Agenda Item 9

NHS Highland

Meeting:	**Board Meeting**
Meeting date:	**24 September 2024**
Title:	**Health & Care Staffing Act (2019) Internal Quarterly Report**
Responsible Executive/Non-Executive:	**Gareth Adkins, Director of People & Culture**
Report Author:	**Brydie J Thatcher, HCSA Implementation Programme Manager**

1 Purpose

This is presented to the Board for:

- Assurance

This report relates to a:

- **Annual Operation Plan:**
  Right Workforce to Deliver Care – Commence implementation of the Health and care (Staffing) (Scotland) Act across relevant areas of the workforce
- **Government policy/directive**:
  Health and Care (Staffing) (Scotland) Act 2019)
- **Legal requirement**:
  Health and Care (Staffing) (Scotland) Act 2019)

This report will align to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

This report relates to the following Strategic Outcome(s)

Start Well		Thrive Well		Stay Well	X	Anchor Well	
Grow Well	X	Listen Well	X	Nurture Well	X	Plan Well	X
Care Well		Live Well		Respond Well	X	Treat Well	X
Journey Well		Age Well		End Well		Value Well	X
Perform well	X	Progress well	X				

2 Report summary

2.1 Situation

The Health and Care (Staffing) (Scotland) Act 2019 (hereafter known as the "Act")
Requires:

Quarterly compliance reporting to the Board by the individuals with lead clinical professional responsibility for a particular type of health care (known as "Board level clinicians")

The Board is being asked to: review the SBAR and appendix for the purpose of assurance.

2.2 Background

The aim of the Act (Health and Care (Staffing) (Scotland) Act 2019) is to provide a statutory basis for the provision of appropriate staffing in health and care services and is applicable to approximately 12,700 staff across all functions of NHS Highland. While many of the Act requirements (Appendix 1) are not new concepts, they must now be applied consistently within all Roles in Scope with an intent to:

- Enable safe, high-quality care and improved outcomes for people
- Support the health, well-being and safety of patients and the well-being of staff

Underpinning all duties and responsibilities placed on NHS HIghland when considering staffing within health care is the application of the guiding principles (Appendix 2); it is beneficial to highlight that no one factor is more important than another.

The Act's accompanying Statutory Guidance describes the internal quarterly reporting requirements as:

- Quarterly (minimum) reports by Board Level Clinical Leaders (Executive Directors of Medicine and Nursing) to members of the Board on their individual views of compliance of the relevant roles in scope under their leadership against all Act requirements to ensure appropriate staffing. Appendix 3 details the information required within these reports of which the Board must take regard.

HIS have duties under the Act to monitor compliance and Scottish Ministers have existing powers under the National Health Service (Scotland) Act 1978 regarding the failure of organisations to carry out their functions. However, it is important to note that the aims of the Act are not about a binary assessment of compliance / non-compliance or pass / fail but rather about identifying risks and addressing these to implement improvement.

The Act requires NHS Highland to publish and submit an annual report. The report should detail how we have carried out our duties under the Act. This report will go to Scottish Ministers. The annual report will include details of any challenges or risk we

are experiencing in relation to carrying out the duties. This includes the steps we are taking / will take in addressing these. All the annual reporting requirements are incorporated within one report. This is referred to as the "annual reporting requirement"

The purpose of the annual report is to:

• Enable monitoring of the impact of the Act on quality of care and staff wellbeing

• Identify areas of good practice that can be shared.

• Identify challenges relevant organisations are facing. What steps they have taken / are taking to address these?

• Identify any improvement support required.

• Inform Scottish Government policy on workforce planning and staffing in the health service.

The annual report will cover the financial year, i.e., the period from 01 April to 31 March.

The report must be published and submitted to the Scottish Ministers by the 30 April following the end of the financial year (2025)

Duties of Healthcare Improvement Scotland (HIS)

HIS have a number of duties within the Act and are described fully within the HIS Healthcare Staffing: Operational Framework and summarised below: HIS-Healthcare-Staffing Operational-Framework

- HIS: monitoring compliance with staffing duties
- HIS: duty of Health Boards to assist staffing functions
- HIS: power to require information

To assist HIS in their functions, NHS Highland has received a formal request for a copy of the Boards Quarterly Report which will be shared following endorsement at Executive Directors Group and Staff Governance Committee.

A quarterly Board engagement session to support awareness and assurance is offered to the board for consideration.

2.3 Assessment

It is perhaps helpful to consider the priorities for NHS Highland in relation to the Act in the following way:

We have the appropriate mechanisms and governance in place to assess and report on staffing requirements across our organisation needed to deliver care to our population.

We have the appropriate mechanisms and governance in place to assess and report on a routine (day to day) basis:

a. how well we meet the staffing requirements
b. that risks associated with staffing challenges are managed, mitigated and escalated appropriately
c. professional advice is embedded and demonstrable in our day to day management of staffing and service delivery.

We use the information from assessing staffing requirements and routine assessment of staffing risks and issues 'in practice' to develop short-, medium- and long-term plans to provide appropriate staffing

An HCSA programme board has been established. The HCSA Programme Board will report into our People and Culture Portfolio Board, chaired by our Director of People and Culture, which oversees the following strategic programmes:

- Leadership and Culture Framework
- Health and Wellbeing strategy
- Diversity and Inclusion strategy
- Employability and workforce development/diversification

The portfolio board in turn reports to the executive level strategic change oversight group which oversees the boards strategy delivery.

Regular updates will be provided to APF, staff governance committee and the board on:

- Progress with the HCSA action plan (programme plan)
- Quarterly and annual reports generated as required by the act

High level update / summary on progress over Q1 with key achievements, key milestones for next quarter and key risks.

Guiding principles for health and care staffing

NHS Highland HCSA Implementation Programme Board and the underpinning Implementation Groups have conducted a range of scoping and self-assessment exercises across all Board functions to measure our current position regards relevant systems and processes as detailed under the individual duties set out within the Act. Self-Assessment returns and verbal assurance to the HCSA Implementation Lead and HCSA Programme Board provides a moderate level of assurance that adequate processes are in place for the professional disciplines cited in the Act.

This has been a complex and time intensive process, teams are congratulated and acknowledged for their effort and level of engagement.
It should be noted that not all functions operate with the same systems or processes. Operational systems and processes are dependent on the service model, size of service and in-patient bedded service, non-bedded service, community or a commissioned service status.
There are areas of excellent practice and areas which have been identified for improvements. The Programme Board have developed a range of workstreams and action logs to support the gaps and areas requiring further work, to ensure oversight of risk, and a pathway to achieving compliance.

Guiding principles etc. in health and care staffing and planning: Processes are in place to provide assurance that where a Health Board or Integration Authority are commissioning Health Services from another provider that the provider complies with the general duty and principles of this Act and to record any challenges faced.

All of those involved in the commissioning and planning of services have fully engaged with the requirement for NHSH to have clearly defined systems and processes in place across all NHS functions and professional groups to ensure that when planning or securing the provision of health care from another person, we have 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. The requirement for appropriate staffing arrangements has been a well-established point of reference in all existing agreements and contracts. There is a requirement for us to refine and standardise supporting documents to have specific reference to the HCSA for all new arrangements/accords since 1 April 2024.

The intent of the Act is to enable the provision of safe, high-quality care with improved outcomes for service users through provision of appropriate staffing and to support the wellbeing of staff.

Assessment and compliance against the following:

section 12IA: Duty to ensure appropriate staffing;

As detailed in Guiding Principles above

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

Clearly defined systems are in place for nursing and midwifery. The wider professional group have successfully engaged and broadly understand the requirement for clear assessment, documentation of risks, decisions and actions. The HCSA Programme Board will continue to oversee multidisciplinary efforts to create a reliable, systematic approach that will apply to all.

Effective e-rostering is a workstream being directed through the HCSA Programme Board and driven by HCSA Implementation Lead. The e-roster roll out was paused indefinitely last year, due to costs associated with ‘double entry’ of SSTS data. This triggered a review of existing e-roster build work which exposed significant data

integrity issues. E-roster rebuild work across the 160 areas currently with e-roster in place is now underway and is expected to take approximately twelve months. In conjunction with the e-rostering rebuild work we are undertaking revision and development of governance structure and practical guides to assist managers and frontline clinicians in e-rostering best practices to:

• Enable the alignment of staffing levels with patient needs and available resource in each department

• Drive effective management of staffing establishments, so increasing efficiencies in the workforce trust-wide

• Ensuring the right staff are in the right place at the right time[3] while improving the management of planned and unplanned non-working time

• Reduce the need for temporary and agency staff, so improving efficiency of resources

• Improve use of staff through clear visibility of contracted hours and staffing levels/skill mix

Aforementioned improvements to our e-rostering practice, adoption of key enabling tools including Optima Health Roster for Consultants, Allocate for Junior Doctors and Safecare will all contribute to compliance with this duty.

section 12IF: Duty to seek clinical advice on staffing;

Clinical advice is consistently available to support staff in decision making. Teams report feeling confident when escalating concerns and receiving support. The OPEL framework successfully supports and records elements of clinical advice provided. We have identified gaps in this provision for more remote services. We have also identified gaps in effective/consistent recording of this decision-making processes.

The Safecare workstream is being directed through the HCSA Programme Board and driven by local HCSA Implementation groups. The planned roll out of Safecare across the organisation over the coming twelve months and Improved use of Datix will support compliance with this duty.

section 12IH: Duty to ensure adequate time given to clinical leaders;

There are many areas of good practice where clinical Leaders, with identified management responsibilities, have time agreed to undertake non-clinical duties.

It is important to note that non-clinical time, may be and often is, subject to change determined by urgent service needs.

This is a workstream being directed through the HCSA Programme Board and driven by local HCSA Implementation groups. There are a range of initiatives currently rolling out to improve e-rostering, Allocate and Optima Health Roster. The job planning and/or activity manager modules associated with the aforementioned enabling tools, once fully rolled out, will provide assurance regarding compliance with this duty, Health roster

monitoring of non-patient facing activities in other professions such as AHP, HCS etc will also evidence compliance once tools are implemented.

In time Safecare will, in real time, identify where leaders have had to re-prioritise focus and work clinically to mitigate risk.

section 12II: Duty to ensure appropriate staffing: training of staff;

We have systems to support accurate records of training for all staff which is appropriate and relevant for the purposes of the role we are asking them to fulfil. There are clear SOP's and formal processes in place.
Where e-rostering is in place this facilitates effective calculation/identification of study/learning time. The provision of training for staff is considered in much broader terms beyond that of HCSA alone and includes organisational wide responsibility to ensure staff are enriched with the knowledge and skills required to deliver safe, high-quality care. Self- Assessment has identified areas for improvement across all professions. Challenges identified with consistent adherence/prioritisation to/of policy, variance in how managers apply policy, deficit of time for managers to monitor compliance and a deficit of time for staff to be released for training due to work pressures/demand.

This is a workstream being directed through the HCSA Programme Board and will be driven by local HCSA Implementation groups to improve consistent adherence to policy and procedures. We are also developing ways in which to incorporate HCSA legislation at a range of initial induction contacts for new recruits.

section 12IJ, 12IK and 12IL, relating to the common staffing method.

This is a high-level priority/legal responsibility to complete annual run (min) for all areas within scope for 2024/2025.

Staffing Level Tools
Common Staffing Method

There is a Tool Run/CSM being Scheduled for Sep -Dec 2024 with engagement from Professional, Operational and Workforce Leads, Finance, Staff Side and SSTS.

Child Health, Highland Council are to be included in a paper based, manual tool run. This is not a desirable approach but one of the limitations difficult to navigate due to Nursing teams employed by Highland Council having no access to NHS Systems.

We have created a revised suite of supporting documents and SOP.s to support staff through the process and have agreed to use HIS developed toolkits and training aids.

In support of applying tools and applying CSM to the wider workforce, the HCSA Programme Board has endorsed AHP proposal to test use of CSM for AHPs.

This workstream is being directed through the HCSA Programme Board and driven by our People and Culture Director to redefine and develop a framework supporting a revised governance structure, delineation of roles, responsibilities and accountability whilst remaining cognisant of the variance across HSCP, A&B and THC.

section 12IB: Duty to ensure appropriate staffing: agency workers;
(Appendix 4)
A manual process to collate data as required for quarterly reporting is in place.

RLDatix have been tasked to provide a national automated solution which will reduce the level of onerous manual data collation. Delivery of this digital solution remains pending.

Quarter 1 report has been compiled. This demonstrates, that in 100% of instances the High Cost Agency expenditure, exceeding the 150% threshold , is entirely attributed to accommodation and travel costs.

Communication to teams setting out revised locum engagement criteria including removal of accommodation and travel costs unless in extreme circumstance/threat to business continuity has been disseminated.

There is a risk we may not capture all staff engaged over the 150% threshold due to variance in mechanisms of engagement. This is an issue all boards are experiencing, and we are working with our local HCSA Implementation groups to establish assurance and rigour around capture of all forms of agency staff engagement.

section 12ID: Duty to have risk escalation process in place.

Risk can be/ are identified at Safety Huddles on a twice daily basis within clinical in-patient services. For non-bedded services such as Pharmacy, Dental, Primary Care & Public Health, workforce shortfalls identified in real time due to unplanned absences are escalated though management/on-call structures. The varying OPEL structures and local Safety Huddle arrangements provide a structure for real time risk escalation. This is less formalised for more remote sites however ‘tacit’ knowledge of escalation process is well embedded. There is a gap in formalised SOP’s setting out these processes.

This is a workstream being directed through the HCSA Programme Board and driven by local HCSA Implementation groups. Self-assessment returns have identified where severe risk cannot be mitigated it can be escalated by direct communication via responsible managers and/or Safety Huddles and where in place RTS and retrospectively recorded on the Datix system. Datix automatically escalates the risk through line management structures with the option to include professional leads. It is important to note self-assessment has identified significant gaps in consistency of this approach in terms of actual recording. With the development of Safecare, escalation processes will be able to be recorded with greater ease on the new system and will provide system wide overview.

Review of OPEL framework and alignment of the current varying approaches is a pending action.

section 12IE: Duty to have arrangements to address severe and recurrent risks;

The self- assessment and scoping exercises have confirmed we have the system functionality to record, identify trends, relating to recurring risks and mitigations. This is of course dependant on the effectiveness of risk reporting in the first instance and therefore variance in reporting practice will impact on the meaningfulness of any thematic reporting. Please see reference workstream above which will also incorporate this duty.
In time our compliance with this responsibility will largely be supported by Safecare.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	X
Limited		None	

Comment on the level of assurance

The Act builds on many existing arrangements which are already in place and is explicit in its intent to promote transparent, open and honest culture.

The scoping work which has taken place to date has highlighted many areas of excellent practice and underlined the many shared challenges services experience daily.

Broadly speaking we have the appropriate mechanisms and governance in place to assess and report on staffing requirements across our organisation needed to deliver care to our population.

We have the appropriate mechanisms and governance in place to assess and report on a routine (day to day) basis:

a. how well we meet the staffing requirements
b. that risks associated with staffing challenges are managed, mitigated and escalated appropriately
c. professional advice is embedded and demonstrable in our day-to-day management of staffing and service delivery

We broadly use the information from assessing staffing requirements and routine assessment of staffing risks and issues ‘in practice’ to develop short-, medium- and long-term plans to provide appropriate staffing

The current moderate level of assurance offered is linked to gaps in recording, consistency and robust ability to evidence and our plans to address these gaps and improve the level of evidence available to demonstrate compliance. The first year of enactment will be an iterative journey as we move forward towards improved compliance

3 Impact Analysis

3.1 Quality/ Patient Care

The intent of the Act is to enable the provision of safe, high-quality care with improved outcomes for service users and support their health, safety and well-being.

3.2 Workforce

The HCSA is fundamentally about providing appropriate staffing to deliver services.
The improvement work and recording of data is resource intensive.
The Implementation Team responsible for rolling out and maintaining the enabling RLdatix digital solutions across the organisation are small but mighty, however their capacity will be a rate limiting factor in terms of roll out pace.

3.3 Financial

There are potential financial implications in relation to addressing staffing risks and issues identified through the mechanisms required to demonstrate compliance with the duties of the act. However, it is important to emphasise that the act does not introduce anything new in terms of the principle that services should already be planned and delivered with an appropriate workforce plan in place to deliver the service to the required standards.

3.4 Risk Assessment/Management

This links to board level risk in relation to workforce availability and ensuring we have appropriate mechanisms to manage and mitigate risks associated with staffing issues

3.5 Data Protection

N/A

3.6 Equality and Diversity, including health inequalities

N/A

3.7 Other impacts

N/A

3.8 Communication, involvement, engagement and consultation

NHSH HCSA Programme Board is now well established and has professional and staff side involvement from all professional and operational leads across all Board functions.

3.9 Route to the Meeting

N/A

4 Recommendation

The Board is asked to take moderate assurance and review and scrutinise the information provided in this paper and appendices.

4.1 List of appendices

The following appendices are included with this report:

List of appendices

The following appendices are included with this report:

Appendix 1: Health and Care Staffing Act: Duties and requirements
Appendix 2: Health and Care Staffing Act: Guiding Principles
Appendix 3: Health and Care Staffing Act: Internal Quarterly Report requirements
Appendix 4: HCSA Quarter 1 External Agency Report
Appendix 5: HCSA: Internal Board Quarter 1 Report

Appendix 1: Health and Care Staffing Act: Duties and requirements

Guiding principles: staffing for health care	Applicable all roles in scope
Guiding principles: staffing for health care (planning and securing of health are from others)	Applicable all roles in scope
Duty to ensure appropriate staffing in healthcare	Applicable all roles in scope
Duty to ensure appropriate staffing: agency workers	Applicable all roles in scope
Duty to have real-time staffing assessment in place	Applicable all roles in scope
Duty to have risk escalation process in place	Applicable all roles in scope
Duty to have arrangements to address severe and recurrent risks	Applicable all roles in scope
Duty to seek clinical advice on staffing	Applicable all roles in scope
Duty to ensure adequate time given to clinical leaders	Applicable all roles in scope
Duty to ensure appropriate staffing: training of staff	Applicable all roles in scope
Duty to follow the common staffing method including Common staffing method: types of health care	Applicable to specific types of health care, locations and kind of employees*
Training and consultation of staff	Applicable to specific types of health care, locations and kind of employees*

*summarised as where staffing level tools already exist; nursing, midwifery and medics within Emergency Department

Appendix 2: Health and Care Staffing Act: Guiding Principles

Improving standards and outcomes for service users
Taking account of the particular needs, abilities, characteristics and circumstances of different service users
Respecting the dignity and rights of service users
Taking account of the views of staff and service users
Ensuring the wellbeing of staff
Being open with staff and service users about the decisions on staffing
Allocating staff efficiently and effectively
Promoting multi-disciplinary services as appropriate

Appendix 3: Health and Care Staffing Act: Internal Quarterly Report requirements

Reports must include assessment of	o ensure appropriate staffing
	o ensure appropriate staffing: agency workers
	o have real-time staffing assessment in place

compliance against various duties	o have risk escalation process in place
	o have arrangements to address severe and recurrent risks
	o seek clinical advice
	o ensure adequate time given to leaders
	o ensure appropriate staffing: training of staff
	o follow common staffing method and associated training and consultation
Reports must also include:	o reference to the steps taken to have regard to the guiding principles when arranging appropriate staffing
	o reference to the steps taken to have regard to the guiding principles when planning and securing health care services from third parties
	o details of the views of employees on how, operationally, clinical advice is sought
	o information on decisions taken which conflict with clinical advice, associated risks and mitigating actions
	o conclusions and recommendations following assessment and consideration of all detailed above

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Quarter 1 Internal Board Assurance Report April to June 2024.

This report is intended to provide the Board with an outline of the extent to which we are complying with the duties in 12IA to 12IF and 12IH to 12IL of the HCSA (Staffing) (Scotland) 2019.

The HCSA Programme Board has facilitated an organisational wide, collaborative approach to collate information/evidencing compliance/intent to address compliance issues and celebrate areas of success. This high-level report is attempting to set out where we assess ourselves to be overall against each section of the Act.

a) How are we doing in respect of each section?
b) How we know this?
c) Actions which we need to take forward to improve our process and systems to support compliance

Duty	Evidence	Assurance Level	Current Position and Planned Action to Progress
12IC Duty to have real-time staffing assessment in place	Do you have documentation of your actual staffing headcount at work per band at least once every day? (negating study leave, annual leave etc… just the staff available to you for the service)	Moderate	This is well embedded for Nursing and Midwifery. Current real-time staffing resources are in place for: • Critical care nursing RTS resources • Mental health learning disabilities nursing RTS resources • Adult in-patient nursing RTS resources • Maternity RTS resources • This provides a mechanism for assessment and recording of real time staffing. • Patient acuity • Number and skill mix of available staff. • Professionally judged staffing required. In addition, this records: • workforce demand • risks

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			• the mitigations and escalation taken to address workforce challenges and provide safe care The Real Time Staffing dashboard provides us with oversight of services, however this was always intended to be an interim solution until the roll out of the national e-rostering and the RLDatix SafeCare Systems. There are areas of good practice and use of this system across the organisation and there are also areas where use is suboptimal or variable, often increasing in use at times of pressure to demonstrate need for supplementary staffing and highlight risk. There are also areas who have developed their own systems for recording and sharing of this information. Whilst this could be used to provide evidence, they are not easily auditable. We have a range of other mechanisms to capture the wider workforces staffing position on a daily basis via the Operational Pressures Escalation Levels (OPEL) Framework which aims to provide a unified, systematic and structured approach to detection and assessment of effectiveness and risk. This is well established within Acute and has more recently been developed in Community. This features in one of the HCSA Programme Boards workstream as an area for development and improvement where a gap has been identified requiring standardisation of parameters and assessment used to assess pressure across the whole system. Twice/thrice daily Safety Huddles require staff to report on current staffing position. And whilst Huddle actions are recorded, we recognise it does not allow us to easily view staffing data over time, but it does help identify areas at risk at a glance on a daily basis. Staff details are also available on SSTS rosters, finance reports and Locations datasheet all of which include bandings and provides details of staff deployment. Our planned roll-out of Safe Care over the coming year will standardise this process and provide greater oversight. The HCSA Programme Board has endorsed the roll-out of Safe Care to non-erostered areas. This was initially seen as a contentious decision by the vendor, RLDatix, however HIS have now sanctioned this approach as the way forward and

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			will be launching a national drive in September to encourage all boards to consider deploying Safe Care to non-e-rostered areas. The level of assurance remains at moderate on account of the variance across professions and services, not all report into these systems however it should be noted that all In Patient areas are covered.
	Do you have processes are in place to provide assurance that appropriate staffing is in place and that guiding principles are taken into account when decisions relating to staffing requirements are made	Moderate	Organisational wide Integrated service planning is currently under development with a view to systematically produce integrated service plans, specifications and workforce plans required to deliver the agreed level of service to the required performance and quality standards, making best use of our resources within the financial resources available. This will include reviewing the funded workforce establishment, required or recommended establishment against available establishment to understand workforce gaps and associated risks. This will be underpinned by use of the common staffing methodology and associated tools where these are available and applicable. This will build on the 3-year workforce plan developed in line with national guidance which already identifies key at risk areas for the organisation and plans for addressing these. Integrated service planning will enable further detail to be added to our workforce plan which is expected to evolve on a 3-year rolling plan basis. This is a complex piece of work and will take time to refine and mature. We have completed a 'deep dive' into our e-rostering systems, data and tools to support effective use of our workforce and manage supplementary staffing and following best practice for staff rostering. This has triggered a requirement to rebuild the e-rostering system configuration of all the 160 areas with e-roster currently in place. We have made the decision to suspend e-roster due to the financial implications of double data entry in the absence of an interface with SSTS. We have implemented the Realtime Staffing Resource (RTSR) for nursing and midwifery and will continue to monitor the effective usage of this however following options appraisal the HCSA Programme Board has agreed on the direction of travel towards exclusive use of Safe Care. We have commenced with a transition plan to deploy Safe Care in all e-rostered areas on completion of the rebuild. We have sought guidance from other health boards on the use of Safe Care in non-e-rostered areas and we have opted to transition to this as the destination product. This was considered contentious by the vendor however has recently been endorsed as an approach by HIS.

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<tr><td></td><td></td><td></td><td>We are rolling out Allocate rostering for Junior Doctors and progressing with Optima Medics for Consultants rostering with ED and Acute/Gen Med.</td></tr>
<tr><td></td><td>Do you have Effective E-Rostering in place to ensure appropriate staffing?</td><td>Moderate</td><td>We have carried out a 'deep dive' in order to develop our understanding the problem(s) we needed to solve in terms of e-roster build process. This is now completed.
We have re-defined the roster build process moving forward and are currently running a ‘Test of Change’ with New Craigs. Work has commenced to apply this learning to a full rebuild. This will be rolled out to re-build all e-rostered areas from September. We currently anticipate this will take us into 2025, evaluation and validation of the new process, including detailed timeline pending test of change completion in September will be shared at the September HCSA Programme Board meeting.

Key Points for Redress
<table><tr><td>Fidelity of initial build information poor. Rosters built on ‘want/need’ not budgeted wte</td><td>Miss calculations/interpretation of PAA calculations</td></tr><tr><td>Lack of knowledge effective rostering practice – including level loading</td><td>Lack of consistency is language and understanding of ‘rules’ across all staff groups including within Finance.</td></tr><tr><td>Quality of e- rostering education and support for SCN’s</td><td>Cessation of agreed governance structure – ‘Confirm and Support’</td></tr><tr><td>Safe, Affordable and Sustainable – reporting functions not understood or used – standardised reporting for</td><td>Safe, Affordable and Sustainable – reporting functions not understood or used – standardised reporting for Supplementary Staffing reporting for V&E to be produced</td></tr></table></td></tr>
<tr><td></td><td>Do you have documentation of what you needed in your Professional Judgement staffing headcount for that that same time per band every day?</td><td>Moderate</td><td>This is well established for Nursing and Midwifery. This is less established for other professions where in many cases there is not such prescriptive guidance on rations of staffing. This information is reported, and the Huddles mentioned above however for many professions out with Nursing and Midwifery there will be no documented evidence of required headcount on a daily basis.
Finance and SSTS reports would provide retrospective details for some of this information.

HCSA Implementation groups are reviewing processes required to be developed to ensure daily information is available for sharing/escalation.</td></tr>
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	Is there a direct correlation between your service workload and patient acuity / complexities of your interventions?	Moderate	This is well established for ward areas and Emergency Department but is less established for other services and teams. There are a range of KPI reports available for patient activity, Practice Management System reports and case mix tools which give a broad measure of patient complexity, scored by clinical staff and reviewed regularly. This becomes less robust and harder to evidence in community settings. The activity takes place less formally, based on tacit knowledge and professional judgment.
	If there is a direct correlation as above, do you record this daily to indicate the impact it has on your ability to provide a good standard of service?	Moderate	This is well established for Nursing and Midwifery within In Patient settings with use of RTS tool at least twice a day for aforementioned In-Patient areas. However not for most of the other service or teams. This has been highlighted by means of Self – assessment returns and feeds into the local HCSA improvement and implementation workstreams.
	When considering your workload, demands on your service and outcomes, do you document your mitigation actions you had to apply if any?	Moderate	As previously described above the OPEL system and daily huddles which take place in each locality and twice weekly as There are formal are formally recorded. Manual audit of the note of mitigation actions is required. This is also captured as part of RTS tool. There is also a range of Management Team weekly meetings, which considers workload, demands and outcomes. Most services generate and maintain action plans which are maintained and available on SMT Teams channels. There are also a broad range of well managed Services Risk Registers, is used and reviewed regularly to identify potential risks that are identified, and mitigations/escalation identified. This may include risks relating to workload, service demands and outcomes. This includes escalation from Managers to immediate and non-direct Line Managers, for issues that cannot be managed by the specific Service. This includes exception reporting via the HHSCP Community/Primary Care Clinical/Acute & Care Governance Groups.
	Do you document supplementary staffing you have used and the source (Bank, Extra hrs etc..) each day?	Moderate	Scrutiny and authorisation of Bank staff is in place to differing degrees across the organisation with some very stringent controls in place and some areas where practice is more flexible as is deemed appropriate to manage risk to patient safety and service continuity. Every supplementary shift is recorded as such, and this should also include information as to the reason for the shift requirement. There are supplementary staffing reports provided on a monthly basis bit no systematic daily summary of supplementary staffing. The Value and Efficiency, Supplementary workstreams have close focus on developments around effective governance, review and challenge use of

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			supplementary staff. The realisation of benefits from the effective e-rostering workstream will also supports this workstream.
12ID Duty to have risk escalation process in place	Do you document any risk in relation to your real time staffing assessment above? (Such as missed or delayed care or tasks due to insufficient staffing or incorrect skill mix).	Moderate	RTS, where in use captures this and when we roll out Safe Care this will be the mechanism for system wide recording of this risk escalation process. Most services manage a Risk Register which is reviewed regularly. However, we recognise that this is a higher-level report, that will not record many missed/delayed care/omitted tasks which will be easier to capture on Safe Care. This is a key workstream for development identified through the completed Self Assessments. Local HCSA Implementation Groups scoping exercises have recognised the requirement for regular formal recording/monitoring of this information. They have identified the availability of Datix system as the mechanism for recording, reviewing and manging risk however acknowledge that whilst there are areas of excellent practice this is not used robustly and consistently across all areas. Individual incidents captured on Datix but can lack specific detail Improvement work as part of local Implementation group action planning in support of implementation.
	Do you document to whom you escalated that risk to and what further mitigations were applied if any following that escalation?	Moderate	There is a mechanism to record this information on Datix however there is variance in how consistently this information is routinely recorded. As described, we do have daily huddles in each locality which are formally noted and information of to whom risk is escalated and decisions on mitigations and measures to manage risk are recorded Local Implementation Groups scoping, and self-assessment has identified the requirement to develop Formal SOP; s /documentation process required for to demonstrate risk mitigations and actions, following escalation, including feedback to colleagues reporting incidents. This will form part of their action plans over the coming year.
	Do you document the outcomes of risk escalation and give feedback to the initial reporter of the risk if it was not yourself that highlighted the concern?	Moderate	As above.
12IE Duty to have arrangements to address severe	Do you have documentation in place that allows you to record the severity and impact on the service that risks have triggered?	Moderate	We can extrapolate thematic/impact/severity reports by service/location from Datix. There is a variable level of capability across the organisation in relation to effective use of Datix. Again, there are some areas of excellent practice and other where this is a weakness and not in place currently for all risks.

and recurrent risks			Development required of a process/documentation of all risks to be develop-ed, with detailed impact and assessment of severity. To be driven by local HCSA Implementation Groups.
	Are there documented trends evidencing severe recurring risks and the arrangements in place to address them along with the outcomes?	Moderate	We have the system functionality to identify trends, relating to recurring risks and mitigations. This is of course dependant on the effectiveness of risk reporting in the first instance and therefore the variance in reporting practice will impact on the meaningfulness of thematic reporting. Huddle notes would, at this time provide the more effective oversight of trend, arrangements and outcomes. The introduction of Safe Care will deliver on many of the above requirements. Improved use of Datix reporting system, education and standardisation of process have been identified by local Implementation groups as areas for development over the coming year.

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Duty	Evidence	Assurance Level	Planned action to progress
12IF Duty to seek clinical advice on staffing	Was it clinical advice on your staffing you sought when you escalated the risk? If so, have you recorded the person that gave the advice and again ensured the person who raised the initial concern was informed and do you record dissemination of guidance?	Moderate	Clinical advice is available to support staff in decision making, we currently know there is a gap in the recording of this decision-making processes however this will be addressed by the roll out of Safe Care. For those areas who currently have Real Time Staffing, they have been directed to utilise this as a mechanism for recording this information until Safe Care is deployed to their area. OPEL huddle actions are recorded, there are other forms of recording agreed actions. Resolution will be found in real time in relation to any conflict/difference of opinion. Any matters of significant disagreement should be reported via Datix or through operational and professional lines of escalation. This is not currently formalised and forms part of our implementation action planning which will require the development of SOPs for conflict recording. The SOP will set out agreed process for clinicians to formally record any disagreement with staffing decisions. This interlinks directly with the other workstream to review, improve and standardise our escalation processes. Safe Care and Datix will be the tools to support this.
12IG Duty to ensure appropriate staffing: number of registered healthcare professionals	Do you record your level of need for ALL disciplines which can be captured in a Real Time Staffing Resource or other daily documentation? The Scottish Ministers must take all reasonable steps to ensure that there is a sufficient available to every Health Board, to enable us to comply with the duty in section 12IA Duty to ensure appropriate staffing	Moderate	Utilisation of Real Time Staffing resources for Nursing and Midwifery. We have not adopted the Generic Real Time Staffing Tool and instead have agreed to roll out Safe Care to all areas including non-e-rostered areas. Only nursing and midwifery and Emergency Medicine have any form of formal establishment set. AHP's have the tools and process to carry this out which has been developed locally but not agreed nationally. The HCSA Programme Board has endorsed a project to run a cycle of these tool for AHPs. OPEL framework will also capture profession judgement concerns escalated for disciplines out with Nursing and Midwifery.
12IH Duty to ensure adequate	Do you have a system in place such as protected time for clinical leaders to allow them to be non-clinical and without a caseload where appropriate to	Moderate	There are many areas of good practice where clinical Leaders with identified management responsibilities have identified time agreed with Line managers to undertake non-clinical duties. Clinical

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time given to clinical leaders	be able to have a helicopter view of their service to review and address the quality / efficiency of the service their team provides and to carry out related managerial duties?		Leaders with specific Service Portfolio responsibilities have identified time to fulfil Portfolio duties. Other clinicians have agreed non-clinical time to carry out non-clinical duties, determined and agreed via the job planning/work plan process. It is important to note that non-clinical time, may be subject to change determined by urgent Service needs, however every effort is made to protect this non-clinical time for clinical leaders. There are designated % for team leads/clinical leads have allocated to carry out leadership role, however in some areas this is not formally protected and can be impacted by clinical pressures and staffing shortages. This is a workstream for development through the HCSA Programme Board. The effective e-rostering work will improve our ability to assess clinicians time to lead and this will be further supported by the launch of Safe Care over the coming year. Once we have rolled out further e-rostering, in particular to medics this will help us greatly with our planning and oversight of time to lead for our clinicians. We have commenced work with the Emergency Department to deploy Medics Optima, e-rostering with a 'Go live' date schedule for November. Once complete we will be moving onto Acute/Gen Med and Orthopaedics.
12II Duty to ensure appropriate staffing: training of staff	Do you keep an accurate record of training for your staff which is considered appropriate and relevant for the purposes for the role you are asking them to perform?	Moderate	We have the systems to support accurate records of training for all staff which is appropriate and relevant for the purposes of the role we are asking them to fulfil. There are a range of mechanisms for recording adequate time and resource to undertake required training. Where e-rostering is in place this facilitates effective calculation of study/learning time. The provision of training for staff is considered in much broader terms beyond that of HCSA alone and includes organisational wide responsibility to ensure staff are enriched with the knowledge and skills required to deliver safe, high-quality care.

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			We are currently working on incorporating the Knowledge and Skills framework for the HCSA at point of on boarding new recruits at our corporate and local induction process. As part of our implementation action plan, we are developing ways in which to incorporate HCSA legislation at a range of initial informative induction contacts for new recruits. The HCSA TURAS based training has been promoted to all staff. Unfortunately, TURAS does not support reporting on this. We have also adopted the use of the HIS developed suite of staffing level tools/tool kits/training resources.
	Do you record such time and resources with the consideration of giving them adequate time to undertake such training?	Moderate	Annual appraisal/revalidation/job planning and 1:1 session is some of the index points of contact at which staff are supported and reviewed in terms of training completion and PDP's learn-pro e-system supports overview of mandatory and statutory training completion.
	Are Staff engaged and well informed?		All areas across the organisation have engaged with HCSA sessions and self-assessment feedback, in addition to Nursing & Midwifery and AHPS this includes Pharmacy, Optometry, Dental, Primary Care, Social Care, Children's Services, OOH, Commissioning, Argyle & Bute, Acute & HSCP. Further workshops are scheduled for facilitated Self Assessments. Outputs from these sessions will further inform the baseline of information on which we will continue to measure our compliance with duties and responsibilities of the Act and build on action plans during the first year of enactment. Acute, A&B and HSCP and Children's Services HCSA Implementation groups have been commissioned to develop local action and implementation plans across all duties and responsibilities. These are all at different stages of maturation. Implementation groups are supported by structured agenda setting, reflecting all duties and report into the NHSH HCSA Programme Board with iterative updates in relation to compliance. The HCSA Programme Board report into the Portfolio Board and Staff Governance Group. Nursing and Medical Directors are aware

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			they retain professional oversight of staff irrespective of whether the service is delegated to an integration authority or not and that we are duty bound to include all staff in our Quarterly Reporting. Whilst there are many areas of good practice supported by systems and processes, we are aware of the variance across professions and teams. We acknowledge arrangements and momentum to support implementation have a still have a lot of progress to make and therefore this is reflected in the moderate level of assurance currently offered. Quarter 3 report submission to Scottish Government has been well received and has shored up our sense of confidence about the effort and work which has taken place thus far.

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Duty	Evidence	Assurance Level	Planned action to progress
12IJ Duty to follow common staffing method	In the case of having a speciality specific workload tool, it is deemed within the legislation that these tools are run for at least 2 weeks, at least once a year, but the full spectrum of the Common Staffing Method (CSM) is currently only applicable to Nursing & Midwifery (& Medical in Emergency Department only) This will be expanded in the future Do you have evidence of intentions to apply the available Multi-discipline Professional Judgement Tool when reviewing staffing within your service? This tool will assist you to evidence your staffing needs at a multi-disciplinary level.	Moderate	We are currently launching the preparatory stage and training programme for our 2024/25 cycle for all areas within scope. Staffing level Tool runs, application of Common Staffing Methodology and resulting outputs require a clear governance and organisational wide approval route to support effective workforce planning. Following consultation and SBAR presented to the HCSA Programme Board, Leads are broadly in agreement of the importance for us to move away from working in professional silos and instead work in conjunction with other job families and take a collaborative approach with professionals and operational leads working in partnership around review and decision making of tool runs and CSM 'out puts'. We are currently working with the mandated tools however we are cognisant of importance of working towards extending use of CSM to the wider workforce and find a way to incorporate other professional families. There is a requirement to agree on overall organisational Workforce Planning Governance structure, approval route for review of output of Staffing Level Tool runs and application of Common Staffing Methodology. Whilst professions currently within scope are predominantly nursing and midwifery, we are working to develop a structure able to evolve with ease and pace in response to incorporation of additional professions and MDTs as required over coming months. This requires a clear governance structure, clear lines of accountability and recognition of the variance across HSCP, A&B and THC. There is a Tool Run/CSM being Scheduled for Sep -Dec 2024.
12IM Reporting on staffing	A clearly defined governance process and system is in place to enable the Health Board to publish and submit a report to Scottish Ministers setting out how during the financial year it has carried out its duties		Well established HCSA Programme Board provided direction to local HCSA Implementation Groups and driving iterative development and updates of reporting across both high-cost agency, quarterly and annual reporting.

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12IB Duty to ensure appropriate staffing: agency worker	Are processes in place to ensure the services of agency workers does not exceed 150% of the amount paid to full time equivalent employee.		The Act states the cost of using an agency worker should not exceed 150% of the amount that the health board would pay a full-time employee to fill the equivalent post for the same period. We are expected to report quarterly to Scottish Ministers on the use of high-cost agency staff. We have a system in place to collate information in place for the majority of agency workers. Where the amount paid does exceed 150%, we detail the number of occasions (shifts) on which we paid over 150%, the amount paid on each occasion, the circumstances that have required this higher amount to be paid travel and accommodation expenses. We no longer engage off framework agency staff. Quarter 1 report has been complied and has demonstrated that in 100% of instances the excess over 150% is attributed to accommodation and travel costs. Communication to teams setting out revised locum engagement criteria including removal of accommodation and travel costs unless in extreme circumstance/threat to business continuity has been disseminated.
	Delivery Challenge		This work is highly resource intensive in particular for staff groups navigating the current high demand and resource limited landscape. Maintaining engagement with professional/teams amid a broad range of competing priorities is at times challenging. The HCSA drives reporting by profession which causing conflict for teams as services are delivered via a collaborative multi professional effort. The binary nature of some of the tools does not easily work/represent teams who work across both Community and Acute. Whilst there are many examples of good practice, systematic and robust approaches we have also identified variance. This in part can be attributed to the expansive nature of the Boards geography and organisational complexity. The scoping work we have done has helped us to articulate this lack of consistency in approaches and recognised where areas are supported by local systems/bespoke/

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			informal/tacit/local understanding of processes with an absence of formalised SOP's/Processes. Teams also describe gaps around a clear framework for accountability and assurance and express a need for us to better support and develop staff to fully fulfil expectations of promoted roles.