NHS Greater Glasgow and Clyde
Real Time Staffing and Risk Escalation
Standard Operating Procedure

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Purpose

This Standard Operating Procedure (SOP) supports NHSGGC to fulfill the duties of the Health and Care (Staffing) (Scotland) Act 2019 (HCSSA), enacted in April 2024. The main duties this SOP relates to are:

- 12IC: Duty to have real-time staffing assessment in place
- 12ID: Duty to have risk escalation process in place
- 12IE: Duty to have arrangements to address severe and recurrent risks
- 12IF: Duty to Seek Clinical Advice on Staffing

These duties are required to be in place and maintained to ensure appropriate staffing for:

- The health, wellbeing and safety of people in our services
- The provision of safe and high-quality health care
- In so far as it affects either of those matters, the wellbeing of staff

NHSGGC must demonstrate that these processes:

- Are embedded in practice
- Inform staffing discussions
- Inform staffing decisions
- Support the short and long-term provision of appropriate staffing

How these duties have been carried out must be reported on a quarterly basis, by senior and corporate management teams to the NHS Greater Glasgow and Clyde (NHSGGC) board and be included in an annual report to Scottish Ministers under section 12IM Reporting on Staffing.

Scope

The duties contained in this SOP apply to all named professions covered in the Act. A comprehensive list can be found here: Roles in scope of the Act - Health and Care (Staffing) (Scotland) Act 2019: overview - gov.scot (www.gov.scot). This list is a living document which can incorporate new professions/roles over time as appropriate. A high-level list is provided in **Appendix 1**.

This SOP is designed to be used by clinical leaders and management teams.

Background

This SOP supports NHSGGC to have robust arrangements in place to ensure appropriate staffing and high-quality care in the daily running of services. This requires real-time assessment through identification, escalation and mitigation of risks caused by staffing concerns which are below that required to provide safe, effective person-centered care.

Risk is an inevitable part of all healthcare services but must be mitigated as far as possible to enable safe and high-quality services.

Real Time Staffing (RTS) processes should also provide a consistent means of recording the escalations and mitigations of any staffing risk.

The NHSGGC Health and Care Staffing team completed multi professional testing of the noted duties in the Act, with the outcomes presented in an SBAR, supporting processes, policies and reports added to an evidence bank and required actions for improvement displayed in a driver diagram. This led to an RTS and Risk Escalation Short Life Working Group (SLWG) which explored various RTS options. The preferred option of the SLWG is a system named SafeCare. This will take time to approve, plan and implement therefore this SOP will describe what to do in the interim period.

Testing found that most teams have an RTS process, so management teams must review and update their local SOPs to align with this overarching SOP.

Education / Training

Essential Learning

These modules must be completed as a once only (or if significantly updated).

Roles in Scope of the Act: Learning resources : Informed level | Turas | Learn (nhs.scot)

Leadership roles: Learning resources : Skilled level | Turas | Learn (nhs.scot)

Local Learning

Management teams are responsible for ensuring local teams receive education on local RTS and Risk Escalation process.

Definitions / Roles and Responsibilities

All staff named in the Act

All staff named in the Act are responsible for escalating staffing concerns to a Lead Professional (LP) in real time, at the earliest opportunity and follow locally agreed processes.

Management teams require to include this in their SOPs.

Patients, families and Carers

A patient, family or carer can also raise a voiced concern to an LP.

Management teams require to include this in their SOPs.

Who is the Lead Professional

Duties 12IC and 12ID require people with LP responsibility (clinical or non-clinical) to have specific responsibilities for the mitigation and escalation of staffing risks identified by members of staff or patient/family/carers. An LP is someone with a leadership role in a particular setting in relation to staffing.

Who LPs are is dependent on the local context in which the service is operating and on professional and clinical governance structures. LPs should be of sufficient seniority. Different sections of the Act describe different types of leadership relevant to the duties in the legislation:

- 12IC duty to have RTS in place and 12ID duty to have risk escalation process in place – “individual with lead professional responsibility (whether clinical or non-clinical)”;
- 12IH duty to ensure adequate time given to clinical leaders – “individual with lead clinical professional responsibility for a team of staff”. This individual must be a clinician
- 12IF duty to seek clinical advice on staffing and section 12IJ duty to follow the common staffing method – “individual with lead clinical professional responsibility for the particular type of health care”. This individual must also be a clinician.

The term clinician is used in its most general sense and covers all professionally regulated colleagues including those without a patient facing role. There may be times when these leaders may be the same individual; however, this is not always the case.

Appendix 2 provides examples of who an LP may be in practice and how they can be identified. Management teams must define who the LPs are within their

services/SOPs. An LP must be available and identifiable on each shift including out of hours, for example, the person in charge.

Who can provide appropriate clinical advice

LPs involved in staffing risk mitigations, and more senior decision-makers reaching a decision on risk, must "seek and have regard to appropriate clinical advice". This is required when the LP or more senior decision-maker:

- is not a clinician
- is assessing risk, or making a decision, in relation to a clinical workforce for which they are not professionally responsible
  and/or
- is making a decision in a specialty/setting in which they are not an expert and/or do not normally work.

Clinical advice is appropriate when it is relevant to the identified risk and is provided by a person with clinical expertise in the relevant clinical area and responsibility for the clinical workforce engaged in the risk. Clinical advice may need to be obtained from more than one person. The LP/more senior decision-maker must consider this advice and, when it conflicts, should use their professional judgement to decide to mitigate, escalate or accept the risk(s). For escalated risks, the person providing clinical advice may record disagreement with the decision and request a review from any decision-maker up to, but not including members of the NHSGGC board.

Management Teams must include appropriate clinical advice processes within local SOPS/flow diagrams to ensure clarity regarding roles and responsibilities.

Who is a "more senior decision-maker"

A more senior decision-maker is someone who receives risk escalations from an LP. Senior decision-makers can keep escalating risks to more senior decision-makers up to the level of the NHSGGC board. Who is a more senior decision-maker is dependent on the local context of a service and on the professional and clinical governance structures in place. A senior decision maker must have sufficient seniority and an agreed understanding within the organisation, supported by NHSGGCs arrangements, of their authority to act to mitigate identified risk(s).

LPs and senior decision makers require to assess how far through the professional or management structure to escalate a risk, at each step, depending on the severity and/or repeated nature of the identified risk and, at times (e.g. out of hours), the availability of staff.

Examples of who this may be in practice are given in Appendix 2. Management teams must define who the LPs are within their services/SOPs.

What are Severe and Recurrent Risks

Severe and recurrent risks are not defined within the Act, the following definition has been adopted by NHSGGC.

A risk is an uncertain event which can have an impact on an organisation's ability to achieve its objectives. To prevent the risk from occurring controls and mitigation actions are required to manage the risks. Some examples of staffing risks can be found in **Appendix 2**.

An incident is any event or circumstance that led to unintended or unexpected harm, loss or damage. A near miss is as a result of chance or intervention, the outcome could have led to harm but on this occasion it did not. Some examples of staffing incidents can be found in **Appendix 2**.

A severe and recurrent risk is defined as a situation in an area where there is a trend in number of incidents (impact severity level of 3-5 as defined in the NHSGGC Risk Management Policy) or near misses that have occurred that directly relate to staffing. These near-miss events without the intervention of management could have resulted in a risk of harm to patients and staff.

Datix

Datix is the NHSGGC System used to record incidents and risks. Incidents and risks are recorded within two separate modules located within Datix. For this SOP any incident that has occurred should be reported in the Incident Module within Datix. Risks should be managed within the Risk Module. GGC-Datix - Home (sharepoint.com)

Management teams must include the use of the Datix Incident module and reporting process within their SOPs.

Real Time Staffing Process

This SOP must not replace Sector/Health and Social Care Partnerships (HSCPs) SOPs and should complement and provide guidance and consistency. All Sectors/HSCPs must review their SOPs to ensure they align with this SOP and the Act. If areas do not have SOPs in place they must be developed.

Appendix 3 provides a Risk Escalation flow diagram to support the development of Sector/HSCP flow diagrams.

Staffing concerns and voiced care concerns can be raised at any point during a working period therefore escalation SOPS/flow diagrams must include in and out of hours process.

Real Time Staffing Assessment

Management teams are required to consider within their SOPs what factors in **Appendix 4** are appropriate for their areas of practice when assessing actual and potential staffing concerns.

Actual staffing concerns are immediate on the day, Example provided in **Appendix 2.**

Potential staffing concerns are the future shift, issues identified within the week, month or longer term. Example provided in **Appendix 2,**

These factors support the consideration of thresholds for risks being identified as severe or recurrent. Where the LP/senior decision maker is not a clinician and/or where decisions are being made in relation to a workforce that the LP/ senior decision-maker is not professionally responsible, they must seek and have regard to clinical advice from an appropriate person.

To support the assessment of RTS management teams require to use the national RAGG classification in their SOPs. Appendix 5.

Risk Mitigation

Appendix 6 sets out what management teams are required to consider as appropriate for their areas of practice when mitigating risk.

Where the LP/senior decision maker is not a clinician and/or where decisions are being made in relation to a workforce that the LP/senior decision-maker is not professionally responsible, they must seek and have regard to clinical advice from an appropriate person.

LPs/senior decision makers must notify the individual who originally escalated the staffing concern of any decisions, reasons and any required actions. LPs must have consideration for mitigations that may affect the wellbeing of staff and must follow NHSGGCs Health and Wellbeing - NHSGGC **guidance. This must be included in local SOPs/flow diagrams.**

Disagreements

Disagreements relate to any staff involved in relation to the real-time staffing assessment or risk escalation in:

- Identifying a risk
- Attempting to mitigate a risk
- Giving clinical advice in relation to mitigation of risk
- Reporting a risk (including onward reporting)
- Giving clinical advice on a risk

Management teams must have arrangements in place for staff to be notified of every decision made and the reasons for it. Where staff disagree with a decision, they may record it and may choose to request a review of the decision. An exclusion from this is where the final decision has been made by the members of the NHSGGC board: these decisions may not be reviewed at the request of individual staff.

Management teams should set out how staff can record disagreements and formally request a review within their SOPs. It is also good practice to review the numbers and reasons for formal disagreements as part of governance arrangements.

Datix Incident Reporting

Reporting on the Datix Incident Module does not replace local escalation, mitigation and recording processes and instead must be used as a retrospective recording tool.

The DATIX Incident Module will be used to report near misses or incidents in relation to staffing concerns. A DATIX incident should be created for every near miss or incident (event) that occurs. The Datix Incident module enables incidents with or without injury to be reported. Incidents must be reported by the LP who made the assessment and escalated, however anyone named in the Act can submit a Datix Incident. The escalations and mitigations taken should be recorded within the incident report. Actions required to prevent a recurrence should be clearly noted against the incident by the reviewer. Incident-management-policy-hs.pdf

No Harm Incidents

All staffing incidents and voiced care concerns by patients, families or carers must be recorded on the Datix Incident Module in relation to potential or actual patient or staff

safety risks, regardless of whether harm/injury occurred. In this circumstance CHI numbers should not be used.

Incidents with Harm

For incidents where a patient or staff member is harmed, and a staffing incident is a contributory factor it must be logged on to the Datix Incident Module separately using the patient's CHI number or staff details. This must be included in the description of the incident. The reviewer can then use the contributory factors field to formally record this.

An individual who provided clinical advice to a decision-maker can be listed in the "Investigators" field if they have a Datix account and will receive updates if this is done; and the original reporter can tick a box to receive feedback once a resolution is reached.

Datix incident reports must be created as soon as reasonably practical.

Local Records

Management teams and local areas are also required to hold local records.
This SOP is not prescriptive regarding how this is captured, **Appendix 2 provides examples** (General Data Protection Regulations must be followed). The minimum Items that must be recorded are:

- National RAGG Status
- Escalations
- Mitigations (Clinical advice provided)
- Staff notification
- Disagreements

SSTS

If SSTS is used by your profession, the borrow function must be used when staff are redeployed to allow reporting. SSTS Interactive Rostering

Reporting

Click on the borrow icon  to create a borrow within SSTS.

You can then run a SSTS BOXI report to identify the borrow ins and the borrow outs.

In SSTS BOXI Manager folder -SCN/Midwife Folder – General.

Report name

1t – Borrowed In hours – by date range select location length of shift

or

1v – Borrowed out hours – by date range select location length of shift

To apply for a Boxi account please see: GGC-Scottish Standard Time System (SSTS) - Home (sharepoint.com)

Staffing Discussion/Huddle/Staffing Meetings

The frequency of discussions/huddle/staffing meetings must be determined locally within SOPs, however, must be held as a minimum at least once per day.

Pre Team discussion/huddle/staffing Meeting

It is recommended that LPs within their own teams have a pre-staffing discussion/ huddle/staffing meeting before the wider team discussion/huddle/staffing meetings. At this stage assessment, escalation, mitigations and disagreements can be explored and may be resolved. Issues that can't be mitigated or unresolved disagreements will be fed into the team discussion/huddle/staffing meeting via telephone, email or shared templates. Local team records must be kept.

Discussion/Huddle/Staffing Meeting

Responsible>Accountable>Consulted>Informed

- Meetings can be in person, via Microsoft Teams, telephone, or through email discussion
- Agenda items and attendees will be determined by the area and local context
- This may be a site/HSCP wide discussion/huddle/staffing meeting. A multidisciplinary approach and joint recording are recommended
- The LP is tasked with completing all the elements of this SOP.
- The meeting must be led by senior decision makers alongside LP representatives
- The information from the pre team discussions/huddle/staffing meetings will be explored in terms of mitigations, disagreements and further escalations to more senior decision makers
- LP representatives and senior decision makers must notify teams regarding the outcomes and any required actions

Considerations:

- IT/Screens/network
- Compliance reporting (for areas that have not completed their staffing information call and ask to complete)
- Information sharing
- Escalation/mitigation/where do unresolved issues go
- Data assurance
- Discussion/Huddle/meeting periods
- Weekends/public holidays/out of hours
- Staff engagement/notification process
- Record keeping

Severe and Recurrent Risk

To identify areas of Severe and Recurrent Risk, NHSGGC Senior Managers shall review staffing Datix incident reports, SSTS (where appropriate) and locally held records monthly to identify severe risks and whether there is a trend of incidents/near misses related to staffing within their area. Each Sector/HSCP will be assigned a Safe Staffing Risk within the Datix Risk Module. Until this work is completed continue to use your current risk recording process. This risk should be managed within the Sector/HSCP and reviewed on a monthly basis, ensuring that the Risk Score (Impact and Likelihood) reflects the events that have occurred within the area.

Each month the Senior Management Team should review the incidents in the previous month and use this data to inform the likelihood and impact of the staffing risk occurring. The controls in place should be reviewed and actions identified to prevent a recurrence. Each action should have an owner and due date. This information should be reviewed in line with the guidance detailed in **Appendix 4**. The Risks should be discussed at each monthly Senior Managment Team meeting. Where there are increased risk levels, discussion should be held to ensure appropriate actions have been identified. The Risk Register Policy and Guidance for Managers must be used to systematically identify, analyse, evaluate and manage RTS risks consistently and at an appropriate level. Risks are assessed on impact and likelihood using a 5x5 impact matrix as noted in the Policy.

Normally risks would be escalated to another level where they require further management. However, the Safe Staffing Risk should remain at the Sector/HSCP level to provide visibility of Staffing Risks across each Sector/HSCP. Should any actions require to be taken to manage this risk further at a higher level, these actions should be

discussed at Senior Management Team meetings as noted above and actions identified in the Action Management Section, with clear action owners and timescales. To provide visibility of Safe Staffing Severe and Recurrent Risks across NHSGGC the Safe Staffing Risks will be reviewed by the relevant members of the senior management and corporate team on a quarterly basis.

Senior Management teams must provide a quarterly report on their Staffing Risk which includes the current risk score and changes over the last quarter. This should include details of the mitigating actions planned to inform the quarterly board report. The GGC Risk Management Strategy details the Risk Hierarchy in place for the escalation of Risks. For example, Risks escalated from Sector Director would be escalated to corporate director.

Appendix 7 provides a useful checklist for senior managers to use when reviewing current SOPs, processes.

Appendices

Appendix 1: Professions within Scope

This list is not exhaustive

- Allied Health Professions (AHP) (All HCPC registrants, all bands, working in all areas)
- Anaesthetics
- Dental
- Health Care scientists
- Assistant practitioners, associate practitioners, healthcare support workers, maternity care assistants and medical laboratory assistants
- Medical
- Nursing and Midwifery
- Operating Department Practitioner
- Optometry
- Pharmacy
- Public Health roles (not covered elsewhere in the list)
- Psychology
- Registered Chaplains

Appendix 2 Frequently Asked Questions

Question. 1

Which Staff groups are Lead Professionals?

Answer.

This list is not exhaustive:

- Senior charge nurse or team leader of a nursing team
- Charge nurse
- Nurse in charge
- Consultant in charge of a medical team or delegated individual in charge for the day
- AHP team leader or delegated deputy
- Operational / general manager of a team or service
- Team leader of a multi-disciplinary team

Question 2.

How can Lead Professionals be identified?

Answer.

Some examples of this are:

- Person in charge badge
- Wearing the appropriate uniform
- Identified on Safety Brief
- Identified on Roster
- Communicated as the responsible LP to the team

Question 3.

Which staff groups are more senior decision makers?

Answer.

This list is not exhaustive

- Lead nurse
- Associate chief nurse/ Professional nurse lead/chief nurse
- Chief midwife or director of midwifery
- Deputy nurse director/executive nurse director
- Clinical director
- Associate chief AHP/Professional AHP lead/chief AHP/AHP director

- Service manager or a general manager in either a hospital or community setting
- Chief operating officer of a hospital or community team

Question 4.

What is an example of an actual staffing assessment concern?

Answer.

E.g.

An immediate skill mix issue.

Question 5.

What is an example of a potential staffing assessment concern?

Answer.

E.g.

The following shift is short a member of staff.

Question 6.

What is an example of a staffing Risk?

Answer.

E.g.

Working in a service area with less than minimum staffing numbers as per local agreements, that without mitigation/action could have resulted in an incident occurring.

Question 7.

What is an example of a staffing incident?

Answer.

E.g.

A staffing event that occurred due to staffing levels/skill mix that even through mitigation resulted in harm. e.g. a fall with staffing recorded as a contributory factor.

E.g.

If an adverse event or near miss has occurred regardless of harm and staffing being a contributory factor.

E.g.

An area has escalated staffing concerns. e.g. Staffing numbers are short.

E.g.

A member of staff was unable to take their allocated break, which impacted on their wellbeing.

Question 8.

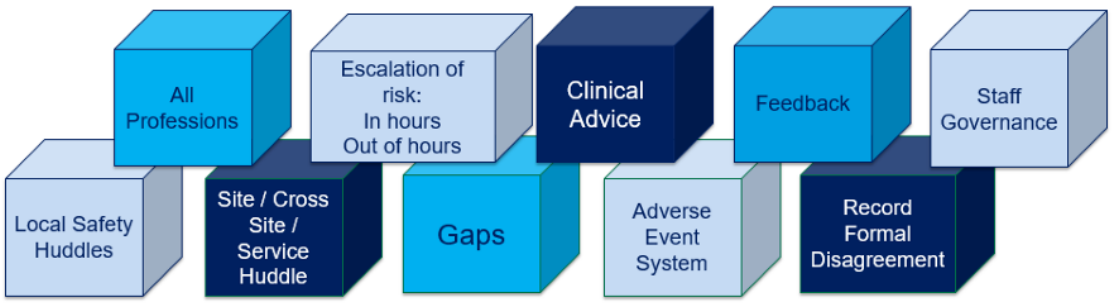
What can I use for local record keeping?

Answer.

This list is not exhaustive

- Locally held Safety Briefs
- Excel huddle/staff meeting templates
- Word
- Email

Appendix 3 Flow Diagram – Health Care Improvement Scotland



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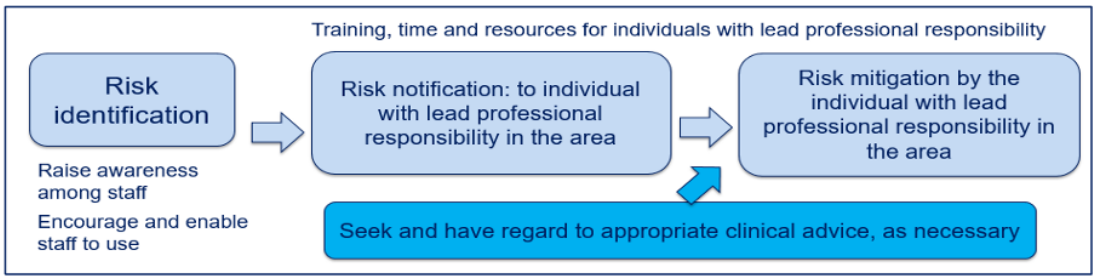

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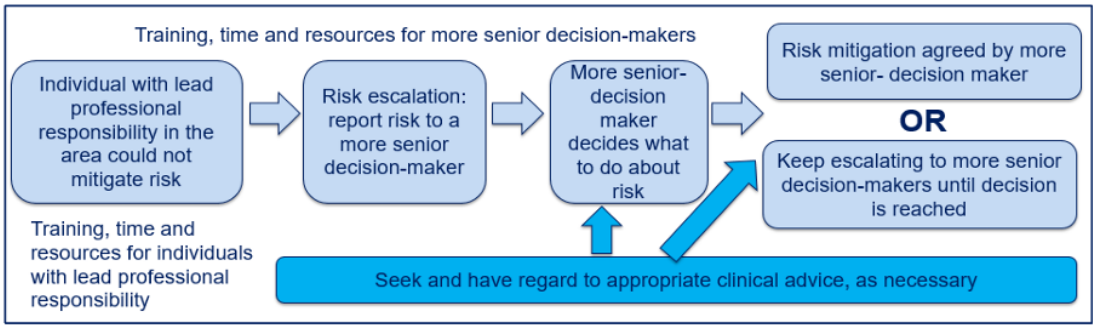

3.

HIS HSP Diagram

Appendix 4 Assessment

When assessing actual or potential staffing concerns, the NHSGGC should take account of, but not limit their consideration to, the following factors:

Workforce:

- Staffing numbers assessment
- Identify and plan for known roster gaps
- Assessment of skills and experience of staff on duty including capacity and capability of staff to undertake role e.g. restricted duties, mental and physical wellbeing of staff
- Consider appropriate roster management
- Consider the impact of supplementary staffing
- Location of staff on duty e.g. in community geographical spread of visit
- Consider appropriate use of on-call staff in the workplace
- Consider impact of staffing deficits across the MDT e.g. AHP or medical support available in a ward, or support available for clinicians to perform clinical interventions or procedures
- Consider staff regulatory requirements
- Ability to fulfil time to lead requirements (linked to the time to lead SOP).

Workload and Capacity

- The number, dependency, acuity and complexity of patient/service users who require care
- Staff workload across sectors, where services are delivered across acute and primary care services e.g. maternity services, or the impact on community nursing or AHP workload to support earlier discharge from hospital
- Any specific clinical issues which increase staffing requirements, including, but not limited to, infection, pandemic, specialist clinical interventions, high level of child protection cases, winter pressures, enhanced observation requirements for service users, number of patients with cognitive impairment, high levels of discharge from acute to primary care settings, high levels of palliative care patients/service users in the community
- Escorting or transfer requirements
- Cross cover arrangements for other clinical areas and sites
- Unplanned staff leave or absence impact
- Supplementary staffing

- The location and spread of the service user group in the community and the impact of this on staff travel time
- Skills deficits

Environmental concerns

- Infection control restrictions
- Consider the impact of any equipment / systems failures / availability
- The physical environment e.g. single rooms / temporary wards etc.
- Workplace disruption e.g. planned building works or emergency repairs
- Travel disruption e.g. weather, roadworks
- Consider staff caring responsibilities e.g. impact of school or day centre closures or reduced social care due to adverse weather etc.

Nationally agreed staffing considerations

- Business continuity
- High Risk to appropriate staffing in the future
- Missed care or service delivery
- Skill mix
- Staff wellbeing
- Voiced Care concern

Appendix 5 National RAGG Classification

Red	Over utilisation safe and appropriate staffing is compromised. Potential of missed care and /or high risk to service delivery. Cannot assist with shortages and action required.
Amber	Over-utilisation potential for safe and appropriate staffing to be compromised. Potential of missed care and /or moderate risk to service delivery
Grey	Acceptable utilisation safe and appropriate staffing. Are working within recommended parameters and do not need any additional staffing hours. Potential to be able to assist with shortages.
Green	Under utilisation safe and appropriate staffing. There are excess staffing hours and the potential to assist with shortages.

Appendix 6 Mitigations

When mitigating actual or potential risks arising, NHSGGC could consider, but not limit their consideration to, the following factors:

Immediate (on the day) including out of hours and weekends:

- Requirement for staff redeployment between clinical areas, considering the need to ensure redeployed staff have the appropriate skills and knowledge in the area they are being moved to
- The use of supplementary bank staffing
- The use of agency staffing
- Any need for reduction in clinical activity (elective activity/planned community visits)
- Any need to transfer clinical activity (emergency admission divert/divert activity to different teams in the community or different acute sites)
- The prioritisation of clinical workload (e.g. prioritising admission avoidance/ supported discharge/palliative care and child protection activity)
- The acceptance of all or part of the risk(s)
- Time to lead suspended to provide support to clinical workload
- Overtime/excess hours
- Training suspended to provide support to clinical workload
- Nonclinical activity suspended to provide support to clinical workload

Short term (approximate timescale of 1 week):

- Any known short-term absence beyond immediate

- Any known increased patient/service user dependency
- The need to redeploy staff with appropriate skills and knowledge for a period where risk is known to be sustained for a few days
- Any environmental factors identified during the assessment are thought to be short-term e.g. bad weather or equipment/system failures that can be corrected quickly.

Medium term (approximate timescale of 1 month)

- Any medium-term absence
- The need to redeploy staff to meet skills mix deficit
- Any environmental factors
- Roster management to ensure most appropriate rostering in place in a timely manner

Long term (more than 1 month):

- Any long-term absence e.g. maternity leave/long term sickness/absence
- The need for a review of staffing establishment to ensure planned staffing is appropriate in the long-term following the section 12IJ duty to follow the common staffing method for those areas where it applies
- The need to plan for long-term solutions to trends in risks identified
- Review service delivery models or patient pathways to reduce risk, e.g. virtual consultation
- Roster management to ensure most appropriate rostering in place in a timely manner

Appendix 7 Checklist

No	Requirement	Yes/No	If no what actions are required?
1.	Is education and training in place at informed level for all roles in the Act?		
2.	Is education and training in place at skilled level for leadership roles?		
3.	Is local education and training in place?		
4.	Is Datix incident reporting process within your SOP?		
5.	Are staffing concerns and voiced care concerns escalation processes in your SOP for in and out of hours?		
6.	Are Staff Wellbeing considerations included in your SOP?		
7.	Are LPs and senior decision makers clearly defined and identifiable in your SOP?		
8.	Are appropriate clinical advice processes included within your local SOP to ensure clarity regarding roles and responsibilities?		
9.	Does your SOP include LPs/senior decision makers notification to the individual who originally escalated the staffing concern?		
10.	Are the factors for assessing actual and potential staffing concerns in your SOP?		
11.	Are the appropriate mitigations included within the SOP?		
12.	Does your SOP set out how staff can record disagreements and formally request a review?		
13.	Are local records held and include the minimum requirements?		
14.	Are LPs recording redeployment (borrowing) on SSTS?		
15.	Are pre team discussion/huddle/staffing meetings in place and recorded?		
16.	Are team discussion/huddle/staffing meetings in place and recorded?		
17.	Are you using Datix reports, SSTS reports and local records to systematically identify, analyse,		

	evaluate and manage RTS severe and recurrent risks consistently and at an appropriate level?		

Useful Resources

GGC-Datix - Home (sharepoint.com)

GGC-Scottish Standard Time System (SSTS) - Home (sharepoint.com)

Healthcare Staffing Programme – Healthcare Improvement Scotland

Health and Care Staffing in Scotland | Turas | Learn (nhs.scot)

Health and Care (Staffing) (Scotland) Act 2019: statutory guidance - gov.scot (www.gov.scot)

Quick Guides relating to the Act | Turas | Learn (nhs.scot)