included in contract review and extensions.

We are identifying a test case tender to use as a case study for learning. At the point of writing this report, there had not been any new agreements out with existing frameworks

A proposal on preparing standardised generic terms for tenders in relation to the Act were discounted, with a preference to ensuring a process where tenders for HealthCare Services ensure that individual specifications are developed to comply with the Act, and its guiding principles clearly defining related staffing arrangements required for delivery of the service, including how the board is notified of any risk or issue in carrying out the service. | Working with National Procurement on National Frameworks to ensure more of a consistent approach under Once for Scotland ambition has been suggested in National forum with NSS. Head of Procurement will engage with NSS and the CLO as necessary to review any proposed tender related terms that will propagate terms and conditions, along with specifications. |
| HSCPs Healthcare contracts or agreements | A review of a Hospice provider agreement has been concluded and a test case template produced that includes some clauses that reflect the guiding principles of the Act and appropriate staffing arrangements, and the specification has been reviewed to ensure this also complies with the Act. This could also cover requirement for a Care service being introduced (an agreement that covers both healthcare and care service) | The Test Case has been shared with the Boards HSCP delivery partners HSCP's and can be shared with other Hospice providers to consider similar updates to agreements on dates of review or renewal. This will also be shared with National HCSSA Workforce Leads (anonymised). |
| Practitioner / Contractor Services

Pharmacy | The Service Level Agreement that Pharmacy Services uses for Independent Pharmacies has been updated with a Clause in relation to the Act and its Guiding Principles. This will be the version used for any new Pharmacies onboarded or for any existing where the arrangements are reviewed or renewed. | |

Areas of escalation, challenges or risks

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / Challenge /	Details	Action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may have been difficulties in planning or securing services from in a particular specialty in relation to having regard to the need for that service to have appropriate staffing arrangements in place.	This should describe what actions have been / are being / will be taken to address the situation. For example, engaging with service providers to ensure they understand what information is required, seeking alternative service providers etc.

Practitioner / Contractor Services Dental Practitioners	Section 1 of the 2019 Act sets out a series of guiding principles to be followed when certain bodies deliver health and care services. Section 2(2) of the 2019 Act provides:- 'In planning or securing the provision of health care from another person under a contract, agreement or arrangements made under or by virtue of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to— (a) the guiding principles for health and care staffing, and (b) the need for the person from whom the provision of health care is to be secured to have appropriate staffing arrangements in place.' The effect of section 2(2) is that when a Health Board engages independent GPs, dental practitioners, opticians and pharmacists to deliver services on its behalf it must take account of the guiding principles, and it must ensure that these independent contractors have appropriate staffing arrangements in place while delivering health services on behalf of the NHS. SG has issued guidance to assist with implementation of the 2019 Act where independent contractors are concerned: Quick Guides relating to the Act | Turas | Learn (nhs.scot). In relation to dental practitioners, the guidance includes the following paragraph:- 'Individual dentists apply to be on a Health Board's Dental List for the provision of general dental services (GDS). It is anticipated that the requirements on Health Boards to have regard to the guiding principles for health and care staffing and the need for any third party – such as an independent dental contractor – to have appropriate staffing arrangements in place, would be included in the application process; however it is for each Health Board to decide how to fulfil their statutory obligations.' GGC have sought council from CLO as to (i) whether the powers set out in the NHS (General Dental Services) (Scotland) Regulations 2010 ('the 2010 Regulations') give a Health Board the power to require dental practitioners to provide staffing information when they apply to be listed; (ii) whether there are any other powers available to a Board to impose such a requirement; and (iii) whether, in any event, the nature of dental practices make it practical to engage with applicants to dental lists about matters of staffing. In response, CLO view is the Act and its associated guidance cannot readily be implemented so far as independent dental practitioners are concerned, and to refer this concern to SG for further guidance, which has been done. NHSGGC await response from SG at the point of drafting this report.	Referred back to SG, awaiting response. This could require a change to regulation or legislation.
Practitioner / Contractor Services Dispensing Opticians	We may have a similar issue with Dispensing Opticians as with Dental and once we resolve the above we will look more closely with the SG Policy area	Awaiting update using GDP as example, to further consider
Practitioner / Contractor Services General Practice	Currently we have no specific actions in regards to GP's but conversation continue with Local and SG Practitioner Services. The Risk is we may have action that is yet not identified or as with Dental and Opticians, we would have difficulty implementing	Awaiting update using GDP as example, to further consider
Board to Organisation Agreements	Currently reviewing any other agreements the Board may have that are with the third sector and not via commercial routes, such as epilepsy services	Ongoing as identified - Introduce suitable references in the agreement relating the Act and its Guiding Principles.

Declaration: The relevant organisation has systems and processes in place to meet the requirements of this duty, and has carried out this duty through the presence and use of appropriate systems and processes as detailed above.

Level of Assurance: Please indicate level of assurance provided

Reasonable Assurance   *Assurance level is improving as implementation actioning is delivered and embedded organisationally*

Projected Qtr 4 Assessment of Substantial Assurance