NHS Grampian

Health and Care (Staffing) (Scotland) Act 2019

Annual Report 2024/25

Submitted to Grampian NHS Board April 2025

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Scottish Government Guidance on Health and Care (Staffing) (Scotland) Act 2019 Annual Report

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. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland 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)

Section 2(1) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland 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 2019 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 requirement. Section 2(4) of the 2019 Act requires this information to include how these steps have improved outcomes for service users.

Section 2(2) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland 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 1978 Act 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 requirement. Section 2(4) of the 2019 Act requires this information to include how these steps have improved outcomes for service users.

Reporting for section 12IB (duty to ensure appropriate staffing: agency workers) is within a separate quarterly report and not included in this template.

Guidance on completing the template can be found below. Completed reports must be returned to hcsa@gov.scot by 30 April 2025. If you require further assistance or have any queries, please contact hcsa@gov.scot.

Report approval

This tab should be completed by the person signing off the report. An electronic signature is acceptable.
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.

Summary
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).

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.

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
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, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus. For example, details of the organisational structures, systems and / or processes being used, such as SafeCare or SOPs in place. If the RAG status is not green then explanation should be provided advising of any gaps or areas of ongoing work, and of the NHS functions and / or professional groups that do not have systems and processes in place / are not using them.

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.

The relevant organisation is then asked to provide details of any areas of risk 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 - to show the 'pathway to green'. Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail.

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.

Two tabs, section 12IA and 'planning and securing services' ask additional questions to enable appropriate feedback to evidence compliance with these duties or requirements. Similar to above, these should be answered in sufficient detail and more guidance is given in these two tabs.

NHS Grampian additional information:

- A national reporting template was provided however for ease of reading and review it has been converted from excel into word and will subsequently be transcribed prior to submission.
- All boxes NHS Grampian requires to populate are bold outlined in red as demonstrated with this box

RAYG Status Definitions

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

Levels of Assurance Definitions

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

Level of Assurance		System Adequacy	Controls
Substantial 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.
Reasonable 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.
Limited 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.
No 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.

Report Approval

Name of organisation:	**NHS Grampian**
Report authorised by:	***Name:*** ***To be completed after April Board Meeting***
	Designation: ***To be completed after April Board Meeting***
	Date: ***To be completed after April Board Meeting***
Location where report is published:	**Grampian NHS Board – April 2025 Board Papers**

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.

- Through the local infrastructure to support the implementation of the HCSA, previously good leadership connections have strengthened between specialist Workforce Planning, eRostering and HCSA work streams. This has been further enhanced by internal workshops for all team members enabling a shared learning environment and networking opportunities.
- The local development of workforce visualisation tools (dashboards) supports easily accessible workforce information to inform several of the Act requirements (time to lead, severe and recurring SafeCare risks, staff wellbeing – absences, training records). These workforce visualisation tools also support more effective review of information held on the Optima system in order to inform areas requiring further action, for example training/process needs or compliance rates using SafeCare.
- HCSA Programme Team and the content of formal reports and self-assessments carried out by Portfolios / Health and Social Care Partnerships (HSCPs) is integral to Workforce Planning Workshops along with Optima/SafeCare, Job Planning and Common Staffing Method (CSM).
- Learning from this report will help to inform the development of NHS Grampian's Route Map for Strategic Change through the involvement of Board Clinical Leads and the HCSA Executive Lead in that process.
- It can also help to inform the national development of Target Operating Models at national, regional and population level.

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

- While the primary focus of year one of commencement has been progressing the necessary systems and processes of each duty, this has limited the ability to consider outcome measures and triangulation of existing Safety, Quality and Workforce frameworks; this will be explored further in subsequent years.
- The Act's concepts are not new, however when progressing the necessary work, it has enabled positive and new opportunities of connecting work streams that overlap while also increasing the visibility of some aspects of workforce data. For example – requirement to report on High-Cost Agency breaches with Value and Sustainability/Finding Balance; Establishment Setting process as part of CSM; Real-Time Staffing risk assessments.

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

- While recognising the progress made during 2024/25, NHS Grampian continues to have limited assurance of compliance across the Act and most individual duties. This is primarily driven by the lack of consistency in which systems and processes are robustly applied and in use, across all roles in scope.

Please summarise any key learning and risks identified as a consequence of carrying out the duties and requirements in the Act.
• Enduring system pressures and organisational financial challenges. Teams across the organisation are delivering care in a very busy healthcare system where other initiatives and work streams may require immediate/urgent actions that impact on time, resource and/or ability to develop and deliver necessary processes required of the HCSA.

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

Duty to ensure appropriate staffing and guiding principles (12IA)

Item	RAYG status	Comment
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 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.	Amber	While recognising the progress made in the first year of Act commencement, particularly following an internal Self-Assessment process alongside the HCSA internal quarterly reports, NHS Grampian has not been able to embed all necessary requirements. This is primarily driven by the lack of consistency in which systems and processes are robustly in place and utilised, across all roles in scope and all NHS functions. Further work is required to address this.
These systems and processes include having regard to the nature of the particular kind of health care provision	Yellow	The Health Intelligence Team provides data and interpretation to support health planning, performance and improvement. Their aim is to provide evidence that improves decision-making throughout the health system. The Health Intelligence Team provide a fortnightly System Overview to a range of operational and professional leaders across the organisation, covering a number of roles in scope. This weekly system overview considers a number of local factors specific to Grampian which professional and operational teams use to inform future service plans and workforce models.

Item	RAYG status	Comment
These systems and processes include having regard to the local context in which it is being provided	Yellow	NHS Grampian's Director of Public Health Report for 2022 described how our health and social care system continues to be under acute pressure and our ability to continue to deliver safe, effective, person-centred and sustainable care is under threat. Scotland's and Grampian's health is also facing other emerging threats from new infectious diseases, climate change and the rising cost of living - all of which have the potential to translate into worsening health and demand on the system if they are not addressed. These threats remain and the Report for 2023 (published 2024) sets out our progress in working together as a population health system to protect and improve our population's health and reduce inequalities. Our population in Grampian is ageing, many are living with multiple health conditions and a greater proportion of our working age population is experiencing ill-health. With the commitment and support of the public sector leaders in the North East we have come together as a Population Health Alliance with a shared commitment to reduce the inequalities that determine poor health and help create a healthier, fairer and safer place to live. The Director of Public Health's 2023 report noted further progress as we engaged with partners to learn together what is working well, recognise gaps in our response and identify opportunities to work together for greater action. Through this work we have strengthened our working relationships, creating opportunities to share good practice and find solutions to achieve our shared goals to improve the health of the population we serve. This has created the building blocks for a healthy, fair and safe environment while acknowledging the greatest deterioration is seen in those groups already experiencing the worst mortality rates and lowest life expectancy.

Item	RAYG status	Comment
These systems and processes include having regard to the number of patients being provided it	Yellow	Grampian's population continues to increase year on year, as well as noticeable changes in terms of demographic, where the number of people over 85 years has doubled since the early 1990s and a rise of 60% amongst people aged 55-74 years. Aberdeen has also seen an increase in school-age children and young adults, but not in students. Having the lowest bed base (all hospitals) per 1000 population of the mainland Boards in Scotland places significant pressure on hospital occupancy and our ability to manage the surges in demand. Our health and care system is in a constant state of change in response to the increasing number of citizens within Grampian as well as the changing health needs, such as rising levels of chronic conditions. We continue to consider ongoing long-term sustainable transformation programmes whilst responding to shorter term improvement projects or safety notices. While we cope with the changing needs of our population and the pressure this brings to bear on services, at the time of writing this report Emergency Department attendances have remained within usual ranges and remain much lower than pre-pandemic. The recent annual publication from Public Health Scotland on acute hospital activity and beds helps us to see longer term trends in Grampian and Scotland, which highlights that the volume of hospital activity continues to be impacted post pandemic and during the recovery phase.

Item	RAYG status	Comment
These systems and processes include having regard to the needs of patients being provided it	Yellow	NHS Grampian's Plan for the Future articulates an ambition to work in equal partnership with colleagues and citizens to develop a more preventative and sustainable system in Grampian. To achieve this ambition, it is recognised that effective engagement cannot belong solely to the remit of a specialist engagement team but requires commitment and action at all levels within the organisation. The Putting People First approach begins a systemic shift in how we welcome, involve and invite all colleagues and citizens to contribute to improving services and help shape the future of health and care in Grampian. It recognised that this is a long-term commitment and to succeed, this must be done collaboratively with Community Planning Partnerships, Health and Social Care Partnerships, third sector, our colleagues and all of our communities. Our ambition is for NHS Grampian to lead the way in how we welcome, involve, and invite all people to contribute to improving services as such, and to improve the health of our population. This requires us to nurture relationships between all NHS colleagues and the citizens we serve, valuing the expertise of people seeking care as much as those providing it.
These systems and processes include having regard to appropriate clinical advice	Yellow	Regard is given to appropriate clinical advice, including through a strong and active Area Clinical Forum and triumvirate leadership model. Further detail on this can be found within the duty to seek clinical advice.

Item	RAYG status	Comment
These systems and processes include having regard to the guiding principles when carrying out the duty	Yellow	NHS Grampian has a strong and established regard to Staff Governance through the application of the Staff Governance Standard which is mapped annually through iMatter. There is also a strong and established Grampian Area Partnership Forum, guided by five Staff Governance Standard strands which supports colleagues working together in a culture of openness, trust and integrity. NHS Grampian has eighteen 'Speak Up Ambassadors' who have undertaken two days' accredited training. The Ambassadors can provide confidential support and advice regarding any type of concern, by any member of staff, trainee, agency, or locum. The Plan for the Future articulates an ambition to work in equal partnership with colleagues and citizens to develop a more preventative and sustainable system in Grampian. To achieve this ambition, it is recognised that effective engagement cannot belong solely to the remit of a specialist engagement team but requires commitment and action at all levels within the organisation. The Putting People First approach begins a systemic shift in how we welcome, involve and invite all colleagues and citizens to contribute to improving services and help shape the future of health and care in Grampian. It recognised that this is a long-term commitment and to succeed, this must be done collaboratively with Community Planning Partnerships, Health and Social Care Partnerships, third sector, our colleagues and all of our communities. Our ambition is for NHS Grampian to lead the way in how we welcome, involve, and invite all people to contribute to improving services as such, and to improve the health of our population. This requires us to nurture relationships between all NHS colleagues and the citizens we serve, valuing the expertise of people seeking care as much as those providing it.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work required to consider escalations following first year of implementation.

Please provide information on the steps taken to comply with this Duty

These are steps taken to comply with this duty 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,

- NHS Grampian continues to develop resources to support staff wellbeing including the introduction of a weekly 'Wellbeing, Culture and Development' update to all colleagues via the Daily Brief every Wednesday. This includes signposting colleagues to a range of in house and external support e.g. National Wellbeing Hub; Financial Education/Retirement Information sessions; Supporting My Wellbeing sessions; Coaching; Mentoring; Guided Journaling; Kindness in Practice; Management Development Programme; Values Based Reflective Practice; Action Learning Sets; Spaces for Listening; Workplace Volunteering; and, Menopause and Wellbeing Tea and Talk sessions.
- A collaboration by NHS Grampian's Area Clinical Forum and Area Partnership Forum launched "At your best with rest" in 2024 to support all roles in scope colleagues in taking breaks during working hours and planning/taking annual leave across the year, ensuring colleagues have opportunity to rest and recover.
- Resident Doctors rotas are monitored on a biannual basis to ensure compliance and thus ensuring that Resident Doctors receive adequate rest and breaks to support their wellbeing. A targeted programme of work to improve Resident Doctor Rota Compliance includes the appointment of Break Facilitators and accompanying materials to support Resident Doctors to take breaks throughout their shifts. While this is still at an early stage, progress has been positive. This programme alongside the pre and post monitoring collaborative discussions and subsequent action plans should also support Resident Doctors wellbeing.
- Workforce teams have delivered two models of Workforce Planning Workshops over the last year to support the development of Multi-professional or Uni-professional Workforce Plans. While both have included a session on HCSA, the most recent model had wider connections between 6-steps methodology, Optima and SafeCare, Job Planning, Workforce Intelligence (visualisation of workforce data) and CSM. This new model enables the HCSA to be seen in context of strengthening and legislating existing processes.
- International Recruitment (IR) is a business-as-usual model, well established in NHS Grampian. Focused efforts within Nursing and Allied Health Professions (AHPs) through Centre for Workforce Supply have enabled increased recruitment avenues for these roles in scope with high vacancy rates. NHS Grampian continues to lead IR in the North of Scotland for Nursing, as the primary route for delivery of necessary education programmes. This has resulted in the first IR Nursing cohort in Scotland for Learning Disability and our fifth cohort for Mental Health Nursing. This is alongside education programmes for Adult Nursing of which there have been almost 40 cohorts. Learning from the vast experience of Nursing IR has enabled developments to improve onboarding, transitional arrangements and educational connections across AHPs. The third cohort of CESR Fellowship Programme has been completed – a process which commenced to improve recruitment into Medical Psychiatry Consultant posts.
- NHS Grampian has embedded the Once for Scotland Workforce Policies since their launch in 2023.
- NHS Grampian has committed to becoming a Trauma Informed Organisation, supporting the wellbeing and resilience of anyone affected by psychological trauma. Work on this will continue in year two.

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; what this data has shown and any trends; and any actions taken as a result.

- NHS Grampian's Area Clinical Forum acknowledged there is a real sense that the engagement and the quality of the concerns being raised through the committees were improving and with collaborative working and a systems approach, it can improve our service delivery.
- The first Community Appointment Day as part of Putting People First and involving a range of clinical disciplines, third sector organisations and those with lived experience, have proved to be extremely popular. It is hoped that these will continue and further strengthen the preventative aspect of our transformational work.
- NHS Grampian recognises the link between increased staff wellbeing and the safety and quality of care provided to service users. 70% of colleagues strongly agreed, agreed or slightly agreed with the statement 'I feel my organisational cares about my health and wellbeing' in the 2024 iMatter, reporting an average score of 73 within the green 'strive and celebrate' range.
- 66% of respondents in 2024 iMatter agreed or strongly agreed with questions mapped to the Staff Governance Standard strand 'Provided with a Continuously Improving and Safe Working Environment, Promoting the Health and Wellbeing of Staff, Patients and the Wider Community'. A further 20% slightly agree with questions mapped to this strand of the Staff Governance Standard. Responses equated to an average score of 78 for this strand of the standard, placing it within the green 'strive and celebrate' range.
- Feedback and patient experiences are used in several ways to improve patient outcomes and experiences. The Feedback Service receives feedback from citizens of Grampian which can be positive or negative and they support NHS services to respond to such feedback in an appropriate manner, whether this be early resolution or an investigation. The experienced team utilise communication skills to help identify what really matters to Grampian's citizens when reaching out through their team and subsequently, supports the clinical team to address this and make positive changes. This ensures that our citizens are impartially supported by Feedback team and the organisation can make positive changes and identify any issues they are currently unaware of.
- NHS Grampian also use Care Opinion to electronically gather feedback from our citizens to share their experience of health and care, both in terms of NHS services and delegated services. This can be what went well or what could be improved. The information is available on a public facing website which demonstrates transparency and a dedication to improvement. The feedback is shared with relevant individuals and if the patient/ family/ carer is agreeable, they can meet/ discuss their experience. This is a positive system as it allows anonymity if required and provides a wealth of information to be utilised by service teams. The information gathered from Care Opinion and the Feedback team is utilised by governance groups to highlight key themes and areas for improvement, as well as highlight any good practise for sharing.
- Adverse event reporting via incident reporting system DATIX allows themes and adverse events to be monitored through governance structures as well as promoting a culture of transparency and learning. Adhering to the Adverse Events Framework allows adverse events to be reviewed in a timely and systematic approach which supports frequent open communication with Grampian's citizens as well as identification of system errors which contributed to adverse events and solutions to prevent reoccurrence. Data is also reviewed within the governance structure to identify themes and highlight new risks. Departmental monthly Morbidity and Mortality meetings contribute to processes for improving outcomes and quality of care. Learning is also shared with teams and our citizens.

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; what this data has shown and any trends; and any actions taken as a result.

- There are many pockets of good practice around listening to and involving people, but there is not a single system wide infrastructure which supports cross-system learning to spread good practice and to identify areas which require collective action.
- Within the various governance structures, there is patient representation network via the Public Representatives; this allows the views of the public and users to be considered when making decisions directly related to care, thereby improving service design and acknowledging lived experiences.
- We are committed to achieving both Magnet Recognition and Pathway to Excellence designations for Nursing colleagues, demonstrating our dedication to delivering outstanding care to our patients while creating a supportive and enriching work environment for our staff. Our journey towards these recognitions reflects our passion for creating an environment where nurses and midwives can thrive. With shared decision-making councils, rewards and recognition, and professional growth opportunities, we ensure that every voice is heard, and all colleagues can contribute to improving care.

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

Area of success / achievement / learning	Details	Further action
International Recruitment (IR).	NHS Grampian continues to embed IR as a recruitment strategy with a North of Scotland model. NHS Grampian is the lead Board for the delivery of Education Programme to meet NMC requirements for Nursing. A strong onboarding, transition, pastoral care model has been developed since 2017 for Nursing with learning now being applied to AHPs and Doctors. In Nursing, almost 40 cohorts for Adult Nursing have been achieved since 2017, 5 cohorts for Mental Health Nursing since 2023 and in 2024/25 the first in Scotland cohort of Learning Disability Nursing. For Doctors, the 3rd CESR cohort has now completed. This was a targeted programme to improve supply for Medical Psychiatry Consultants.	Continue to embed IR as a business-as-usual recruitment mechanism.

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
Financial Challenge in relation to IR.	National funding has ceased and with local financial constraints, the ability to support international colleagues through attractive relocation packages is now limited.	IR team considering alternative options and solutions.
Enduring system pressures and organisational financial challenges.	Teams across the organisation are delivering care in a very busy healthcare system where other initiatives and work streams may require immediate/urgent actions that impact on time, resource and/or ability to develop and deliver necessary processes required of the HCSA.	Implementation of 'Finding Balance' methodology which considers the need to find balance between clinical, staff wellbeing, financial and prevention priorities. Development of Route Map for Strategic Change.
Further pause of Optima roll out.	While compliance of the Act does not necessitate the use of electronic rostering systems, the use of Optima is considered a significant enabler. Unfortunately, with the ongoing lack of interface between Optima and Payroll systems resulting in manual transfers, NHS Grampian has further extended the pause of Optima roll out to new areas. Its wider deployment is dependent on the resolution at national level of compatibility issues with Payroll, which is out with our direct control.	The pause will continue to be reviewed across 2025/26.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

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

Item	RAYG status	Comment
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.	Amber	While it is acknowledged that all roles in scope do have a mechanism for determining Real-Time Staffing (RTS) risks, it is recognised that the processes / outcomes of risk assessment are not consistently documented or they are documented through a variety of means (personal notes, huddle report, shared space/Microsoft Teams). This can be seen within Daily Situation Reports for main hospital sites and Grampian Operational Pressure Escalation System (G-OPES) levels. Progress has been made to ensure all roles in scope across all NHS functions have appropriate systems and processes in place, however further work is required. Implementation of SafeCare (in rostered and non-rostered areas) is within nursing teams across most main sites, community hospitals and one HSCPs community nursing and physiotherapy teams. Discussions continue regarding future roll out plans with a focus on areas of impact, including AHPs and exploratory work with Medical colleagues. Each site/collective group using SafeCare have their own Standard Operating Procedure (SOP) in place. The use of Real-Time Staffing Resource (RTSR) on TURAS is embedded within Midwifery Services. For areas not currently using SafeCare/RTSR, a RTS Checklist was developed to support local operational / professional teams to consider the necessary processes required to comply with the Act. The RTS checklist is also being used as a pre-requirement for SafeCare roll out. SOPs have also been developed for Pharmacy, Psychology and within one laboratory service for Healthcare Scientists.
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	Any colleague can raise a concern regarding staffing levels. Guidance is currently in draft to support colleagues articulating the concern into a risk. While further work is required to ensure this is consistently applied in all processes, this is an integral element of the RTS Checklist.

Item	RAYG status	Comment
These systems and processes include the means for the initial notification / reporting of that risk to the relevant individual with lead professional responsibility.	Amber	While further work is required to ensure this is consistently applied in all processes, this is an integral element of the RTS Checklist. Post SafeCare implementation follow up and evaluation highlights and addresses where this has not been fully embedded.
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.	Amber	While further work is required to ensure this is consistently applied in all processes, this is an integral element of the RTS Checklist. Post SafeCare implementation follow up and evaluation highlights and addresses where this has not been fully embedded.
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.	Amber	While further work is required to ensure this is consistently applied in all processes, this is an integral element of the RTS Checklist. Post SafeCare implementation follow up and evaluation highlights and addresses where this has not been fully embedded.
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.	Amber	While further work is required to ensure this is consistently applied in all processes, this is an integral element of the RTS Checklist. Post SafeCare implementation follow up and evaluation highlights and addresses where this has not been fully embedded.
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.	Amber	While further work is required to ensure this is consistently applied in all processes, this is an integral element of the RTS Checklist. The RTS Checklist was developed to be a self-service resource as training capacity on its application is limited. Training opportunities for areas with SafeCare is provided through a range of mechanisms (e-learning modules, virtual training sessions, face-to-face training sessions and post implementation review meetings).

Item	RAYG status	Comment
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	To fully implement, evaluate and embed at team/department/site level requires significant time and resource. Data is available within SafeCare on recurrent real-time risk and trend analysis relating to leadership time and mitigation of it. Within a busy system of competing priorities and implementation of other Act requirements, this can be challenging.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work required to consider escalations following first year of implementation.

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

Area of success / achievement / learning	Details	Further action
Development of RTS Checklist for all roles in scope where SafeCare/RTSR is not currently in use.	RTS Checklist was developed as a self-service resource to assist teams in ensuring relevant systems and processes are in place. Testing was undertaken, including with AHPs, and refinements made to increase ease of use. Teams where initial mitigations reduce risk have required additional support to identify the real-time benefits (i.e. where cancellation of activity reduces/removes real-time risk). Roll out plans are limited by training/support capacity however where it has been provided has been impactful (some AHP teams). Pre-SafeCare preparations require the checklist to be completed.	RTS Checklist to be rolled out to all relevant roles in scope during year 2 in a targeted approach, although this will be dependent on resource availability.
Use of SafeCare in non-rostered areas.	NHS Grampian identified that SafeCare can be utilised in non-rostered areas as a mechanism for RTS risk assessment. Currently in use across in-patient and community nursing and physiotherapy teams.	Roll out of SafeCare in non-rostered areas to continue given further pause of Optima roll out. Use learning for roll out in planned and unscheduled professional teams to inform ongoing learning and application. Year 2 roll out plan to be agreed.

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
Further pause of Optima roll out.	While compliance of the Act does not necessitate the use of electronic rostering systems, the use of Optima is considered a significant enabler. Unfortunately, with the ongoing lack of interface between Optima and Payroll systems resulting in manual transfers, NHS Grampian has further extended the pause of Optima roll out to new areas. Its wider deployment is dependent on the resolution at national level of compatibility issues with Payroll, which is out with our direct control. While SafeCare can be used within non-rostered areas to meet this duty, the lack of underpinning roster limits the realisation of all benefits of the SafeCare system.	The pause will continue to be reviewed across 2025/26. Continue SafeCare roll out in non-rostered areas.
Perceived value of RTS in areas where activity can be moderated on a shift-by-shift basis to ensure delivery of safe and appropriate care. These areas' level of risk is assumed to be low unless escalation by exception. Daily assessment perceived as additionality with limited value.	Tested RTS using SafeCare in a number of areas with planned activity (Physiotherapy, Laboratories – Healthcare Sciences) and feedback was that it did not contribute to managing risk on a real-time basis other than documented record of actions taken. Recognising that data over time will provide support for identification of severe and recurring risks, although other mechanisms would be able to support this without entries into a system.	Continue testing and understanding impact in planned activity areas. Support teams to understand Act requirements.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

Duty to have risk escalation process in place (12ID)

Item	RAYG status	Comment
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.	Amber	While it is acknowledged that all roles in scope do have RTS risk escalation processes in place, it is recognised that the processes / outcomes of risk assessment are not consistently documented or they are documented through a variety of means (personal notes, huddle report, shared space/Microsoft Teams). However, the Daily Situation Reports for main hospital site, Daily System Connect meetings and G-OPES levels are examples of where it is undertaken across all NHS functions and roles in scope. It is further acknowledged that where these mechanisms are in place, they continue to be most visible within Nursing. Work continues to address this. Progress has been made to ensure all roles in scope across all NHS functions have appropriate systems and processes in place, however further work is required. The RTS Checklist is explicit in the need for risk escalation processes to be agreed and in place. Areas where RTS SOPs (including those where SafeCare is in use) are in place, articulate the risk escalation processes. In addition to RTS escalations, the Establishment Setting through CSM SOP also includes risk escalation processes. While the process for prospective staffing risk escalations is unclear, the use of the Risk Register is evident across the organisation.
These systems and processes include the means for the lead with professional responsibility to report the risk to a more senior decision-maker.	Yellow	Current systems and processes create a means for any lead to report a risk to a senior decision maker. While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist. NHS Grampian was a testing board/early adopter of the Senior Review functionality within SafeCare. This has been rolled out to all nursing and physiotherapy teams where SafeCare was already embedded and will be included for all roles in scope in future roll out plans.

Item	RAYG status	Comment
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	While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist. NHS Grampian was a testing board/early adopter of the Senior Review functionality within SafeCare. This has been rolled out to all nursing and physiotherapy teams where SafeCare was already embedded and will be included for all roles in scope in future roll out plans. Within the current processes, the senior decision maker may also be able to provide clinical advice and where this is not the case, clinical advice may be available via mechanisms described within that duty. Escalations can take place through a variety of mechanisms including local, site and/or HSPC huddles and onwards to Daily System Connect where clinical advice can be sought.
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.	Amber	While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist.

Item	RAYG status	Comment
These systems and processes include means for this onward reporting (referenced above) to escalate further, as necessary, in order to reach a final decision on a risk, including, as appropriate, reporting to members of the board of the relevant organisation.	Yellow	While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist. Onward staffing risk escalations continue from local teams' where agreed mitigations are unable to address all risks and can be escalated through agreed escalation routes to Executive Director on-call. While these escalation routes are known, there is inconsistency as to whether these are documented and accessible to all roles in scope. Services across all NHS functions and roles in scope have Business Continuity Plans. HSCP senior leaders can recommend that identified risks (real-time and/or prospective) are escalated to the Integration Joint Board, Risk Audit and Performance Committee which includes Integration Joint Board members if appropriate. Staffing risks can be reported via DATIX with automatic escalations depending on risk classification.
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.	Amber	While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist. It is recognised that there is inconsistency in current processes to ensure that all decisions made are fed back to the individual raising the initial risk and/or there is corresponding documentation that this has been undertaken. For nursing and physiotherapy teams using SafeCare, there are opportunities for individuals to access information relating to agreed mitigations/decisions to hold risk. The Daily Situation Report, including staffing, is communicated widely via email each day; while this does not meet all necessary requirements, it creates openness and transparency of staffing assessments. DATIX has a feedback functionality which can be utilised to provide feedback by the risk reviewer to the risk reporter.

Item	RAYG status	Comment
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.	Amber	While existing processes are in place to raise disagreements on staffing decisions made, including recording via DATIX on potential/actual harm, further work is required to ensure that they meet HCSA requirements consistently across all roles in scope and NHS functions.
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 board of the relevant organisation).	Amber	While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist. An Executive Level Director is available 24/7 where incidents warrant escalation to Board Level.
These systems and processes include means for raising awareness amongst all staff of the arrangements stated above.	Amber	While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist. Highlighting the roles and responsibilities of colleagues is an integral part of the programme of roll out for SafeCare and follow up discussions. Programme Team feedback to services following the self-assessment process and discussions with Implementation Team and Programme Board Members, provide opportunity to raise awareness of Clinical Service Leaders and Professional Clinical Leaders for further cascade as relevant.

Item	RAYG status	Comment
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.	Amber	While further work is required to ensure this is consistently applied in all processes, it is an integral element of the RTS Checklist. The RTS Checklist concept was a self-service resource with supporting links to national training materials (HCSA TURAS Quick Guides). Individual team training on the checklist is limited due to capacity however where undertaken, all necessary arrangements required are discussed. Highlighting the roles and responsibilities of colleagues is an integral part of the programme of roll out for SafeCare and follow up discussions. Specific training on the role and implementation of Senior Review functionality within SafeCare was delivered to Clinical Service Leaders and Professional Clinical Leaders where SafeCare was already in use and will be covered in pre SafeCare implementation training going forward. Programme Team feedback to services following the self-assessment process and discussions with Implementation Team and Programme Board Members, provides opportunity to raise awareness of Clinical Service Leaders and Professional Clinical Leaders for further cascade as relevant. Training is available for those who undertake 'on-call' in delegated and non-delegated services and Director Level. While this primarily considers major incidents / business continuity incidents, escalation routes are considered. Scoping of these materials from a HCSA perspective with Civil Contingency colleagues will progress over year two.
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	While processes are in place to ensure colleagues receive appropriate time and resource, Clinical Teams are delivering care in a very busy healthcare system where other initiatives and work streams may require immediate/urgent actions that impact on protected time to implement arrangements.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work to consider required to consider escalations following first year of implementation.

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

Area of success / achievement / learning	Details	Further action
Development of RTS Checklist for all roles in scope where SafeCare/RTSR is not currently in use.	RTS Checklist was developed as a self-service resource to assist teams in ensuring relevant systems and processes are in place. Testing was undertaken, including with AHPs, and refinements made to increase ease of use. Teams where initial mitigations reduce risk have required additional support to identify the real-time benefits (i.e. where cancellation of activity reduces/removes real-time risk). Roll out plans are limited by training/support capacity however where provided, it has been impactful (some AHP teams). Pre-SafeCare preparations require the checklist to be completed.	RTS Checklist to be rolled out to all relevant roles in scope during year 2 in a targeted approach, although this will be dependent on resource availability.
Development of SOPs: RTS process using SafeCare.	Each site / collective group of staffing develop a local RTS process using SafeCare SOP that meets their local structures using a consistent (and HCSA aligned) methodology.	Consider how the SOP could be developed and generalised as a template for areas not currently using SafeCare. Undertake SOP reviews as per scheduled review periods.
Early adopter of Senior Review functionality within SafeCare.	NHS Grampian was a testing Board for the Senor Review functionality within SafeCare and early adopter of it. Individualised sessions took place with Clinical Service Leaders where SafeCare was in use, to advise of functionality and determine its local application.	Completion of training sessions with all Clinical Service Leaders and Professional Clinical Leaders using SafeCare. Amendment to SOPs and flow diagrams to represent new processes.

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
Variations between known and documented processes.	While it is acknowledged that all roles in scope do have processes in place, it is also evident that variation occurs in how well these processes are formalised and/or documented. They are often documented through a variety of means such as personal notes, huddle reports or via a shared space/Microsoft Teams.	To be considered as part of ongoing implementation with the development of formally documented processes/SOPs.
Finding Balance and impact of financial pressures and efficiency savings on Clinical Leader capacity.	Implementation of 'Finding Balance' approach, which considers the need to find balance between clinical, staff, financial governance and prevention priorities. Clinical teams are delivering care in a very busy healthcare system where other national and local policy initiatives and work streams may require immediate/urgent actions that impact on leadership responsibilities, service plans and colleague availability/resource.	Impact of other initiatives and work streams on time and resource requirements for clinical leaders to be escalated through local governance arrangements. Development of Route Map for Strategic Change.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

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

Item	RAYG status	Comment
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.	Amber	The RAYG status here reflects the need for further consideration for consistently applied systems and processes for locations not currently using SafeCare. A dashboard has been created on Microsoft Power BI to visualise RTS severe and recurrent risks in line with how these are identified in SafeCare. Definitions of SafeCare severe and recurring risks have been locally agreed. The RTS severe and recurrent risks dashboard is formally reviewed each quarter at NHS Grampian Clinical Risk Meeting. Non-delegated services consider severe staffing risks within the Accountability and Assurance (A&A) process, reporting to their Portfolio Board. Across delegated NHS services, new and/or escalating high/very high risks are discussed monthly via Clinical Governance structures for awareness and support with mitigations.
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.	Amber	NHS Grampian has a Risk Management Protocol in place including the use of DATIX for Risk Registers. In non-delegated services, the A&A process reviews risks quarterly with reports discussed thereafter at the relevant Portfolio Boards. Within HCSPs, risks are considered within Clinical and Care Governance structures. To support identification, definitions of SafeCare severe and recurring risks have been locally agreed. A Dashboard has been developed to aid visualisation of these with quarterly reports presented at Clinical Risk Meetings and onto Clinical Governance Committee.
These systems and processes include the means for recording risks that are considered severe and / or liable to materialise frequently.	Yellow	Staffing risks can be reported via DATIX with automatic escalations depending on risk classification. The Risk Management Protocol is in place for Risk Registers within DATIX for risks that are being held/unable to be fully mitigated. RTS risk assessments recorded within the SafeCare system can be visualised over time through SafeCare Severe and Recurring Risk Dashboard.

Item	RAYG status	Comment
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 board of the relevant organisation as appropriate	Amber	Risk Management is a key element of our internal controls. The Risk Management Policy outlines that all identified risks with potential to cause harm should be managed in line with Risk Management Protocol. Risks are managed at the lowest operational point as possible, however can be escalated up to Board Committees through relevant governance structures including Clinical Governance, Staff Governance, Population Health and Performance, Assurance, Finance and Infrastructure Committees. Chief Executive Team review strategic risks on a recurring basis (bi-monthly or as necessary). The Audit and Risk Committee scrutinise Strategic Risk Register entries. In non-delegated services, the A&A process reviews risks quarterly and reports are discussed thereafter at the relevant Portfolio Boards. Within the A&A process “red line” metrics are being introduced; these define accepted risk tolerances that Portfolios and operational teams can manage themselves. If the measures/metrics go beyond a certain point (the red line) the outcome of the A&A process will be a requirement for a written response to the Portfolio Executive Leads, Head of Performance Management, Acute Nurse Director and Acute Medical Director from the relevant Portfolio team outlining: why the situation has arisen; their assessment of the risk this represents; and their actions and timelines for resolution. HSCP senior leaders can recommend that the measures to address severe risks are escalated to the Integration Joint Board’s Risk Audit and Performance Committee which includes Integration Joint Board members. The existing systems and processes are predominately for severe risks; further work will be required to include recurring risks going forward.
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.	Amber	Across the various non-delegated services, the A&A reports are shared with colleagues from Nursing (including Health Care Support Workers (HCSW)), Doctors (including Physician Associates), Midwifery (including Maternity Care Assistants), AHPs, Healthcare Sciences (Laboratories) and Pharmacy leadership structures. All recipients can provide clinical advice as necessary. Operational Risk Registers will be managed and reviewed through various governance structures which includes Professional Clinical Leaders.

Item	RAYG status	Comment
These systems and processes include means for identification of actions to prevent the future materialisation of such risks, so far as possible.	Amber	Local risk registers should include actions and timelines for resolution to prevent future materialisation of risks as far as possible. For non-delegated services, the prevention of future risks is integral to existing A&A process, however further work is required to ensure consistency across all roles in scope and NHS functions. Severe and recurrent operational risks for HSCPs are reviewed and discussed during Clinical and Care Governance meetings, and actions to mitigate or prevent future materialisation of the risks are identified.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work to consider required to consider escalations following first year of implementation.

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

Area of success / achievement / learning	Details	Further action
Microsoft Power BI dashboard developed for severe and recurrent SafeCare risks.	A dashboard has been created on Microsoft Power BI to visualise RTS severe and recurrent risks in line with how these are identified in SafeCare. Definitions of SafeCare severe and recurring risks have been locally agreed. The SafeCare severe and recurrent risks dashboard are formally reviewed each quarter at NHS Grampian Clinical Risk Meeting.	Further development of Microsoft Power BI dashboards, including supporting manager self-service.
Internal A&A reports for non-delegated services.	Non-delegated services consider severe staffing risks as part of A&A process, with reports shared quarterly with strategic leads/triumvirate leadership teams from across each service.	Severe and recurrent risks highlighted within the reports are monitored and discussed at relevant Portfolio Board meetings.

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
Further consideration required for areas not on SafeCare.	It is acknowledged there are processes in place to support meeting this duty however there is no consistent method for recording and reporting on severe and recurrent risks in the absence of SafeCare.	To be considered as part of ongoing HCSA implementation and SafeCare roll out.
Recurring and enduring risks often used interchangeably across the organisation.	It is recognised that recurring risks are often referred to interchangeably with enduring risks, across various roles in scope and NHS functions. NHS Grampian has an Enduring Risk Management Protocol however it is acknowledged that from an HCSA perspective, the requirement is on recurring risks.	To be considered as part of ongoing HCSA implementation and awareness raising on the specific requirements of this duty.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

Duty to seek clinical advice on staffing (12IF)

Item	RAYG status	Comment
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 the duties and to record and explain decisions which conflict with that advice.	Amber	In real-time, clinical advice can be sought as part of existing systems and processes of clinical leaders and is available during the working day and on-call systems as seen within the Daily Situational Report for main hospital site, Daily System Connect and Rotawatch. NHS Grampian's Professional Assurance Framework details the professional leadership and assurance structures across all regulated roles in scope. Non-delegated services operate a triumvirate system with senior Nursing, Medical and Operational/General Manager as the managerial and leadership team for all roles in scope within the service area. While a different model exists across the delegated services, there are senior leadership roles for a range of those in scope including AHPs, Nurses and Doctors. Processes to enable raising a disagreement where actions conflict with advice requires further work to ensure consistency in discussions and documentation of these; at present documentation may be across a range of mechanisms including personal notes, huddle notes or SafeCare. Assurance of these processes is greater when specific roles in scope are in greater numbers. Further work to understand smaller staffing groups (Optometry, sub-speciality Healthcare Science teams, Registered Chaplains) is ongoing. The requirement for clinical advice is detailed within the staffing establishment management through application of CSM processes.
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.	Yellow	It is accepted that discussions on staffing decisions, including seeking clinical advice, will consider risks and mitigations. However, these may not be robustly or consistently documented and/or they are documented across a range of mechanisms.

Item	RAYG status	Comment
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	While existing processes are in place to raise disagreements on staffing decisions made, including recording via DATIX on potential/actual harm, further work is required to ensure that they meet HCSA requirements consistently across all roles in scope and NHS functions and to enable this to be reported against within the HCSA internal quarterly reports by Board Level Clinicians (BLCs).
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 board of the relevant organisation on at least a quarterly basis about the extent to which they consider the relevant organisation is complying with several duties.	Green	NHS Grampian has 3 BLCs: Executive Nurse Director, Executive Medical Director and Director of Public Health. Professional accountability structures are described in the NHS Grampian Professional Assurance Framework. Staff Governance Committee receive internal quarterly reports by BLCs (professional assessment of HCSA compliance) on behalf of NHS Grampian's Board. These reports also include external quarterly high-cost agency reports. The professional assessment undertaken by each BLC is easily identifiable within the internal quarterly report.
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 this section and to record those views in the reports to the members of the board of the relevant organisation.	Amber	NHS Grampian has a number of Area Professional Advisory Committees, representing many of the regulated roles in scope where the voice and views of colleagues can be heard and sought. Professional Clinical Leaders can share views via Clinical Professional Directors Forum. Views of colleagues are gained annually through iMatter (60% response rate during 2024). Further work is required to incorporate colleagues' views within the HCSA internal quarterly report.

Item	RAYG status	Comment
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	BLCs are supported by the current Programme Team to implement the quarterly HCSA reporting requirements. As other processes develop to support this duty (themes/data from decisions conflicting with clinical advice), these will be incorporated into future reports. It is recognised that the mechanism for reporting will evolve over time as processes are embedded, enabling a shift of focus to outcomes and triangulation of them.
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.	Yellow	Reporting timelines for HCSA internal quarterly report, external quarterly high-cost agency report and annual report agreed for 2024/25 are communicated to BLCs. Medical Job Planning processes requires the protection of clinical leadership time for Consultants and SAS Doctors. Areas with Optima can identify those in clinical leadership roles (e.g. shift, team level) and through its reporting functionality, can monitor when an individual is deployed into direct clinical care as part of RTS mitigations.
These systems and processes include means for the relevant organisation to have regard to the reports received.	Green	Three HCSA internal quarterly reports have been received by Staff Governance Committee by February 2025 with timelines agreed for Q4. To date, Staff Governance Committee have been assured that BLCs have, in context of being at an early stage of HCSA Implementation, appropriately considered the organisation's Act compliance and that these views will be regarded as part of the boarder assurance process.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work required to consider escalations following first year of implementation.

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

Area of success / achievement / learning	Details	Further action
Professional Assurance Framework for all professional roles in scope with statutory regulation.	Previous Framework has been updated to reflect current professional leadership structures and to ensure accurate and relevant references following HCSA commencement. The BLC structure is used for the HCSA quarterly reporting requirements (High-Cost Agency and internal quarterly reports).	Updated version of Framework to be widely shared via professional structures as a mechanism to support clinical advice discussions. Sharing of professional assurance updates to Clinical Governance Committee and amongst relevant roles in scope.
Clinical Leader definitions for all roles in scope.	The HCSA Statutory Guidance has many interchangeable references to clinical leadership/ clinical leader. To support local operational and professional teams in their understanding and application of requirements, local Board definitions were created from first level to Board level clinical leadership.	Development of further examples to assist application across all roles in scope. Sharing of document within communication strategy.
Introduction of Senior Review Functionality in SafeCare.	NHS Grampian was a testing Board for the Senior Review functionality within SafeCare and early adopter of it. Individualised sessions took place with Clinical Service Leaders where SafeCare was in use, to advise of functionality and determine its local application.	Completion of training sessions with all Clinical Service Leaders and Professional Clinical Leaders using SafeCare. Amendment to SOPs and flow diagrams to represent new processes.

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
Mixed model for professional and/or operational leadership for some roles in scope.	For some roles in scope, line management is different from professional leadership, resulting in potential for clinical advice being missed.	Roles in scope where this has been identified (AHPs, Healthcare Scientists) are actively exploring solutions.

Area of escalation/ challenge / risk	Details	Action
Further pause of Optima roll out.	While compliance of the Act does not necessitate the use of electronic rostering systems, the use of Optima is considered a significant enabler. Unfortunately, with the ongoing lack of interface between Optima and Payroll systems resulting in manual transfers, NHS Grampian has further extended the pause of Optima roll out to new areas. Its wider deployment is dependent on the resolution at national level of compatibility issues with Payroll, which is out with our direct control.	The pause will continue to be reviewed across 2025/26.
Inability to report on all processes required of this duty.	Clinical advice can be sought through several routes across all roles in scope and NHS functions. They are however locally driven to meet the various staffing arrangement discussions. There is no single mechanism for understanding the processes and therefore we are unable to report on it.	To be considered as part of ongoing implementation.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

Duty to ensure adequate time given to clinical leaders (12IH)

Item	RAYG status	Comment
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.	Amber	Optima identifies the Clinical Team Leaders with functionality to report on planned leadership time and/or when this used for RTS risk mitigations. Data is available within SafeCare on recurrent RTS risks and trend analysis relating to leadership time and mitigation of it. For teams where Optima or SafeCare is not in use, there are no consistent processes to understand if sufficient time and resources are planned. However, it is noted that these systems do not directly ensure the time is available but supports the monitoring of it. Further work will be required going forward, particularly given the further pause to Optima roll out. Consultant Job Planning incorporates sessional time for Medical Leadership including Clinical Lead, Service Clinical Director, Unit Clinical Director, educational and clinical supervisor commitments. The latter specifically supports Residents with their training and professional development.
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.	Amber	The Wellbeing, Culture and Development team continue to offer training which focuses on the current appraisal process, supporting managers to provide effective appraisal processes in support of colleague review and development. The Annual Delivery Plan includes internally agreed targets for appraisals.
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	Local Clinical Leadership definitions have been developed to align Statutory Guidance with local structures. Clinical Leaders (Clinical Team Leader, Clinical Service Leader, Professional Clinical Leader and BLCs) are assigned the relevant hierarchy within eEES system. At present updates from eEES are fed to TURAS via SWISS although automatic interface is expected in Q2 2025/26. Where Optima is in use, Clinical Team Leaders are identifiable.

Item	RAYG status	Comment
These systems and processes include the means to determine what constitutes sufficient time and resources for any particular individual.	Amber	The Annual Appraisal /Job Planning processes are the mechanism for reviewing time and resources required to fulfil the three key requirements of the Act. There is currently no infrastructure to determine the consistent application of fulfilling the three key requirements. Professional Clinical Leaders have a professional responsibility to escalate risks if they are unable to meet their leadership responsibilities.
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.	Amber	When a Professional Clinical Lead is appointed for a specific team, the corresponding responsibilities are detailed within the job description. Compliance reports for completed/signed-off Job Plans are monitored via A&A reports and discussed at Portfolio Board Meetings within non delegated NHS functions. Workforce Planning Workshops have HCSA as an integral topic, enabling service discussions to ensure effective systems and processes are developed.
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.	Amber	Service Workforce Planning Workshop (including 6 Step Workforce Planning Methodology) and CSM provides a mechanism to consider leadership time requirements in the future.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work required to consider escalations following first year of implementation.

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

Area of success / achievement / learning	Details	Further action
Clinical Leaders definitions for all roles in scope.	The HCSA Statutory Guidance has many interchangeable references to clinical leadership/ clinical leader. To support local operational and professional teams in their understanding and application of requirements, local Board definitions were created from first level to Board level clinical leadership.	Development of further examples to assist application across all roles in scope. Sharing of document within communication strategy.
Professional Assurance Framework for all professional roles in scope with statutory regulation.	Previous Framework has been updated to reflect current professional leadership structures and to ensure accurate and relevant references following HCSA commencement. The BLC structure is used for the HCSA quarterly reporting requirements (High-Cost Agency and internal quarterly reports)	Updated version of Framework to be widely shared via professional structures as a mechanism to support clinical advice discussions. Sharing of professional assurance updates to Clinical Governance Committee and amongst relevant roles in scope.
Medical Leadership Framework.	A Framework is available for Medical Leadership within the Portfolios across the non-delegated services. The vision is the integration of the tiered Medical Leadership Framework across the Portfolios, contributing medical management and leadership in the delivery of NHS Grampian's Plan for the Future. Within the Framework, roles are defined in a way that will ensure consistency across the non-delegated services.	To be considered as part of ongoing implementation, including exploring inclusion of accurate and relevant references following HCSA commencement.

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
Finding Balance and impact of financial pressures and efficiency savings on clinical leader capacity.	Implementation of 'Finding Balance' methodology which considers the need to find balance between clinical, staff wellbeing, financial and prevention priorities. Clinical teams are delivering care in a very busy healthcare system where other initiatives and work streams may require immediate/urgent actions that impact on leadership responsibilities, service plans and colleague availability/resource.	Impact of other initiatives and work streams on time and resource requirements for clinical leaders to be escalated through local governance arrangements. Development of Route Map for Strategic Change.
Further pause of Optima roll out.	While compliance of the Act does not necessitate the use of electronic rostering systems, the use of Optima is considered a significant enabler. Unfortunately, with the ongoing lack of interface between Optima and Payroll systems resulting in manual transfers, NHS Grampian has further extended the pause of Optima roll out to new areas. Its wider deployment is dependent on the resolution at national level of compatibility issues with Payroll, which is out with our direct control. Unable to track use of leadership time for RTS mitigations or consider as report for severe and recurring risk for areas not currently using Optima.	The pause will continue to be reviewed across 2025/26.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

Duty to ensure appropriate staffing: training of staff (12II)

Item	RAYG status	Comment
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 the appropriate staffing section, and such time and resources as considered adequate to undertake this training.	Yellow	The Wellbeing, Culture and Development (WDC) Team has a lead responsibility for the development of a competent and sustainable workforce including all roles in scope across all NHS functions. WCD resources include Statutory and Mandatory Training Framework, Corporate Induction, TURAS Appraisal, TURAS Learn and Manager Development. The Professional Assurance Framework articulates the need for relevant professional, mandatory, statutory and organisational training requirements for all regulated roles in scope. Practice Education and Development Team support professional training and development for Nursing, Midwifery, AHPs and HCSWs. A newly updated induction for HCSWs was launched in 2024 to better meet the needs of new colleagues and services, while enabling monitoring and support for the completion of the national HCSW Workbook. Residents within their Foundation years are supported to attend NHS Education for Scotland (NES) facilitated lunch and learn sessions as part of their training programme. NHS Grampian endeavours to provide appropriate time and resources to attend training and development opportunities that will be of benefit to the individual, their patients and/or the wider organisation. Annual appraisal processes can identify and address training gaps. Responsibility for completion of training sits within operational structures; oversight and assurance is through Clinical and Staff Governance Committees. HCSA educational resources are promoted through a variety of means including system wide and targeted communication to professional groups and operational teams, inclusion in all HCSA presentations, and 6-Step Workforce Planning Training.
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	NHS Grampian offers a range of Corporate Induction programmes to appropriately meet the needs of Clinical, Resident Doctor, Medical and Physician Associate colleagues. A Statutory and Mandatory Training Policy is embedded with an accompanying framework for eLearning modules and face-to-face courses. Training material is regularly reviewed with notable recent changes to streamline several modules into a single resource and the development of learning assessments for colleagues who have previously undertaken full modules.

Item	RAYG status	Comment
These systems and processes include the means to deliver the agreed level of training to all relevant employees.	Yellow	Regulated roles in scope have their professional educational and training requirements considered within the Professional Assurance Framework and are reviewed/managed via professional leadership structures. Foundation Resident Doctors training is led by NES. Nursing, Midwifery, AHP and HCSW colleagues have an embedded Practice Education and Development Team to support training requirements.
These systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training.	Yellow	While processes are in place to ensure colleagues receive appropriate time and resource to undertake training, with current workforce, system and financial challenges, the cancellation of protected study time is a likely mitigation in real-time.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work required to consider escalations following first year of implementation. Training targets are monitored through quarterly Annual Delivery Plan milestones with assurance updates at Staff Governance Committee. Non-delegated services monitor training compliance as part of the A&A process and governance groups include Partnership Forums and Clinical Governance meetings.

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

Area of success / achievement / learning	Details	Further action
Protected Learning Time (PLT) subgroup.	PLT subgroup established and surveys issued to all staff, leadership teams and subject matter experts respectively to support design of new statutory and mandatory framework which aligns to job families.	Local NHS Grampian work has been paused pending clarity of the national approach to avoid duplication. Updates from the national work stream will continue to be provided to the PLT subgroup, which will 'stand-up' as the national work builds momentum.

Area of success / achievement / learning	Details	Further action
HCSA integral in Workforce Planning Workshops.	Work had previously progressed to sign-post colleagues to HCSA related educational resources within pre-read resources. As part of a new model of multi-professional/service led Workforce Planning Workshops, HCSA, Optima and SafeCare sessions are included.	Continue to evaluate for realised benefits for this integrated model. Future considerations include direct follow up with service from HCSA Team, following Workshop.
Promotion of HCSA specific resources.	Programme Team continue to promote HCSA duties, requirements and national resources during all HCSA related engagement, feedback and learning sessions. The multi-professional Implementation Team promotes shared learning in relation to HCSA between services and professional groups.	Development of a specific NHS Grampian HCSA intranet page is underway to include all internal and external resources, which will be linked to the new NHS Grampian SharePoint intranet home page once launched.
Internal A&A reports for non-delegated services.	Non-delegated services review training compliance as part of A&A process, with reports shared quarterly with strategic leads/triumvirate leadership teams from across each service.	Compliance metrics within the reports are monitored and discussed at relevant Portfolio Board meetings.
Engagement and collaboration with NES in review of HCSA materials on TURAS platform.	NES are leading on a rapid collaborative Expert Working Group (EWG) review of existing HCSA materials on TURAS platform. NHS Grampian has Dentistry and Pharmacy representation on the EWG to influence future direction. NHS Grampian is facilitating connections with NES and NHS Scotland Workforce Planners.	NHS Grampian representatives will provide updates to Programme Team. Programme Tem remain connected with national networks for shared learning of how resources are utilised and promoted in other boards.

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
Lack of reporting functionality for HCSA TURAS resources.	Clinical Team Leaders and Clinical Service Leaders are unable to monitor colleague's compliance/utilisation of existing Informed and Skilled Levels. Limited meaningful data to inform Board monitoring from Healthcare Improvement Scotland's Healthcare Staffing Programme (HSP) TURAS Resources via analytics shared via HSP: unable to identify local areas for specific target.	Raised with Chief Nursing Office Directorate in variety of forums across 2024/25 with offer to support any testing. Raised with NES colleagues in January 2025 as part of HCSA TURAS resource review.

Area of escalation/ challenge / risk	Details	Action
Prioritisation of learning time within a system of enduring pressures.	With current workforce, system and financial challenges, the cancellation of protected study time is a likely mitigation in real-time. No current clarity on Agenda for Change (AfC) pay deal requirements for protected learning. Plan for non-AfC roles in scope also required. Challenge for Foundation Residents where rota compliance is regularly breached.	To be considered as part of ongoing implementation including exploring any crossover connections with Break Facilitators in improving Resident Doctors rota compliance.
Ensuring sufficient protected time for learning.	There is inconsistency in the ways in which national terms and conditions support time for core learning and other forms of continuing professional development. In context of current system pressures, this makes some staff groups particularly vulnerable to not having sufficient working time available for learning. This is reflected in ongoing work to try and improve statutory and mandatory training compliance amongst established staff.	We await the outcomes of the PLT strand of the AfC reform programme.
Impact of financial pressures, efficiency savings via Value and Sustainability Programme and Reduced Working Week (RWW).	Challenge to balance the training needs of all roles in scope to ensure competence, with reduced working hours available due to AfC Non-Pay Reforms RRW step 1, alongside the recommended removal of additional hours/overtime payments as an option for colleagues completing training modules/sessions and increasing clinical demands. This is also alongside targeted vacancy controls and a reduction in the availability of corporate services, as a result of service change required to reduce financial resources.	Implementation of 'Finding Balance' methodology which considers the need to find balance between clinical, staff wellbeing, financial and prevention priorities. Development of Route Map for Strategic Change. Plans in place for 93% of all AfC colleagues to reduce their working week. Backfill Funding agreed for a number of services based on a risk assessment criteria prioritising service which were both 24/7 and Emergency/Essential.

Level of Assurance - Please indicate level of assurance provided	Reasonable Assurance

Duty to follow the Common Staffing Method (12IJ)

Item	RAYG status	Comment
Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed under this duty (essentially nursing, midwifery and doctors in ED), to follow the common staffing method no less often than the frequency prescribed in Regulations (minimum once per year).	Amber	NHG Grampian's agreed processes in 2024/25 for Nursing, Midwifery and Doctors in Emergency Departments (ED) were not being consistency applied across Q1 and Q2. While the minimum regulations for application of Staffing Level Tools (SLTs) had been set in the NHS Grampian 2024/25 SLT schedule, the inconsistency of processes resulted in missing intelligence/oversight of entire CSM. During Q3 and Q4, the Sustainable Nursing Workforce project led by the Value and Sustainability Programme have led a multi-stakeholder task and finish group to actively develop a SOP: Staffing Establishment Management through Application of CSM, that will ensure robust and consistent processes and governance arrangements. Executive sign-off was received in Q4 2024/25 and implementation now ready for Q1 2025/26.
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.	Amber	NHS Grampian's 2024/25 SLT schedule ensured compliance with prescribed regulations with Adult Inpatient, Small Ward, Mental Health Learning Disability (MHLD) Inpatient and SCAMPS speciality specific tools along with Professional Judgement Tools planned to exceed them. As the Emergency Care Provision Tool is not due to be applied until Q4 2024/25 and due to the timing of this report preparation, the assessment of compliance for this duty is focused on Nursing and Midwifery only. As described above, it was identified across Q1 and Q2 of 2024/25 the agreed processes were not consistently applied. A multi-stakeholder task and finish group was established in Q3 to develop a SOP to ensure robust and consistent processes and governance arrangements. This will be implemented for Q1 2025/26.
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 by Scottish Ministers (including any measures developed as part of a national care assurance framework).	Amber	The current CSM analysis template includes a variety of references (including Excellence in Care, Scottish Patient Safety Programme, HEAT targets) for local teams to consider as appropriate for their areas. Due to inconsistencies in processes, it is unclear how this triangulation was undertaken. This will be addressed through the SOP.

Item	RAYG status	Comment
These systems and processes include taking into account current staffing levels and any vacancies	Yellow	The current CSM analysis template includes the need to consider local staffing levels and vacancies. This will also be included within a new template as part of the SOP. While inconsistencies have been identified in processes, staffing levels and vacancies are regularly taken into account.
These systems and processes include taking into account the different skills and levels of experience of employees	Amber	The current CSM analysis template includes reference to service/professional skill requirements and level of experience for local teams to consider. Due to inconsistencies in processes, it is unclear how this triangulation was undertaken. This will be addressed through the new SOP.
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.	Yellow	The role of Clinical Team Leader (e.g. Senior Charge Nurses, Senior Charge Midwives or Team Leader) is considered within the Professional Judgement Tool and current funded and actual staffing sections of current CSM analysis template. This will continue in the new template as part of the SOP.
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).	Amber	Any changes to local staffing arrangements would be considered within existing and/or wider operational service models however current processes would not consistently have these documented. This will be addressed as part of the transparent risk based decision making by operational services as per SOP.
These systems and processes include taking into account the local context in which health care is provided.	Yellow	The current CSM analysis template is explicit in the need to consider local context of the roster area. This will continue in the new template as part of the SOP.
These systems and processes include taking into account patient needs.	Yellow	The current CSM analysis template is explicit in the need to consider the specific patient needs of the local area. This will continue in the new template as part of the SOP.
These systems and processes include taking into account appropriate clinical advice.	Amber	The requirement to seek clinical advice is included in proposed SOP; this will enhance previous suggested processes.
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.	Amber	The current CSM analysis template includes references to local (and shared learning of others) assessments by Healthcare Improvement Scotland and/or other organisations as appropriate for their areas. Due to inconsistency in processes, it is unclear how this triangulation was undertaken. This will be addressed through the SOP.

Item	RAYG status	Comment
These systems and processes include taking into account experience gained from using the real-time staffing and risk escalation arrangements	Amber	There will be new data sources available to be included going forward, given the roll out of SafeCare to many nursing teams, local intelligence and the SafeCare severe and recurring risks dashboard. Midwifery colleagues currently use NES's Generic RTSR on TURAS with Clinical Service Leaders having access to the necessary reports. While experience from RTS is included in current CSM analysis template, further work is needed to ensure consistency in processes to connect real-time experience, staffing level tools and prospective planning.
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 to ensure appropriate staffing	Amber	The current CSM analysis template is explicit in the need to consider comments and feedback from service users. Clinical Team Leaders are involved in local complaints handling processes and review/respond to Care Opinion. Some services have additional service user feedback mechanisms. Due to inconsistency in processes, it is unclear how this triangulation was undertaken. This will be addressed through the SOP.
These systems and processes include taking into account comments by employees relating to the duty to ensure appropriate staffing	Yellow	The current CSM analysis template is explicit in the need to consider feedback and comments from colleagues; this can include any data and/or action plans from iMatter, Best Practice Australia Culture Matters Survey and/or other local surveys.
These systems and processes include means to identify and take all reasonable steps to mitigate any risks.	Amber	A lack of consistency in processes to identify and mitigate risk was identified in Q1 and Q2 2024/25. This will be addressed through the SOP using the NHS Scotland risk matrix.
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.	Amber	A lack of consistency in processes to identify and mitigate risk was identified in Q1 and Q2 2024/25. This will be addressed through the SOP.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the internal quarterly report (professional assessment) with further work to consider required to consider escalations following first year of implementation.

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

Area of success / achievement / learning	Details	Further action
Identification of inconsistencies in agreed processes allowing opportunity for learning and addressing.	A multi-stakeholder task and finish group established to develop a SOP enabling robust and consistent processes and governance arrangements for Nursing, Midwifery and Doctors in ED. Executive sign-off was received in Q4 2024/25 and implementation now ready for Q1 2025/26.	Relevant distribution and highlighting of new processes across professional and operational structures. Monitoring areas of risk based on establishment deficit through the risk register as outlined in SOP. Compliance assessment of new SOP to be included within internal quarterly report (professional assessment).
Participation in observation studies associated with SLT review and development.	Nursing and Midwifery colleagues participated in Quality Audits and observation studies for development of new Maternity and inpatient MHLD SLTs. Shared learning experience and user confidence in currency of tool can positively impact future tool use.	HCSA Executive Lead followed up with Clinical Service and Professional Clinical Leaders acknowledging work undertaken.

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
Variation and inconsistencies identified all in all elements of CSM within agreed 2024/25 processes.	The CSM is commonly mistaken as the process of critically analysing the outputs of SLTs alongside additional performance indicators, quality metrics and making a recommendation on staffing establishment requirements. This is only one component of a larger process to ensure that staffing establishments are appropriately managed to minimise risk and ensure safe delivery of care. A lack of clarity on governance routes for CSM along with inconsistent application of processes by local teams was identified and required addressing.	A multi-stakeholder task and finish group established to develop a SOP enabling robust and consistent processes and governance arrangements for Nursing, Midwifery and Doctors in ED. Executive sign-off was received in Q4 2024/25 and implementation now ready for Q1 2025/26.

Area of escalation/ challenge / risk	Details	Action
Fatigue and perception of duplication of colleagues involved in observation studies associated with SLTs.	Colleague fatigue as observation studies were in addition to existing SLT schedule processes. Perception of duplication of work and potential for misunderstandings in purpose and outcomes of scheduled processes and observation studies.	Shared learning from Maternity and MHLD colleagues with any future services involved in observation studies associated with SLTs. SOP will create clarity of purpose of CSM.
Competing priorities and demands on Nursing, Midwifery and Doctors in ED colleagues.	Clinical teams are delivering care in a very busy healthcare system where other initiatives and work streams may require immediate/urgent actions that impact on service plans, colleague availability /resource and CSM preparations.	Impact of other initiatives and work streams on CSM processes to be escalated through local governance arrangements.
Leadership time for data collation/assurance and critical analysis.	The robust completion of CSM in Departments and collation within Unit/Portfolio structures requires significant leadership time and administrative resource. Leadership time required at department level to robustly undertake SLTs. Planned leadership time is vulnerable as it is the likely mitigation for RTS risks. Data sources are not available in a single platform.	Inability to meet CSM requirements to be escalated through local governance routes.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

Common Staffing Method - Training and Consultation of Staff (12IL)

Item	RAYG status	Comment
Clearly defined systems and processes are in place, and utilised, for the training and consultation of nurses, midwives and medics in ED.	Amber	Identified lack of specialist expert knowledge to internally deliver training. Teams are sign-posted to national resources (HSP Staffing Level Toolkits, HCSA TURAS resources) and ad hoc locally developed materials. Informal access to previous subject expert. Escalation and Request for Assistance to HSP for training support on Emergency Care Provision Tool with plans in place for Q4 to address this. Consultation with colleagues is included as part of existing processes and will remain within the new SOP for 2025/26.
These systems and processes include means to encourage and support nurses, midwives and medics in ED to give views on staffing arrangements	Yellow	Nurses, Midwives and Doctors in ED have a range of opportunities to provide their views on staffing arrangements. This includes as part of Professional Judgment Tool, RTS assessments and escalation of risks, annually through iMatter, Best Practice Australia Culture Matters Survey, Professional Advisory Committees (for most regulated roles in scope), team meetings and local agreements.
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.	Amber	The current CSM analysis template includes reference to workforce guidance (Professional Bodies, Royal Colleges etc.) for local teams to consider as appropriate for their areas, alongside the views of staff. Due to inconsistencies in processes, it is unclear how this triangulation was undertaken. This will be addressed through the SOP.
These systems and processes include training nurses, midwives and medics in ED who use the common staffing method, on how to use it.	Amber	Identified lack of specialist expert knowledge to internally deliver training. Teams are sign-posted to national resources (HSP Staffing Level Toolkits, HCSA TURAS resources) and ad hoc locally developed materials. Informal access to previous subject expert. Escalation and Request for Assistance to HSP for training support on Emergency Care Provision Tool with plans in place for Q4 to address this. SOP includes flow diagram describing governance routes that allow for transparent risk based decision making and will act as a self-led training resource.

Item	RAYG status	Comment
These systems and processes include ensuring that employees who use the common staffing method receive adequate time to use it.	Amber	Significant leadership time is required at department level by Clinical Team Leader to robustly undertake CSM (including SLTs). Planned leadership time is vulnerable as it is a likely mitigation for RTS risks. Other organisational and/or service work streams, initiatives and demands may have to be prioritised by Clinical Team Leaders. Significant leadership time is required by Clinical Service Leaders and Professional Clinical Leaders to robustly review and quality assure CSM outputs, collate at Unit/Portfolio level and where necessary, prepare for onward risk escalation.
These systems and processes include providing information to nurses, midwives and medics in ED about its use of the common staffing method, including the results from the staffing level tool and professional judgement tool; the steps taken under and the results of the decisions taken as part of CSM duty	Amber	A lack of consistency in providing information, outcomes and decisions was identified in 2024/25. This will be addressed through the SOP in 2025/26.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Monitoring of this duty is considered as part of the HCSA internal quarterly report (professional assessment) with further work required to consider escalations following first year of implementation.

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

Area of success / achievement / learning	Details	Further action
Identification of inconsistencies in agreed processes allowing opportunity for learning and addressing.	The SOP will provide the framework (and therefore training) to complete the CSM through understanding of governance routes for transparent risk based decision making and management of residual risk.	Relevant distribution and highlighting of new processes across professional and operational structures. Monitoring areas of risk based on establishment deficit through the risk register as outlined in SOP. Compliance assessment of new SOP to be included within HCSA internal quarterly report (professional assessment).

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
Lack of internal specialist knowledge across the entire suite of SLTs.	Previous subject expert currently seconded resulting in temporary redesign of role. As inconsistencies of processes were identified, it was evident temporary redesigned role was not appropriate to address the emerging risks. Subject expert/redesigned post currently vacant.	Self-service model with signposting to national HSP resources. Escalation to and Request for Assistance of HSP Team for Emergency Care Provision Tool. Informal access to previous subject expert.
Lack of single point of information for entire CSM.	Establishment of generic email account to support single point of contact however currently no post holder to respond to contacts. Development of a specific NHS Grampian HCSA intranet page is underway to include all internal and external resources, including a specific CSM page, which will be linked to the new NHS Grampian SharePoint intranet home page once launched.	Informal access to previous subject expert for contact responses. Incremental entries on intranet page in advance of publication of site.
Limitations of HSP resources to enable self-service reporting of SLT outcomes.	No national resources available to assist users in extracting relevant SLT reports (from SSTS Platform) or how to interpret outcome reports. Variation of SLT output reports across various specialty specific tools increases possibility of confusion and additional time/effort for Clinical Service Leaders. No internal resource to support local materials in absence of consistent national resources.	Raised with HSP previously through HSP Hub, SLT reviews and wider discussions. Ad hoc internal support materials produced.
Unrealistic user time limits to access SLT output reports.	Many nursing and maternity teams only access SSTS BOXI platform for SLT output reports as other workforce reports are available on Optima. SSTS BOXI user access is removed centrally when accounts are not accessed within defined period (approx. after 9-12 months). Where areas comply with minimum regulations (once annually), permissions will have been removed between each tool run. Permission request processes result in additional steps and delays for Clinical Team Leaders.	Raised with local SSTS Manager and HSP.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance

Planning and Securing Services

Item	RAYG status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that when the relevant organisation is planning or securing the provision of health care from a third party, it has regard to the guiding principles for health and care staffing and the need for that third party from whom the provision is being secured to have appropriate staffing arrangements in place.	Amber	With a strong embedded culture of Staff Governance and Partnership working, the guiding principles and appropriate staffing arrangements are considered when planning services from others. However, these considerations are not fully documented and development of robust processes will require further consideration. NHS Grampian would be supportive of a Once for Scotland agreement that this duty could be fulfilled by an agreement with Chief Executives that one part of NHS Scotland procuring services from another part of NHS Scotland can reasonably assume that the provider Board will be following their legal responsibilities, rather than clauses stating this being introduced into every single Service Level Agreement. Not all NHS functions agreements, arrangements and contracts are managed through NHS Grampian's Procurement Team which has limited the ability to identify key personnel to progress with necessary processes. While further considerations are required, this duty is described, accompanied with service specific examples, when the Programme Team are working with professional/operational teams and supporting delivery of Workforce Planning training. Primary Care Team continue to consider this duty with some minor/light modifications in language when planning or securing new services with Independent Contractors (IC), although this is an area where further clarity is required (see area of challenge below). NHS Grampian supports Fair Work First criteria when planning and securing services from a third party.

Please provide information on the steps taken to comply with this Duty *These are steps taken to comply with this duty 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.*
Discussions have taken place with range of stakeholders including Primary Care Contracts, Primary Care colleagues, and NHS and HSCP procurement colleagues. Work is progressing to expand these conversations to those involved with commissioning/agreements within secondary care. One HSCP has progressed by including mandatory compliance criteria for all new tenders to ensure providers are aware of the need to ensure appropriate staffing. Learning will be shared across Grampian and further steps will be taken to progress consistently across all functions. Engagement with Commissioning Academy (hosted by one HSCP) on HCSA with a specific focus on planning and securing services.

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; what this data has shown and any trends; and any actions taken as a result.*
As described elsewhere, the primary focus of our year one implementation has been on progressing the necessary systems and processes rather than outcome measures; this will require further consideration going forward. With limited tangible outcome measures for patients receiving care within NHS Grampian directly relating to HCSA, considering this for patients who receive care by a third party on our behalf has not been possible. It is noted that Independent General Dental Practitioners are required to undertake a minimum of 15 hours of clinical audit in a three year audit cycle leading to improvements in service delivery and patient outcomes – further work to understand improvements to patient outcomes across our population is required. The Dental Performance Management Group will report performance issues related to Independent Dental Practitioners to the Clinical Governance and Quality in Dentistry Group, and to the Medical Director. For Pharmacy IC services, there is a reliance on the Patient's Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012 and the Patient's Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions 2012. A Performance and Governance Group for Pharmacy contracted services exists with representation from the HSCPs, Primary Care Contracts Team, Pharmacy and Medicines Directorate and contractor representatives where contractual performance, Datix reports and intelligence is discussed and any actions agreed.

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

Area of success / achievement / learning	Details	Further action
Ongoing awareness raising of the specifics/nuances regarding this requirement within the Act.	Programme Team acknowledge that there is more to this requirement than is initially perceived by operational/professional teams. Programme Team have looked to address this by clarifying requirements during HCSA related engagement, feedback and learning sessions.	Continuing engagement with relevant key stakeholders, including procurement and finance colleagues, across all NHS functions to consider and develop processes further.

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
Lack of national approach for application between NHS Scotland Boards.	Insourcing and Outsourcing Frameworks, managed by National Services Scotland (NSS), are in place. While additional wording in future specifications can be considered, NHS Grampian would prefer a Once for Scotland solution is built into the Framework rather than it being considered for each new specification.	Despite attempts though national network of Board Workforce Leads (and associated roles around implementing HCSA) with NSS, and Board connections with Centre for Sustainable Delivery, no progress has been achieved to develop a national collective solution.
IC Dental Practitioners.	NHS General Dental Services Regulations 2010 do not give a Health Board the power to require dental practitioners to provide staffing information when they apply to be listed. 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 do so. This means we are unable to provide assurance on this duty for IC Dental Services. It is unclear at present if this would also be applicable to other IC services including Optometry and General Practice.	Programme Team remain connected with national networks and await updates shared. Discussions are taking place within Scottish Government to consider CLO advice.
Lack of routine sharing of complaints and adverse events with referring Board.	Complaints to another Health Board providing treatment (specialist or planned elective care) by an NHS Grampian citizen receiving care, are not automatically or routinely shared with the referring Board. Adverse Events involving NHS Grampian citizens receiving care by another NHS Scotland board on our behalf, are not automatically or routinely shared with referring Board.	NHS Grampian to consider how best to address this going forward as part of wider work to progress triangulation of Act and patient outcome measures.

Level of Assurance - Please indicate level of assurance provided	Limited Assurance