



# Optimising capacity in health systems under pressure

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# Introduction

In March 2020, in response to the COVID-19 pandemic, NHS Scotland commissioned a new 1,000 bed hospital, the NHS Louisa Jordan (NHS LJ). The hospital was setup within the Scottish Events Campus and completed within 3 weeks. Because of the continued efforts to reduce the spread of the virus, the NHS LJ was not required to treat COVID-19 patients. However, the learning from tools and the techniques applied during the rapid establishment of the facility has much to offer NHS Scotland. This toolkit is underpinned by patient safety and it offers services and teams a range of techniques and approaches to support systems currently under pressure to optimise their capacity.

The aim of the toolkit is to reduce risk and increase safety whilst building confidence and competence in the workforce as they deal with new tasks or an unfamiliar environment, ultimately avoiding harm. To achieve this, safety science recommends a focus on enhancing teamwork and using non-technical skills such as communication and risk management. The wellbeing of those that interact with the system must also be at the forefront of the planning. The following tools assist in that process:

- The **‘Seven Questions’ (7Qs)** is a sequential planning tool which can support the structure and development of a plan.
- The **‘Rehearsal of Concept’ (RoC) drill** techniques to develop, rehearse and implement any new system.
- A **‘Check-in for Change’** tool that promotes a continuous learning system.

## Background

The construction of the NHS LJ required in-depth clinical risk assessments to inform the design, layout and a series of detailed risk mitigation plans to support the build. If it opened, the NHS LJ staffing model would have relied on the clinical workforce being sourced from existing NHS Boards and volunteer cohorts. The main challenge was how to operationalise the facility at pace with a workforce unfamiliar with the environment and with each other. All staff selected attended induction training which allowed some familiarisation with the new working environment. The intent was to create a functional workforce who were engaged and supported, essential to the provision of a viable clinical effort.

Realistic planning, testing and rehearsal of that plan is fundamental to creating a safe and effective service that staff are confident to work in. The sequence which is recommended when using these tools follows the ‘Plan, Do, Study, Act’ cycle. The 7Qs provides the structure to establish the **‘Plan.’** The RoC drill provides a structure which allows the simulation of the plan within the workplace. Implementation within a realistic context and challenging the plan using accurate scenarios to test it, is the **‘Do’** element. The evaluation of the RoC drill is then subject to **‘Study,’** and we can then **‘Act’** upon the outcomes, either by adjusting the plan or changing aspects of the workplace or environment.

The ‘Check-in for Change’ tool then becomes an enduring part of the Quality Improvement process. This toolkit offers models to support teams and systems to build capacity as a part of their suite of interventions when dealing with a surge in demand.

# Seven questions (7Qs)

## What is the 7Qs tool?

The 7Qs tool is an aid to provide structure to a planning process. It can be modified and applied to meet the needs of various challenges and situations. It is a method which lends itself to decision making by groups and can aid ownership and commitment of decisions. It is best operated by those who understand the challenges within the system and that can use the 7Qs in collaboration to produce a safe, workable plan.

## Aim

The aim of the 7Qs tool is to produce a safe, timely, and patient focused plan which best meets the needs of the situation.

## Purpose

The purpose of the 7Qs tool is to provide a structured planning framework which follows a sequential approach to planning for a known event or in anticipation of potential scenario. The 7Qs tool is a guide rather than a set of rules and is based on a series of questions which follow a logical order.

Link	7 Questions: Supporting Decision Making	
<a href="#">Question 1</a>	<b>What is the situation and how does it affect us?</b>	<ul style="list-style-type: none"> <li>• Why do we need to do this?</li> <li>• Who do we need in the team?</li> <li>• What is the impact on patients and staff?</li> <li>• How does this effect safety?</li> <li>• What do we urgently need to know now to start planning?</li> </ul>
<a href="#">Question 2</a>	<b>What have we decided to do and why?</b>	<ul style="list-style-type: none"> <li>• What do we need to achieve and by when?</li> <li>• What else is happening and how may it impact on our decisions?</li> <li>• What are the limitations on what we can do?</li> <li>• Remain flexible things may change?</li> </ul>
<a href="#">Question 3</a>	<b>What do we need to achieve?</b>	<ul style="list-style-type: none"> <li>• What things do we need to do and in what order?</li> <li>• What are the key things that need to happen?</li> <li>• What safety measures do I need in place?</li> <li>• What does success look like?</li> </ul>
<a href="#">Question 4</a>	<b>What are the priorities of work?</b>	<ul style="list-style-type: none"> <li>• All tasks need to be considered and a plan and priority agreed for each one.</li> <li>• Which ones are vital for success?</li> <li>• How do we achieve each of them?</li> </ul>
<a href="#">Question 5</a>	<b>What resources do we need?</b>	<ul style="list-style-type: none"> <li>• People, space, stuff and finance.</li> <li>• Plan ahead ask "so what and what if?"</li> <li>• Communicate, communicate and communicate more.</li> </ul>
<a href="#">Question 6</a>	<b>How robust is the plan?</b>	<ul style="list-style-type: none"> <li>• Coordinate and be prepared to change priorities.</li> <li>• Do things need to happen in sequence or can things happen concurrently?</li> <li>• Time management is critical monitor the agreed timescales.</li> <li>• What are the key milestones that must be achieved and when?</li> </ul>
<a href="#">Question 7</a>	<b>How do we maintain safety and monitor progress?</b>	<ul style="list-style-type: none"> <li>• What are the key safety and progress items that must be monitored and how will this be done?</li> <li>• How are we going to communicate, timings of meeting, who will record meetings, reporting processes, action logs, email and telephone contacts?</li> <li>• How do we back-brief on progress or issues and to whom do we escalate?</li> </ul>

## How to use the 7Qs

The 7Qs process is a team activity and it is best carried out by the team members who can support implementation of a plan. For example, the challenge may be to expand bed capacity quickly within an unused area, therefore Infection Prevention and Control (IPC), Estates, Fire Safety and the clinical staff who will be working in the area should be members of that team. The principle is that those who will be responsible for clinical and non-clinical services in the area should participate in the planning stage.

## Sequence

- The first three questions provide a logical approach to establishing a plan by identifying:
  - the situation and the challenges that the team are facing
  - the patient focus and impact
  - risks and mitigation are identified, and
  - timescales are agreed.
- The following three questions provide greater detail and should be considered in sequence. However, these questions can be condensed if time is a constraint. These elements provide:
  - Consideration of the sequencing of tasks, for example, what needs to happen to support other tasks?
  - What are the resources and building blocks of the plan and where can they be sourced from?
  - Identifying risks and contingencies through questioning, for example, “if we do that, what will happen?” and “what if we do this...?”
  - Coordination of decisions, time management and establishing and monitoring milestones.
- The final question provides consideration of the control measures which support safety, communications and governance structures.

The 7Qs act as a precursor that provide help to plan and prepare for the RoC drill.

### Question 1: what is the situation and how does it affect us?

To plan effectively we need to understand what we are being asked to do, what the outcome needs to be and why we are being asked to do something. This provides context to the challenge which supports good communication, develops trust and helps reduce ambiguity.

The quality of planning improves in direct relation to the quality of the overall understanding of the challenges.

The key elements are:

- What is happening?
- Why is it happening?
- What is the intended effect or outcome we need to achieve?

## Question 2: what have we decided to do and why?

Answering 'what' and 'why' are essential to the success of any plan and need to be very clearly defined. It is recommended to start with the 'why' to ensure that whatever we do is in context of what the higher-level impact needs to be and this may influence our decision making. The 'what' is the output of our plan and needs to be underpinned with a rationale that outlines 'why' we want to achieve this. For example, a request may be to produce an expansion in capacity (the 'what') but we also need to understand 'why' in order to achieve our output in the most effective manner.

The key elements are:

- Defining the need to deliver this work.
- Define what the outcome needs to be. Are there any interim steps we need to achieve, by when and what does success look like?
- What objectives do we need to set to provide and maintain focus on the final outcome and what are the time scales?
- What actions are explicit from the original direction and what additional actions have been identified from the analysis of the task?
- What are the factors critical for success and how do we measure them?

## Question 3: what do we need to achieve?

This is where the plan begins to take shape, based on the analysis and understanding of the outcome. Having identified where we want to get to, we need to establish the pathway of how to get there.

The key elements are:

- What are the tasks we need to achieve and in what order do they need to occur to achieve the desired outcome?
- What resources do we need to support these tasks?
  - **People** – Specialist advice, IPC, Facilities Management advice, Human Resources, Workforce planning, Fire Officer, Health and Safety, Information Technology (IT).
  - **Logistics** – Additional space, equipment, building work, heating, electrical supply, water provision.
  - **Finance** – How much and when but will vary in priority depending on the situation.
- Establish a schedule of work based on the relationships and dependencies between the various activities, sequencing the activities and establishing the critical path for optimal performance.
- Agree control mechanisms to support good governance. For example, reporting structures, timelines, performance milestones, risk assessments, risk management reports and budget control.
- Use the team to check the viability of the plan, the controls and if necessary, test the plan with someone outside the team.

## Question 4: what are the priorities of work?

When the initial analysis is completed, the focus should now shift to developing the detailed plans. This adds additional elements to Question 3 to build a clear direction for the team and the assigning of responsibilities.

This is also the stage where the team formally agree the intent of the plan, outlining what they intend to achieve and what needs to be done to achieve it. This is a milestone in the process where we can describe:

- What we are trying to achieve?
- By when?
- Success will look like...

The confirmation of intent should also include who is doing what and by when, guidance for coordination and cooperation, reporting pathways and timelines.

Additional detail, formed in Question 3, is also added to the schedule of the programme to provide greater granularity and information on timings. This must be agreed by the team and those who are contributing to the plan.

This is also an opportunity to check the control measures and make any changes.

## Questions 5: what resources do we need?

Once the detailed priorities are agreed, the required resources need to be confirmed with risks reviewed and the worst-case scenarios explored.

This supports the development of the contingency plan, and the crucial process of planning for the unexpected, considering “what can go wrong, will go wrong.”

The control measures to address the anticipated and unknowns need to be refined and identified.

The team are engaged, and the schedule is in place. Now is the time to plan for the unexpected.

This requires engagement with all stakeholders with a direct influence on the plan or who will be impacted by the plan.

## Question 6: how robust is the plan?

This is the penultimate stage in the process where the environment is stress tested in order to ensure its robustness and sustainability. The coordination is checked to ensure that the sequencing is correct and supports the intended outcome.



This phase in the process checks the plan and allows the responsibilities and the deliverables to be confirmed. Most importantly it allows the identification of any elements that need to be adjusted and the impact of any changes to be assessed.

In order to achieve this, the following principles must be employed:

- The plan is being tested and not the people involved in the test.
- This can take a number of forms, for example, table-top exercise or a RoC drill. The aim is to rehearse the plan with the main players and test it sequentially in order to identify any weak points or elements which haven't been considered.
- Testing needs to be controlled and any observations and outcomes recorded for analysis and action where appropriate.
- Any changes to be made as a result of the test must be clearly communicated to all team members.
- Depending on the governance structure the plan may require sign off, and the plan will be constantly scrutinised for sustainability and appropriateness.

### Question 7: how do we maintain safety and monitor progress?

The plan must now be monitored and maintained using the control measures already agreed within the plan. An active monitoring programme will ensure that the plan is regularly updated regarding objectives, outcome key performance indicators and milestones.

The monitoring ensures that the delivery team remain on track or that variances and risks are forecast, and appropriate mitigations are in place.

The key elements are:

- Actively monitor the plans especially in areas of identified risk.
- Ensure that governance processes are applied and that risks are assessed and managed.
- Communication is the vital element for success. Sending emails, recording risks and fulfilling the reporting criteria are vital. However, bringing a human element to the communication is key to success. Planning is a human factors rich activity and the best way to reduce "planning noise" with all of its inherent frictions is by speaking. Acknowledge challenges but celebrate successes with at least equal diligence.

## 7Qs summary

The 7Qs are very much a structure to support and guide the planning process. It provides prompts and guides and may not provide all the answers. The process is a team activity with local knowledge and experience guiding each step.

For the plan to be successful everyone involved needs to feel free to speak up. The process should be structured so that everyone has a time to participate and has an opportunity to voice their opinion. To get the best out of the process it is important to think about how this could be practiced.

# The RoC drill

## What is the RoC drill tool?

The RoC drill process can be used as a vital element in the development of new services and in the adaptation of existing services to new contexts. The model has been used in a variety of healthcare settings to test and rehearse the practicality of plans and processes.

The process is scalable, ranging from discussions using a diagram of the area to a full-scale rehearsal. The RoC drill is a flexible approach that can be adapted to meet the needs of short notice rapid expansion of a ward, larger units or larger scale projects. It provides a way of testing a plan within a simulated environment to find out what works and what does not work without risk to patients or the organisation.

Like a table-top exercise, a RoC drill provides a step-by-step testing framework which can be applied to a range of situations and environments.

## Aim

The aim of a RoC drill is to rehearse and test a draft plan. The learning gained from the rehearsals allows for the refinement of the plan's details and produce solutions which are safe and ready for operation.

## Purpose

The purpose of the RoC drill is to:

- Provide a forum in which a plan can be safely simulated and tested without risks to patients or workforce.
- Identify key areas within the plan and the proposed systems of work which may generate risk.
- Harness the collective efforts and knowledge of the participants to generate workable operational solutions.
- Produce a detailed view of how the area or department will operate by taking the assumptions within the plan as to how the work will be carried out. Then testing those assumptions by simulating the challenges of the workplace using scenarios based on real world experience.
- Supports the introduction of the 'Check-in for Change' model to support staff and embed continuous improvement.

*"The ROC Drill in this context empowers individuals to use their specific areas of knowledge and experience to challenge project managers, planning assumptions, procedures and perceptions."*

*David McArthur, Operations at NHS Louisa Jordan*

## Creating conditions for RoC drill

For a RoC drill to be successful, planning and preparation are vital. Essential steps include:

- Clear aims and objectives for the process. Why are we doing this and what do we need to achieve? (The 7Q's framework can help to structure each step).
- An outline plan or clinical model of care which can be rehearsed.
- A structured process to test the draft plan. The method may vary according to the time constraints and space available but should include the RoC drill purpose described above. This may range from a simple walk or talk through to a full scenario-based rehearsal.
- Establishing the timeline in which we need to be ready to operate.
- Incorporating representatives with the relevant expertise to ensure that the working environment is safe and meets the needs of the service as planned. This may include those used during the 7Qs tool alongside others to add objectivity to the testing. For example, if opening a new ward, the inclusion of IPC, Estates, Facilities and Fire Safety will be required together with everyone who provides direct or indirect patient services to the area.
- Detailed understanding of the routine and exception reporting obligations.
- Confirmation of the information needed to get immediate tasks started and further information that can wait until later.

## RoC drill in operation

### Aim

The aim of the RoC drill is to prepare services to be safe and ready to operate.

The RoC drill process helps test and validate the service plan's effectiveness by identifying risks, and the capacity and capability requirements to operate a safe and effective service. The goal is for the operational plan to be tested and rehearsed to a point where it is safe to proceed with implementation.

It helps to ensure connecting processes that the layout of the working area in relation to patient and staff safety, equipment access and storage; emergency procedures; logistic support; key standard operating procedures (SOPs) and communications systems all work together.

RoC drills are planned in a series of learning cycles in which key points are generated by testing the plan. Changes required are recorded after each cycle at the immediate debrief for further consideration in the next cycle. Each cycle builds on the knowledge gained from the previous one and informs a process of rehearsal and testing for any new system. This allows ideas and plans to be tested in a controlled way to understand what works well and what still needs to be improved upon. It also allows teams to model how plans will work by questioning and using experience in a series of scenarios. For example, a request to an increase bed numbers by expanding into a new area would include consideration of the layout, accessibility and what needs to be done to ensure patient safety. As the cycles progress the level of detail increases providing knowledge that ultimately refines the plan of how the work may be done.

Each part in the process involves testing and employs a PDSA (Plan Do Study Act) approach for each of the cycles to refine the plan. The process enables teams to participate in co-design to anticipate and prepare for new activities with decisions made as a collective.

## The PDSA cycle

The PDSA cycle is an effective framework that can be used to transform ideas into action through testing on a small but rapid scale. This type of testing provides a wealth of learning regarding what works well, what could be improved upon and what challenges need to be addressed before the test ideas are implemented.

The successful delivery of a PDSA requires effort and discipline. It incorporates careful and detailed consideration of the following:

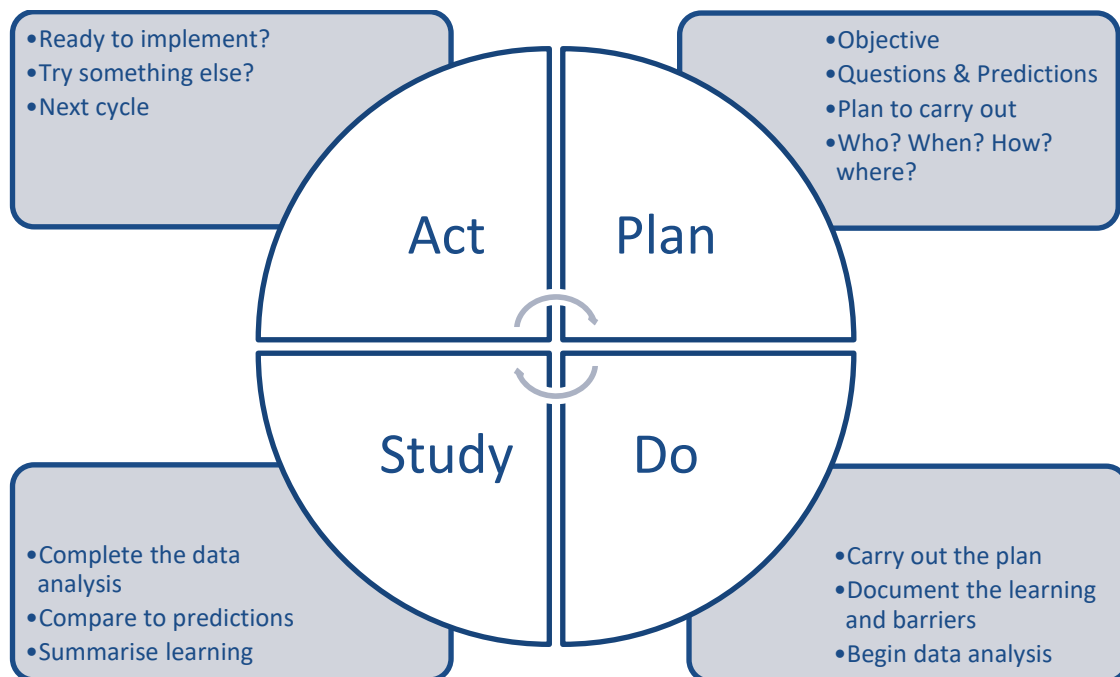
**Plan:** A plan of what is to be tested including questions to be answered by the testing, predicted results to the questions being asked and a plan for collection of data to answer the questions.

**Do:** Carry out the test of change according to the plan, recording observations including unexpected outcomes and observations.

**Study:** A comparison of the data against the predictions made in the plan and a review of the results and learning.

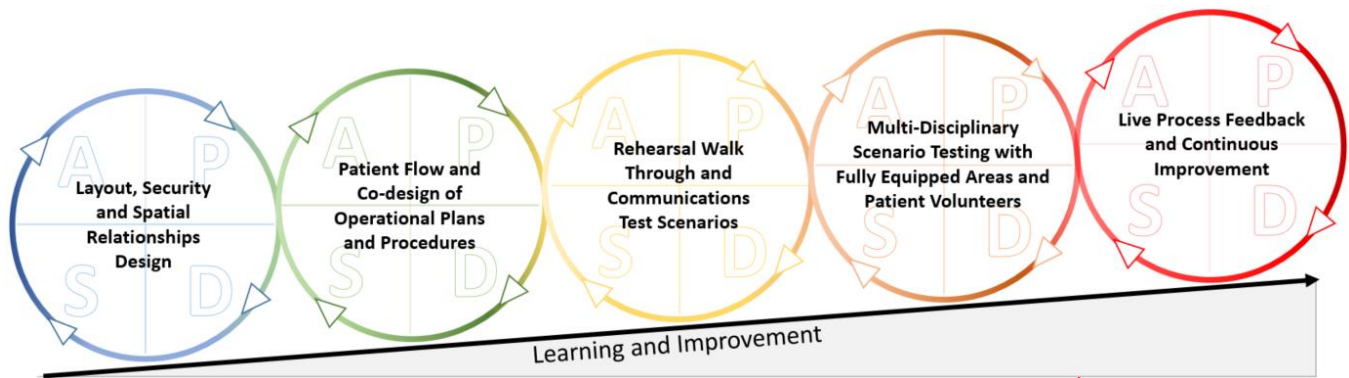
**Act:** Make a decision about the next course of action

Whilst the PDSA cycle originates from industry, its use and success has grown significantly through its incorporation into the [Model for Improvement](#). However, its flexibility as a tool allows it to be used effectively in real or simulated contexts across a variety of working environments.



It is vital that all staff who contribute across the spectrum of patient care have a voice in each step of the process. Continuous feedback is embedded to enable the inclusion of everyone's professional expertise and knowledge of the operating environment. This encourages ownership and supports staff wellbeing which is a key output of the process.

The priority is to frame person-centred services by building capability from the bedside, utilising the expertise of all. The RoC drill example detailed below is presented in five cycles of activity. However, using the RoC drill in different contexts may require fewer or more cycles depending on the complexity of the task and the time available. The process is all about establishing a safe environment, recognising and mitigating risk and ensuring that services are ready to operate.



### Cycle 1 – Layout, security and spatial relationship design

This cycle allows consideration of the spatial relationships of the built environment such as walkways, access, fire safety and security using a floor model. Each step sets the scene, and the layout model is used by teams to inform the operational plans and clinical demand scenarios. Key guidance on the consideration of risks within the built environment is available from [NHS Scotland Assure](#).

### Cycle 2 – Patient flow and co-design of operational plans and procedures

Imagining or using a trial patient journey (from admission to discharge) is examined to review and understand each step in the pathway. This considers who is involved, the risks which may arise and the mitigation required. This enables assumptions and draft SOP's to be developed and tested with co-dependencies clearly identified. Service leads involved should describe each functional contribution to the operational plan. For example, how will access to the area be achieved, is the 'Infection Control' plan viable, how will catering provide food, can estates provide a patient call buzzer system?

### Cycle 3 – Rehearsal walk through and communications test scenarios

This cycle takes the form of a full rehearsal walk through of the clinical area, with the clinical and support teams, following the patient journey. A series of clinical scenarios are required to test safety, emergency procedures, communications, patient flow procedures and the location of key points, for example, nurse's stations, emergency equipment and specimen uplift. This step can also include staff training requirements within clinical and support areas. The 'Check-in for Change' model is introduced, tested and embedded in the daily communications systems.

## Cycle 4 – Multidisciplinary scenario testing with fully equipped areas and patient volunteers

This cycle creates the opportunity to rehearse “a normal working day” through a programme of events and using volunteer patients within a fully equipped and fully staffed area. This cycle enables the testing of: patient safety procedures, staff handovers, communication huddles, bedside learning and operational systems in general. When complete, it should confirm that the system is ready to operate with any risks being mitigated and managed as much as possible.

## Cycle 5 – Live process feedback and continuous improvement

A continuous review and revision of all aspects of any new systems is essential. The first four cycles are systematically reviewed as a group with methods of learning and improvement embedded within the communications framework of the service.

## RoC drill summary

Checklists provide a structured approach to reviewing a plan or process. The checklist below may support teams using a RoC drill approach.

The RoC drill process if used appropriately tests the ability to generate capacity, provide capability and operate effectively. The checklist below uses the three components required to generate clinical capacity and capability as a structure:

- Conceptual – Having an understanding, ideas and vision to develop a plan and method to achieve a successful outcome.
- Physical – Having the resources of space, equipment and most importantly, people to help generate the plan, make it work and sustain it.
- Morale – Most importantly to ensure that the team are motivated by a thorough understanding of their contribution to the plan supported by effective communication and feedback.

Using the following checklist may help to guide teams through each of the RoC drill learning cycles.

*“The testing of processes at all levels and the involvement of the workforce from the bedside up produced a range of additional benefits.*

*Two major challenges were building the team, almost from scratch; and ensuring that the continuous improvement effort was enduring. Both elements were crucial to patient safety and the ongoing refinement of our processes and procedures.*

*Working in an unfamiliar environment with new colleagues can compromise patient safety, and impact on team confidence and competence in the workplace. This can create uncertainty across operational and clinical domains.”*

*David McArthur, Chief Nurse – Operations at NHS Louisa Jordan*

## RoC drill checklist

Component	Stage 1	Stage 2	Stage 3	Stage 4
Conceptual	High level plan endorsed by management	Shared concept of the RoC drill with key stakeholders	Time allocated	Anticipated outcomes
	Further information request	Range of activities identified for rehearsal	Constraints identified	Data sets required and capture method
	Key contact for further authority	List of identified and informed team members	Freedom of decision making	Methods identified to analyse the data
Physical	Resources required	Range of workforce required for the RoC drill	Preparatory training required	Identified trainer and facilitator
	Equipment required and tested within allocated space	Level of support allocated	Sufficient trainers and facilitators	Lead and Management of RoC
	Specific infrastructure requirements	The priority this activity has	Person identified to prepare and execute the main events list	Process and person to collect the data and method of recording
Morale	Preparation and engagement required	Detailed communications plan	Are the identified staff groups the correct ones	Ensure an open and candid dialogue with mixed workforce groups
	Participant group identified and informed	Steps taken to engage the workforce and other stakeholders	Training and preparation required to ensure coproduction	Format for workforce to use to feedback
	Timescale and content to provide sufficient detail to the participants	Type of engagement most appropriate for that group	Identified steps to encourage and gain support from the workforce	What do the workforce need from this process that they would value

## Systems under pressure checklist

The checklist that provides a structured approach from NHS Boards when opening a new ward, changing a function of an existing ward, or expanding the current ward capacity. The checklist and other resources are available as part of the HSP Learning Community. Those with an NHS email can request access to the community [here](#). If you do not have an NHS email address you can request access via the [online form](#). Alternatively, you can [download the checklist here](#).



## Staff involvement in the RoC drill

It is essential to ensuring all staff and services required for the new areas of operation are represented in the RoC drill process. Local services may already have an attendee list and SOP for this purpose. The list below is an example of a staff and service representation and may support you in the development of an attendee list.

Category	Representation	Why
Clinical Care	SCN	Patient safety, staffing, clinical plan environmental risks, coordination
	Medical	Medical staffing, clinical plan
	IPC	Environmental IPC assessment monitoring and advice
	Bed Manager	Plotting patient movement and inclusion within the bed management system
	Service Manager	Finance and cost centre
	AHP (OT, Physio)	Patient safety and staffing, additional roles
	Pharmacy	Integration of management systems and staffing
	Quality Improvement	Migration and integration with current systems
	Practice Education	Training needs analysis for staff from other areas including bank staff
	Scottish Ambulance Service	Required if admissions and discharges are direct from the unit
Estates	Building Management Services	Integration with safety systems
	Health and Safety	Environmental assessment, risk assessment support, safe systems of working
	Water Supply	Clean water supply and drainage
	Electrical Supply	Right place, safe access, correct form (for example, three phase if required)
	Estate Management	Management and coordination of space allocation
	Fire Safety	Integration of alarms on fire board, access and evacuation plan
Support Services	Porter	Patient movement, deliveries, removal of waste, specimen collection
	Catering	Pantry and food hygiene, food provision and special dietary requirements and numbers
	Domestic Services	Laundry arrangements, environmental cleaning assessment, staffing
	Waste Management	Disposal of clinical and non-clinical waste
	Clerical Support	To assess clerical staffing requirements, roles and responsibilities
Logistics	Clinical Stores	Basic range and stock levels to be agreed
	Clinical Monitoring Equipment	Range, type and support
	Domestic Stores	Furniture allocation, beds, lockers, curtains,
	Consumable Stock	Stock levels and range, delivery routines
IT	IT Department	Access to local area networks and wide area networks
		Hardware and software allocation and location
		Email addresses for area and individuals if required
		Telephones (including type) and telephone numbers
		Coordination with switchboard

### Notes:

- All attendees must understand why they are attending and their role specified in attendance notice.
- Not all functions require a single individual, one person can cover multiple roles.
- Keep the team as small as possible without losing expertise.
- Everyone attending (planning or the RoC drill) should have the authority to make decisions.
- Regularly ask the question “Are we safe to operate?” at all stages to encourage a focus on safety.

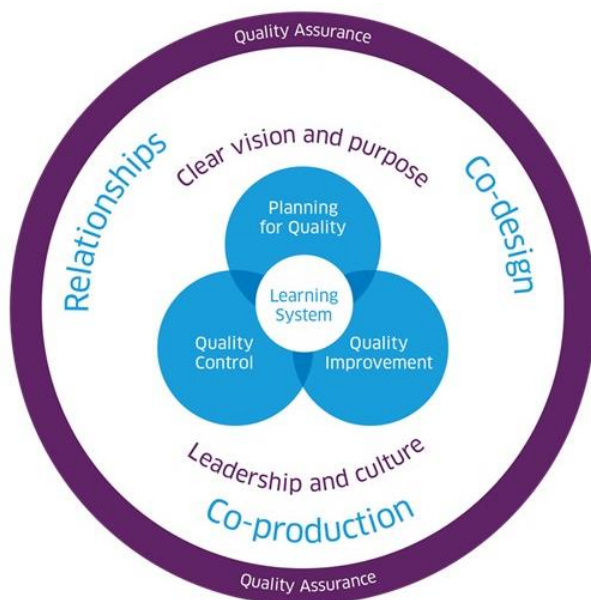


# The workforce plan

In line with the Health and Care (Staffing) (Scotland) Act 2019 it is essential that at all times suitably qualified and competent individuals from a range of disciplines, are working in such numbers as are appropriate for the health, wellbeing and safety of patients and staff and the provision of safe and high-quality health care.

In periods of continuous system pressure and reduced workforce capacity, informed decision making is essential to manage staffing risks, to inform resilience planning, to ensure delivery of safe and effective care and to promote the wellbeing of patients and health and care staff. The staff modelling tool is a useful resource to inform workforce planning but should be used in conjunction with professional judgement.

Using a 'Quality Management System' (QMS) approach to maintaining safe and effective staffing promotes a coordinated and consistent method to managing the quality and effectiveness of staffing in health and care services.



## [Quality management framework – maintaining safe and effective staffing learning system](#)

A development of a national learning system provides a platform and opportunity for:

- Shared learning on what arrangements, systems and processes are supporting the maintenance of safe staffing and the health, wellbeing and safety of patients and staff and the provision of safe high-quality health care.
- Building knowledge and informing the scaling up of new service and workforce models that optimise service and workforce capacity whilst maintaining the safety and quality of health care.

Healthcare Improvement Scotland's [Healthcare Staffing Programme](#) have developed a [National Learning System](#) for health boards to encourage the implementation of the QMS approach and provide a platform to share resources that they have developed to support the maintenance of safe and effective staffing.

## Maintaining quality

It is acknowledged that significant changes to systems, processes and practice could potentially impact on delivery of quality care. During the COVID-19 pandemic clinical teams had to form, adapt and implement changes at an unparalleled rate. It is vital to identify quantitative and qualitative data (tracked over time) that will enable teams to monitor quality without adding unnecessary burden. This may include utilising available electronic data such as your [Excellence in Care](#) (EiC) Care Assurance and

Improvement Resource (CAIR) dashboard or alternative local dashboards (such as adverse events, falls, workforce, complaints), data from other teams (such as business intelligence), qualitative data (staff, carer or family feedback, Care Opinion) and care assurance data (for example, local audits). Early recognition of themes or trends will allow teams to identify and progress improvement action. All of the tools and approaches within this toolkit are designed to be used in parallel and compliment EiC which is the national approach that aims to ensure people have confidence that they will receive a consistent standard and quality of care no matter where they receive treatment in NHS Scotland. During the COVID-19 pandemic the EiC Health Board lead developed [‘Quality of nursing and midwifery care during the COVID-19 pandemic: principles and best practice’](#) with the aim of providing teams with guidance to enable quality of nursing and midwifery care to be maintained during a period of system pressure which may include:

- the redeployment of staff across the health system
- dilution of skill mix
- reduced specialty-specific knowledge and experience
- increased patient-to-staff ratios
- decreased nursing and midwifery capacity (sickness or self-isolation), and
- prioritising fundamentals of nursing and midwifery care.

Another useful resource that was developed during the COVID-19 pandemic and now forms the building blocks for each of the Scottish Patient Safety Programme’s (SPSP) of work is the Essentials of Safe Care. The [Essentials of Safe Care](#) is a practical package of evidence-based guidance and support that enables Scotland’s health and social care system to deliver safe care.

# Team building and embedding learning in new systems

Working in an unfamiliar environment with new colleagues can compromise patient safety, and impact on team confidence and competence in the workplace. As a result of service pressures, staff are often redeployed from their usual practice area to new environments. Whilst necessary to provide patient care, this can create uncertainty across operational and clinical domains. Creating opportunities to learn and adapt together within the daily routine of clinical practice is fundamental. When at full capacity, communication must start at the bedside, be person-centred, with safety and improvement at the core. Within NHS LJM the new teams convened and quickly recognised they required a system of communication and learning to ensure patient safety and support each other. Using active learning processes, they developed a 'Check-in for Change' tool to gather insights and data for critical learning 'in the moment.' These conversations helped to identify risks, instigate change and agree issues requiring escalation.

## Aim

Capturing real time information in the changing environment is key to supporting rapid learning and adaptation. The intent of the check-in model is to create a "whole system" of learning from the 'Bedside to the Board' with less bureaucracy, more action and change whilst continuously improving the safety and quality of care. The 'Check-in for Change' tool supports effective person-centred clinical care and ensures patient safety.

## Purpose

In co-design, the teams developed the 'Check-in for Change' model with six questions that they considered helpful to identify where changes were required to improve patient care, the environment or staff wellbeing. Potential risks may be avoided with on-the-spot fixes. Issues identified by the check-in that cannot be resolved locally are escalated rapidly within the daily communications processes creating a system of learning from the 'Bedside to the Board.' In a similar bedside learning model<sup>1</sup> 55 % of issues were fixed or improved locally. The template below presents a simple check list where staff can note issues and apply a score to share, fix and escalate to the line manager or to a more senior executive level.

The simple and quick check-in system developed formed an integral part of the handover and huddle processes. The information gathered can be an important part of the clinical daily routine led in rotation by the unit lead staff nurses and team members. The check-in process is not confined exclusively to nursing and should include all team members who contribute to patient care and safety. For example, this may include porters, pharmacists, cleaners, allied health professionals, nurses, doctors, managers and ambulance staff to drive change and improvement.

Once the data is gathered using the check-in, the information can be shared daily at the start of the shift, end of the shift and the whole hospital huddles, as well as with the executive group. Issues requiring immediate address, happen daily at the bedside 'in the moment,' at the ward level, at whole

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<sup>1</sup> Shand J, Allwood D, Lee N, Elahi N, McHenry I, Chui K, Tang S, Dawson-Couper Z, Mountford J, Bohmer R. Systematically capturing and acting on insights from front-line staff: the 'Bedside Learning Coordinator'. *BMJ Quality & Safety*. 2021 Jun 1;30(6):509-12

hospital level and with the executives. At the same time good practice solutions can be shared for wider learning.

### **'Check-in for Change' model**

The appeal of the check-in model is that changes can be done quickly without seeking permission or decisions from senior individuals. The focus is on rapid communication and action and allows the collection of simple data. The questions within the tool may include:

- What did we do well yesterday?
- What is going well today?
- Things that could be better?
- How are we all feeling?
- What changes we have made?
- Things we need or need help with?

*"It really important and one of the lesson learning from COVID is that we are constantly checking in with staff, what we plan for services or change might not always go to plan or staff have a much better way of doing things, it adds the dimension of well-being too. I really like the Legend Action Score often we don't take the action required even if we have checked in."*

*Anonymous feedback following testing*

## “Check-in for Change”: data capture tool

Check-in		Points to Note	Action Score
1	What did we do well yesterday?		
2	What is going well today?		
3	Things that could be better?		
4	How are we all feeling?		
5	What changes we have made?		
6	Things we need or need help with?		

Action Score Legend	
1	Share
2	Fix
3	Escalate Line Manager
4	Escalate Executive

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