NHS Shetland

Meeting:	**Shetland NHS Board**
Meeting date:	**28 April 2026**
Title:	**Health and Care Staffing Act Annual Report incorporating Internal Compliance Report –Q4**
Agenda reference:	**Board Paper 2026/27/05**
Responsible Executive/Non-Executive:	**Kathleen Carolan, Director of Nursing and Acute Services / Kirsty Brightwell, Medical Director**
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1 Purpose

This paper presents the second Annual Report on progress towards compliance with the duties of the Health and Care Staffing (Scotland) Act across NHS Shetland and Health services delivered within the Community Health and Social Care Partnership (CHSCP). This report also forms the internal compliance report for Quarter 4.

The Act was enacted as of 1 April 2024.

This paper is being presented to the NHS Board for:

- Awareness and Assurance
- Decision – Approval to publish the Health and Care (Staffing) (Scotland) Act Annual Report 2025/26 in national template form as set out in Appendix 3.

This report relates to:

- Clinical and Care Strategy 2021-2031;
- Shetland Health and Social Care Integrated Workforce Plan 1st April 2022 – 31st March 2025;
- NHS Shetland Annual Delivery Plan 2022-2023;
- Legal Requirement – Health and Care (Staffing) (Scotland) Act 2019;
- NHS Board Governance Procedures.

This aligns to the following NHS SCOTLAND quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

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

Within NHS Shetland to date those identified as Board Level Clinicians are the Medical and Nurse Directors. The Statutory Guidance notes advise that in some NHS Boards the Director of Public Health may also be included if they have responsibility for clinical professions. Further discussion will be held with the Director of Public Health as to the best way for this group of staff to be represented in the quarterly reports going forward.

NHS Shetland established a Health and Care Staffing Programme Board (HCSPB) in March 2022 to provide guidance on the overall strategic direction of the Health & Care Staffing legislation for NHS Shetland.

The HCSPB also retains oversight of the implementation of the 10 specific duties placed on NHS Shetland through the Health & Care (Staffing) (Scotland) Act 2019.

Due to the key responsibilities of the HCSPB, progress to date has been reported to both the Clinical Governance Committee (CGC) and Staff Governance Committee (SGC).

Workforce is one of the strategic risks for NHS Shetland and therefore it is important that both standing committees have an understanding of the work of the Programme Board and ongoing progress towards implementation, and overall compliance, with the requirements of the Act.

This report pertains to services provided directly by the NHS Board and to NHS services delivered as part of the Community Health and Social Care Partnership (CHSCP).

This is the NHS Board's second Annual Report on progress towards compliance with the duties of the Health and Care Staffing (Scotland) Act across NHS Shetland and Health services delivered within the Community Health and Social Care Partnership (CHSCP). This report also forms the internal compliance report for Quarter 4, 2025/26.

2.2 Background

The aim of the Act is to provide a statutory basis for the provision of appropriate staffing in health and care services and is applicable to staff across all clinical areas of practice in NHS Shetland.

While many of the Act requirements are not new concepts, they must now be applied consistently within all Roles in Scope with an intent to:

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

Underpinning all duties and responsibilities placed on NHS Shetland when considering staffing within health care is the application of the Guiding Principles.

The Guiding Principles, as specified in the Act, are:

- To provide safe and high-quality services and to ensure the best health care or (as the case may be) care outcomes for service users - our patients.

This ensures that staffing for health care and care services is to be arranged while:

- Improving standards and outcomes for service users;
- Taking account of particular needs, abilities, characteristics and circumstances of service users;
- Respecting dignity and rights of individual service users;
- Taking account of the views of staff and service users;
- Ensuring wellbeing of staff;
- Being open with staff and service users about decisions on staffing;
- Make the best use of available individuals, facilities and resources – allocating staff efficiently and effectively;
- Promoting multi-disciplinary services as appropriate.

It is beneficial to note that no one factor is more important than another.

As well as introducing Guiding Principles, the Act outlines the following 10 duties which are now placed on NHS Boards, namely:

12IA - Duty to ensure appropriate staffing
12IB – Duty to ensure appropriate staffing: agency worker
12IC – Duty to have real-time staffing assessment in place
12ID – Duty to have risk escalation process in place
12IE – Duty to have arrangements to address severe and recurrent risks
12IF – Duty to seek clinical advice on staffing
12IH – Duty to ensure adequate time given to leaders
12II – Duty to ensure appropriate staffing: training of staff
12IJ – Duty to follow the common staffing method
12IL – Training and Consultation of Staff – Common Staffing Method
12IM – Reporting on Staffing

The Act applies to all Clinical Staff and Senior Leaders within all Healthcare Professions, ie Nursing & Midwifery, Allied Health Professionals, Medical, Dental, Pharmacy, Psychology, and Healthcare Scientists.

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

- Reporting assessment of compliance against the duties;
- Steps taken to have regard to the guiding principles when arranging appropriate staffing;
- Steps taken to have regard to the guiding principles when planning and securing health care services from third parties;
- Views of employees on how, operationally, clinical advice is sought;
- Information on decisions taken which conflict with clinical advice, associated risks and mitigating actions; and
- Conclusions and recommendations following assessment and consideration of all areas detailed above.

The Act also outlines a number of duties for Healthcare Improvement Scotland. These are described fully within the HIS Healthcare Staffing: Operational Framework (HIS-Healthcare-Staffing-Operational-Framework-June-2024.pdf) and are summarised below:

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

To assist HIS in carrying out their functions, formal requests will be made for a copy of the Board's Quarterly Report. A quarterly Board engagement meeting was held between HIS and NHS Shetland representatives to review the quarterly report.

Following review of this practice, the engagement calls have been reduced to 6 monthly in 2025/2026 with HIS using other intelligence held by them in order to monitor performance of the NHS Board overall. Where any gaps are noted, or further clarity sought, this can be requested at any point during the year. The Board engagement calls have been revised to Board review calls and a key lines of inquiry approach adopted since October 2025.

2.3.1 Assessment

Reporting assessment of compliance against the duties;
Throughout 2025/26, in order to report compliance with the duties across all services, Professional Leads were asked to complete a standardised template to report current compliance with the duties, within their areas of professional responsibility.

The Professional Leads are as follows:
Medicine – Dr Kirsty Brightwell, Medical Director
Nursing & Midwifery – Prof Kathleen Carolan, NMAHP Director
Allied Health Professionals – Cathrine Coutts, Exec Manager AHP
Dental – Antony Visocchi, Dental Director
Pharmacy – Tony McDavitt, Director of Pharmacy
Psychology – Consultant Clinical Psychologist (returned from period of leave March 2025)
Healthcare Scientists – no overall Professional Lead.

In order to inform both the quarterly and Annual Reports, information has also been sought from a range of individuals at Service Manager level. This has included Associate Medical Director (Acute), Chief Nurse (Acute & Specialist), Chief Nurse (Community & Mental Health), Chief Midwife, Head of Mental Health Services (prior to the return of the

Clinical Psychologist from a period of leave), Head of Medical Imaging (for Imaging and Audiology), Cardiac Physiologist and Laboratory Services Manager.

Although Professional Leads were provided with a self assessment template to support reporting progress towards compliance within their area of responsibility, to date, not all Professional Leads or required service areas have submitted their returns at the end of each respective Quarter and therefore an overview of current progress, as understood from the information provided in the self assessment returns received, and from the Clinical Workforce Lead's knowledge of service areas and systems progress has been presented in each of the quarterly reports and this information has also been used to inform the Annual Report.

Discussion at the Healthcare Staffing Programme Board suggested that we trial a different approach to reporting into the Clinical Workforce Lead by ensuring that all Professional Leads have ongoing access to the reporting template, via the shared MS Teams channel, allowing for updates to be made at any time with a formal reminder being issued to the Professional Leads when time is approaching for reporting at the end of the quarter so that any further update can be made in time for inclusion in the quarterly report. This approach was trialed to support the completion of the report for the end of Q1 and Q2, however, it had limited success and therefore this was a key topic for discussion, at the Health and Care Staffing Programme Board meeting held in January 2026. Programme Board members felt that the reporting template was the most easy and straight forward way for Professional leads to provide updates. Having gained commitment to this approach, the Clinical Workforce Lead agreed to continue to remind Professional leads as to when an update was required to coincide with the compliance reporting timeframes.

The challenges being experienced with engagement across the Professions was escalated to the Executive Management Team. A dedicated session on the requirements of the Act and our current position against these was held for Executive Management Team members on 14 January 2026. A range of areas were discussed and some management actions agreed. It is hoped that this will support increased understanding and participation across the organisation. In addition, a regular feature in relation to the Act and it's duties is being issued via the monthly Corporate Newsletter.

The BAU team have now supported the full implementation of Allocate Optima in almost all service areas across NHS Shetland and within health services in the Community Health and Social Care Partnership (CHSCP), with the exception of medical services. Some additional targeted support has been offered to Levenwick Health Centre in order to support them to be live in their use of Allocate Optima before the end of this year.

The challenges with staffing levels and overall engagement impacting on progressing the organisational roll out of SafeCare was also discussed at the EMT meeting. Monthly reports on progress with implementation in relevant services is now sent to the respective Executive Managers and Team Leaders for the areas. This has resulted in some more positive engagement within specific areas.

Over the last quarter, dedicated support has been provided to Occupational Therapy services and to Child Health, encompassing Health Visiting, School Nursing, Children's nursing and Public Protection services, however, these service areas still have issues to resolve with the use of Allocate Optima prior to being able to move forward successfully with the implementation of SafeCare.

An additional session was also provided for Dietetics and Speech and Language Therapy to assist with understanding and implementation of SafeCare in their services. The eRostering Lead and Clinical Workforce Lead will continue to offer support directly to teams where issues with implementation have been identified.

In summary information received to date indicates that:

Systems for Realtime staffing are in place within both the Acute sector and Community Health and Social Care Partnership (CHSCP). All areas operate dynamic risk assessment either through their safety huddles or in response to unplanned absences/vacancies which impact on staffing levels.

Staff can voice concerns about staffing levels in real time directly to their line manager, who can then take action to mitigate any risk identified either by redeploying staff across areas, securing supplementary staff or by reprioritising work according to staffing levels available in the area.

Various different mechanisms have historically been used across the different disciplines to record staffing level discussions. NHS Shetland decided in 2024/25 going forward to use SafeCare within clinical services, on an organisation wide basis, to standardise our approach.

As noted before, work is actively being progressed across the Acute Sector and AHP services to complete the roll out of Allocate Optima and SafeCare to these areas and then the focus will be on services within Primary care. A session with key managers in Primary care, Community Nursing and Pharmacy was held on 4 December 2025, with agreement reached to progress work across these services over the period January to March 2026 with an aim of a ‘go live’ date for all services use of SafeCare and hence the ability to then benefit from the use of the SafeCare sunburst to support staffing discussions in morning huddles. It is anticipated that the sunburst will be able to both reflect staffing at individual Health Centre team level, as well as at Primary Care service level on a pan-Shetland basis. Unfortunately due to delays in implementation, and the lack of consistent and accurate use of the system, we have not yet reached the point where the use of the SafeCare Sunburst can be used meaningfully in Primary Care huddles. This will continue to be progressed in 2026/27.

The implementation of SafeCare across the organisation will provide the opportunity to create a standardised approach to the assessment and recording of staffing positions.

This complies with the requirement of 12IC – Duty to have real-time staffing assessment in place.

Guiding principles when arranging appropriate staffing;
Processes are in place to provide assurance that appropriate staffing is in place by utilising the nationally developed staffing level tools to support workforce planning, conducting real time staffing assessment and implementing escalation plans as required.

Within nursing and midwifery there are staffing level tools which are appropriate for use in particular clinical areas and these are conducted as a minimum for a 2 week period, on an annual basis, in line with the requirements of the Act.

Other disciplines, without dedicated staffing level tools, undertake a review of their service demand and staffing levels as part of the annual cycle of service, workforce and financial planning with any subsequently identified need for additional resources submitted as Business cases for consideration by the Executive Management Team.

Staffing level tools are used as part of the Common Staffing Method approach to workforce planning. As part of this approach, consideration is given to a range of metrics which include patient/user feedback, national and locally identified quality measures eg excellence in care measures, other sources of feedback (from staff, external reports, best practice guidance) as well as taking into account the local context in which services are delivered. Training and support for staff in completing the staffing level tools and in using the Common Staffing Method is available from the Chief Nurse (Corporate) / Clinical Workforce lead and is delivered prior to undertaking tool runs.

In addition, the wider Chief Nurse (Corporate) portfolio assists with securing staff access to information on the range of metrics required for consideration in the Common Staffing Method. The staffing level tools for all relevant staff groups locally were last run between January and March 2026. Having undertaken the process of conducting this year's tool runs we have experienced a number of problems with being able to retrieve the tool run reports from the reporting system. These issues have been brought to the attention of the Health and Care Staffing Programme Team nationally and to the SSTS team in NHS Grampian who are responsible for SSTS and BOXI system access. No apparent cause of this problem has yet been identified but this has impacted on our ability to retrieve data from the system and to undertake the remainder of the Common Staffing Method process in a timely way, meaning that completion is now rolling into 2026/27. The information on the Board Compliance Dashboard, developed by the Healthcare Staffing Programme in order to report on Staffing level tool completion, also does not appear to be reflective of our local progress with the staffing level tool runs. This has also been highlighted to the national team.

As noted last year it takes 6-8 weeks to conduct and complete a tool run and therefore there is a need to spread the tool runs throughout the year in order that the entire process can be undertaken in a timely way allowing for the undertaking of the staffing level tool run, review of the output alongside other relevant data and the drafting of the Common Staffing Method report, all in preparation to support the annual strategic, workforce and financial planning cycle. The challenge experienced this year with data retrieval has further highlighted the increased importance of undertaking the tool runs earlier in the financial year. This will be discussed at the Strategic Nursing meeting in May 2026.

Realtime staffing assessment and dynamic risk assessment both enable consideration of the numbers of patients requiring the service, as well as the staffing level available to support delivery of the service. Consideration of patient acuity and staffing numbers allows for the identification, mitigation and escalation of any risk identified either in relation to staff welfare or patient safety.

The Board's current Adverse Event and Risk Management system, Datix, can be used to record either a staffing risk or to report adverse events, whether an actual incident or a 'near miss'. The Datix system has open access which supports the reporting of any concern by any staff member.

During 2026/27 we will move forward with the implementation of Healthcare Guardian as our new Healthcare Governance system. Training and support will be provided to Staff to assist them to use this new system going forward.

Following the recording of patient acuity and staff numbers within SafeCare there is also the opportunity for staff to record the staffing levels they feel are necessary in their Professional Judgement in order to provide safe and high-quality services and to ensure the best health care or care outcomes for service users - our patients.

If Professional Judgement indicates that there is insufficient staffing then a Red Flag can be raised, noting concerns and the issue escalated within the management structure. The use of SafeCare will provide data on risk escalations, including mitigations put in place, which will enable more rigorous monitoring of any staffing challenges going forward. Within SafeCare there is also a function which enables any patient or carers concerns regarding staffing and /or care provision to be recorded. These would be recorded as 'voiced care concerns' and can be reported on via the system.

Staff training is also key to delivery on the Guiding Principles. The Staff Governance Standards highlight that both Employers and staff have a responsibility to ensure that they adhere to regulatory standards and keep themselves up to date. All employees attend Corporate Induction and have a local departmental Induction when commencing employment with the NHS Board and CHSCP.

Organisationally there is a process in place to develop a Corporate Training Plan. The Corporate Training Plan has been trialled on a 3 year basis, with an annual update. A Training Plan for the next cycle covering a 2 year timeframe is currently in development. Training requirements for all staff, based on professional or service needs, are identified at dept/service level and then fed into the overall Corporate Training Plan.
Annual Appraisals are conducted across the organisation, however, monitoring data indicates that our appraisal and PDP completion rate is low. This remains a focus for action across the organisation.

Staff time for training is challenging and resources are limited and therefore bids to alternative funding mechanisms, both locally and nationally, are made to supplement core funding for staff training and development. Where training needs are identified as Essential for role or service development these are generally funded through the training plan, if identified and agreed as part of the proposed service development.

Whilst there is a strong commitment to support staff training across the organisation, ongoing service pressures over the last 12 months means supporting staff to attend training is challenging. Currently information on cancelled training sessions is available on an adhoc basis from Learning and Organisational development or via individual trainers, however this may / may not always include the reason for why training has been cancelled.

A flexible approach is adopted to support staff to attend training eg attendance in work time, attendance in own time with time in lieu given and early rescheduling of any cancelled training is encouraged, although we recognise that this may not be possible depending upon whether the training is local or provided by an external source.

Full implementation of SafeCare will also support better recording and monitoring of time provided to support staff training and also support tracking of training opportunities cancelled as a result of clinical pressures impacting upon the ability to release staff to attend training. Where SafeCare is already in place, codes have been made available to enable teams to reflect staff training time given for both core statutory and mandatory training and for profession specific training. Organisationally we will begin to formally report on this from April 2026.

All of the above support our compliance with the following duties:
12II – Duty to ensure appropriate staffing: training of staff
12IJ – Duty to follow the common staffing method
12IL – Training and Consultation of Staff – Common Staffing Method

Guiding principles when planning and securing health care services from third parties;
Having due regard to the Guiding Principles within the Act is a key requirement going forward both for NHS Board provided services and for any commissioned service. The expectation of confirmation of compliance with the requirements of the Act will be built into any future commissioning agreement.

A working group is being set up to consider the contracts in scope for this duty, taking into account the specific features of local service provision which include that the NHS Board's Primary Healthcare service model is predominantly an NHS Board directly provided salaried service with only one of the 10 General Practices being an Independent Provider and that Contracts exist with a number of Special Health Boards where services are provided at a national level, as well as a range of shared care pathways are in place with other Boards eg via NECU arrangements.

Discussions will be held with the Director of Finance, as responsible Director for commissioning, and with relevant procurement team colleagues to establish a process by which the Guiding Principles and the requirement to confirm that they have appropriate staffing arrangements in place is built into any procurement and/or commissioning process going forward. The impact of the move to sub-national planning and service delivery, on the application of the guiding principles, will also need to be considered going forward.

It should be noted that there is no requirement to ensure that due regard to the Guiding Principles be specified within commissioning arrangements which were in place before 1 April 2024.

Clinical Advice
Most health services delivered by NHS Shetland and through the CHSCP are professionally led and managed. Processes are in place to support the provision of clinical advice on a day to day basis via safety huddles and the use of a realtime staffing method with escalation as necessary within both the NHS Board and Community Health and Social Care Partnership.

In the out of hours periods, a 'Silver command' rota is in place in both areas of the service, some of the postholders on this rota can provide appropriate clinical advice. There is also a Gold Command rota in place at Executive Management Level, some of whom are the Professional Leads and therefore the need for clinical advice can be escalated to this level, if required.

As services in Shetland are small scale it is also recognised practice that if issues arising cannot wait until the next working day and specific professional advice was required that the relevant professional leader may be contacted in the out of hours period whether formally oncall or not.

Having regard to appropriate clinical advice is also one of the features of the Common Staffing Method. This is reflected in practice by the workload/ workforce reports from utilising the Common Staffing Method being shared with the appropriate Senior Clinical Leader for authorisation and escalation into the annual service and financial planning cycle.

The time needed for clinical leadership should also be considered whilst undertaking the Common Staffing Method. The output from staffing level tools will provide evidence on whether there is adequate leadership time available and if not the requirement for additional time should be discussed with the individual and built into future workforce planning.

Professional leads are currently ensuring that appropriate time to lead is built into all relevant Job Descriptions and that this is reviewed both on an annual basis at the time of Appraisal, and at other appropriate key times eg as part of service redesign.

The use of SafeCare will provide a mechanism for systematic monitoring across services the time given for leadership activities and any reasons for this being compromised eg if due to staffing capacity the clinical leader has to leave leadership duties to provide direct patient care.

Within acute services all Senior Charge Nurse/Midwife postholders are considered to be 100% supernumerary to the department staffing levels and therefore any deviation from this where they have had to assume direct care responsibilities can be recorded and monitored via SafeCare with due consideration being given to the frequency of this need when undertaking future workforce planning within the service.

Information available via the Risk and Incident management system, Datix, can also be used to inform whether or not there is adequate time and resources in place to implement the duty.

The activities noted above support our compliance with the following duties:
12IF – Duty to seek clinical advice on staffing
12IH – Duty to ensure adequate time given to leaders

Views of employees on how, operationally, clinical advice is sought;
The management structure for services within NHS Shetland and the health services provided through the CHSCP has to date been professionally led and managed and therefore as noted clinical advice is readily available to staff at all levels of the organisation. The implementation of the silver and gold command rosters also supports access to clinical advice across the 24 hour period, on a 7 day a week basis.

As NHS Shetland is a small organisation with a relatively flat management structure, escalation can occur from front line services direct to the Board level clinicians relatively quickly and easily.

Within workforce planning in current services, the use of the Common Staffing Method requires consideration to be given to a range of measures, which includes data and staff concerns eg Adverse Event reports, iMatter, issues raised under whistleblowing which will help inform whether or not staff feel we are paying due regard to the guiding principles and specific duties in the Act.

Whilst no specific formal mechanism exists asking staff to give their views on section 121F, at an organisational level staff are encouraged to complete the questions in iMatter (annual staff survey) on how well they feel that their views are listened to and acted upon.

In 2023, the Board scored highly on the listened to question but less well on the acted upon which may reflect that we need to be better at providing feedback to staff on ideas/suggestions put forward. Unfortunately, over the last 3 years, whilst there has been a slight decrease in staff completing the iMatter survey this year with completion being by 56% of the workforce, in comparison to 60% of the workforce in 2024 and 2023, a downward trend can be seen in our results on both questions with a slightly greater decrease on the "confident that concerns will be followed up and responded to".
These results will be considered in detail at the Whistleblowing Steering Group and due consideration given to actions which it may be possible to take which could help to improve these results. The Clinical Workforce Lead is a member of the Whistleblowing Steering Group and therefore can actively participate in the discussions.

Question	2025	2024	2023	Trend
I am confident that I can safely raise concerns about issues in my workplace	80	81	82	↓
I am confident that my concerns will be followed up and responded to.	73	75	76	↓

Formal monitoring of compliance with this duty will be supported by the organisational implementation of SafeCare where seeking and receiving clinical advice can be systematically recorded. Any non-compliance or concerns re potential non-compliance can be reported to the person with Lead Professional responsibility at any time. This will be formally documented as part of our processes to meet this duty.

The activities above support our compliance with the following duty:
12IF – Duty to seek clinical advice on staffing

Decisions taken which conflict with clinical advice, associated risks and mitigating actions
During 2025/26 there have been no reports of decisions taken which conflict with clinical advice provided. Monitoring compliance with this duty and escalation, when required, is currently undertaken within clinical practice with escalation occurring within clearly defined management structures in both the NHS Board and CHSC Partnership.

Currently Datix Adverse event/Incident reports should be raised to record any conflict and any subsequent risks created by a decision made which is in conflict with clinical advice. The implementation of SafeCare will support the recording and evidencing of clinical advice having been sought and the subsequent outcome of that advice, including any disagreement with the advice provided. This will also support the provision of feedback to the person who escalated the risk.

Risks

Work has almost completed across the organisation to support teams to be using Allocate Optima effectively as a precursor to moving forward with implementation of SafeCare. Whilst the percentage level of implementation is variable across the services, as of the 12 March 2026, approx. 92% of the organisation overall are now registered as live on the eRostering system. This figure represents most of the organisation with the exception of medical staffing. A more detailed review of the teams actively using the system shows that within the 88% implementation across the entire organisation, this ranges from 94% in nursing and midwifery, 90% in support services, 93% in AHPs with lower levels in the use of the Medics system at 55% and 75% in Bank/Agency.

Overall these figures continue to show further positive progress across all sectors since the last update provided to the Staff Governance and Clinical Governance Committee's in December 2025, where the active use was 85% across the entire organisation, ranging from 94% in nursing and midwifery, 90% in support services, 93% in AHPs with the lower levels in the use of the Medics system at 55% and 75% in Bank/Agency.

There are small incremental improvements occurring across most services, on a month by month basis, however, there are also areas where consistency is not being maintained for which additional management support has been requested. The importance of accurate consistent use of the system will be crucial ahead of the link being made to Payroll systems which we anticipate to be later in 2026. System reports have been sent to Directors and Team managers from January 2026 to ensure effective oversight of individual teams progress and to highlight any areas where there may be a need for additional support.

The eRostering team are actively supporting all teams who are already "live" on the system, with day to day enquiries or issues as and when they arise. In addition they are actively supporting the remainder of the teams who are either in the planning to "go live" or not commenced yet sections of the roll out plan.

Overall approx 42% of the organisation is now live on SafeCare, generally we note a positive incremental increase month on month since implementation first commenced. Percentage usage within nursing and midwifery and AHP services has now reached 50% in nursing and midwifery and 72% within AHP services. However, having introduced formal reporting on SafeCare we have identified that there are some data quality issues in terms of accuracy and consistency in reporting and therefore additional support is being offered to address these points.

The process of using the SafeCare Sunburst is now embedded in the Gilbert Bain Hospital site and Acute Silver command huddles, to inform the huddle discussion and to record any mitigation and/ or escalations required. Following discussions with the relevant teams we are now expanding this further to give generic access to the system for the night shift site co-ordinator to support them to be able to update the census data with any changes in staffing in order to ensure that the data is current across the 24hour period. Training has been provided for additional Accident & Emergency staff in order to support them in using the system.

Full details of progress with implementation of health roster and Safe Care can be seen in Appendix 1.

As noted before, the Risk Management system, Datix, can be used to both record specific incidents / near misses in relation to staffing levels or to record a staffing risk for areas with a severe or recurrent risk due to staffing levels.

In order to enhance openness and transparency regarding compliance with the Health and Care Staffing Act and any issues arising organisationally, going forward it is planned to provide reports from SafeCare on Red Flags raised complete with actions taken, along with Adverse Event reports and risks recorded relating to safer staffing to the NHS Board as part of the quarterly reports. This will be introduced from April 2026.

Plans to discuss with our Public Health & Planning / Informatics colleagues to explore being able to create a local dashboard which can triangulate data from the hospital occupancy levels, Safecare information – patient and staff numbers, acuity, professional judgement & red flags and Adverse event reports from Datix to give a whole system perspective on activity and safety on a shift by shift basis had to be postponed due to service capacity issues. We plan to progress this in 2026/27.

Services across the NHS Board and CHSCP continue to be under considerable pressure which is impacting upon services ability to deliver a clinical service. These pressures are also impacting upon staff and service capacity to participate fully in the implementation of this change programme.

The persistent nature of this pressure has resulted in delays in the roll out of Allocate Optima, and the subsequent move to SafeCare, which does have an impact on the pace at which the Board will be able to demonstrate full compliance with the Act. However, as evidenced in this report we have now achieved almost full compliance with the use of Allocate Optima across NHS acute and health services within the CHSCP and are overall making steady progress, if small percentage gains, on a monthly basis in the roll out and use of Safe Care within teams.

The capacity issues experienced presented a challenge for moving forward with the roll out of both Allocate Optima and SafeCare to a strict roll out plan, and therefore, both systems have been progressed on an opportunistic basis with departments as their capacity allows. However, as noted above, we have undertaken some targeted work to assist specific areas and teams and have found this to have been beneficial in supporting completion and full implementation of Allocate Optima and SafeCare in their area.

We intend to continue with a blended approach of providing general set up and training for teams, offering general access to the eRostering Lead and Clinical Workforce Lead as required and then a follow up targeted session with any area who do not appear to then be utilising the system regularly in order to provide early support and address any problems encountered. In addition we have provided details of areas of concern to Directors and the introduction of management reports will enable closer oversight and early supportive action for any teams who are not continuing to use the systems as intended.

Progress made to date has been through the good support provided by the eRostering Business As Usual team and positive feedback for the Team continues to be provided from various areas across the organisation. An organisational risk, reflecting some of the challenges faced, is in draft and has been considered at the Health and Care Staffing Programme Board prior to being considered at the Audit and Risk Management Group at its first meeting in 2026.

The use of Safe Care and the Risk Management System, Datix, are supporting our compliance with the following duties:
12ID – Duty to have risk escalation process in place
12IE – Duty to have arrangements to address severe and recurrent risks

Local Policy and Procedures
The Clinical Workforce Lead is in the process of drafting local policy and procedures to support the implementation of the duties of the Act in practice. All of these will be circulated for wider comment prior to being put forward for approval through the relevant governance routes.

Guidance to support the standardised use of SafeCare across both inpatient and community/non in-patient areas has now been issued across the services. Within this guidance, there is information relating to the redeployment function within SafeCare. This function should be used when staff members are required to work in another area that is not their normal base location. This function can enable the recording of a redeployment of a staff member to a different area from a period of a few hours to an entire shift to assist with covering gaps in staffing or enhanced care needs in an area.

The Ministerial Scottish Nursing and Midwifery Taskforce Report, Delivering Together for a Stronger Nursing and Midwifery Workforce" (Feb 2025), Outcome 2 requires that "Employers are taking active steps to reduce the frequency of staff moves and where those take place that they are carried out ensuring staff are suitably supported to work within their knowledge, skills and experience and minimise impact on patient safety". Using the redeployment function within SafeCare will enable managers to have oversight of which staff members have been reallocated to work in other teams and can help with ensuring equity of redeployments as well as tracking the frequency and reason for these redeployments taking place. All of this information can support workforce planning as well as ensuring that the redeployment of staff is carried out on a fair and equitable basis, as and when required.

The use of the redeployment function was considered at the Strategic Nurse Meeting on 30 September 2025 and additional training sessions were provided for staff before the official 'go live' date of 10 November 2025. This will be monitored and formally reported, on a quarterly basis, from April 2026.

Local Reporting
Now that Allocate Optima is implemented and being actively used in most teams across the organisation, attention is being turned to the development of workforce management information reports. Allocate Optima contains a module, Roster Perform, which enables the production of management information reports. The eRostering Lead has demonstrated the functionality of this module at both the Strategic Nursing Meeting in September and the Health and Care Staffing Programme Board. Based on these demonstrations, some management reports are now being implemented from January 2026 across all the Professional Leads areas of responsibility.

Having trialled the use of Roster Perform reports within nursing and midwifery, we have identified some data quality issues with the entries being made by staff. This is being followed up via the line management route, with support from the eRostering and Clinical Workforce Lead as necessary. Additional sessions have been held with the Band 8 Nursing managers in order to support their interpretation and understanding of these standard reports. At individual service level, it is possible for the line manager of the area to be able to retrieve workforce reports directly from within SafeCare, support on how to do this is available from the eRostering Lead and BAU Team.

With the introduction of regular management reports we will also aim to provide regular reports on Staffing Adverse Events and/or Risks as recorded on Datix, and for the teams active on SafeCare, reports on mitigations and escalations in relation to Professional Judgement and details of Red Flags raised within teams. This information will also be reported to the NHS Board via these quarterly reports going forward.

Quarterly Reporting

From the date of enactment, 1 April 2024, the requirement for Quarterly reports to be submitted to the NHS Board has been built into the Board's Business Programme with the first quarterly report being presented to the Board at it's meeting in June 2024. Throughout 2025/26, reports were presented to the Board at the end of each quarter, with Q4 report being incorporated into the Annual Report due to the timing of the NHS Board meetings. We have also adopted this approach to this year's Annual Report.

Prior to the presentation to the NHS Board meeting, the quarterly reports are considered by the Clinical and Staff Governance Committees, both of which are Standing Committees of the NHS Board. The Health and Care Staffing programme Board has agreed that this approach will continue throughout 2026/27.

Due to the timing of this NHS Board meeting this report, as the Quarter 4 report, has not been considered separately at the Staff Governance and Clinical Governance Committee's prior to the presentation to the NHS Board. Any issues of concern raised will be discussed as part of the presentation of the Annual Report to the NHS Board at the end of April 2026.

Annual Report

For the Health and Care Staffing Act Annual Report, a national reporting template is required to be completed. The national template asked for reporting to be made in relation to progress with all duties, across all professions, as we have variable levels of progress against all the duties, across the professions we have rated our overall level of assurance for year ending 31 March 2026 as 'reasonable'.

A summary table outlining levels of Assurance across all the 10 Duties of the Act can be viewed at Appendix 2.

The full Annual Report is presented to the NHS Board at it's meeting on 28 April 2026, and following approval will be published on the NHS Board website and submitted to the Scottish Ministers as per the duty 12IM Report on Staffing.

The Annual Report for 2025/26 can be viewed in Appendix 3.

Reporting on Agency Spend in excess of 150%

Section 12IB requires NHS Boards to report on the Duty to ensure appropriate staffing: agency worker which relates to the cost of securing the services of an agency worker during a period which should not exceed 150% of the amount that would be paid to a full-time equivalent employee of the relevant organisation to fill the equivalent post for the same period.

Throughout 2025/26, NHS Shetland has continued to provide a "Nil" return for Agency staff who cost in excess of 150% of substantive staff costs. However, during 2024/25 the Board provided commentary to Scottish Government to advise that there was significant challenge in attributing travel and accommodation costs for some staff members and therefore these were omitted from the costs associated with individual postholders.

This means that whilst there is the potential for inaccuracy in the reported costs, we have not received any requests to review our data submission and therefore we have continued to report using the same approach, throughout 2025/26.

Whilst the cost of Agency staff may be greater than 150% due to the travel and significant challenges associated with the availability and provision of accommodation locally, all Agency staff sourced have been from nationally contracted Agencies and therefore the cost has been aligned with the costs to other NHS Boards across Scotland.

Travel and accommodation costs are a significant cost pressure to NHS Shetland and this has been highlighted to Scottish Government as part of our Annual Operating Plan submission.

Healthcare Improvement Scotland (HIS) Monitoring & Compliance

As of enactment on the 1 April 2024, Healthcare Improvement Scotland (HIS) introduced their new monitoring and compliance role, as specified in the Act, and no longer provide support directly to the Workforce Leads and NHS Boards.

During 2024/25 review meetings were held between representatives of HIS and the NHS Board on a quarterly basis. These meetings were led by the HIS Senior Programme Advisor, attached to our NHS Board area, with the Director of Nursing and Acute Services, HR Services Manager and the Clinical Workforce Lead representing NHS Shetland. At each meeting our quarterly compliance report was discussed, we were commended on the format of our report and no issues of concern were raised in relation to our progress.

For 2025/26, HIS revised the schedule of review meetings, reducing these to 6 monthly with calls being held in Q1 (April to June) and Q3 (October to December). It is recognised that these calls may no longer coincide with the timing at which NHS Board's may have quarterly internal compliance reports available.

Our Q1 call was held in May, with the Q3 call held on 30 October 2025. HIS have introduced a 'guided line of enquiry' format for these meetings and this was used for the review in October. This requires a significant level of detailed reporting. As feedback was invited on this new approach, we requested that notification of the lines of enquiry be issued 2-3 weeks ahead of the scheduled meeting in order to allow time for appropriate preparation. The slides used for the Board Review calls in Q1 and Q3, along with the post meeting notes issued by HIS, have been included in the quarterly reports to the NHS Board in 2025/26 for oversight and assurance.

In Q2 and Q4 HIS noted their intention to review all data, evidence and intelligence that they hold on NHS Board's and may request the submission of additional information to support their monitoring role and function, where necessary. No request for further information was received. For 2026/27 Board Review calls will continue to be held twice yearly, in Q1 and Q3.

Development of our quarterly reports in combination with participation in these quarterly reviews, supported the process of building our annual report for 2025/26, which in turn supported our compliance with the following duty:
12IM – Reporting on Staffing.

The same approach will be adopted throughout 2026/27 to support the development of next year's annual report.

Health and Care Programme Board meetings

The Health and Care Programme Board has had in place a schedule of quarterly meetings throughout 2025/26, which will continue in 2026/27.

In addition to the Health and Care Programme Board, an operational management group, the Allocate Management Group, has been established in 2025/26 under the chairmanship of the Director of Finance, to support the ongoing development of eRostering within NHS Shetland.

This group is meeting on a monthly basis and is providing an opportunity for operational managers to gain support in the adoption and standardising of the Allocate Optima system across NHS Shetland, identifying opportunities for improvement and development of the system thus supporting making organisational decisions and recommendations on the efficient operational use of the system within NHS Shetland.

2.3.2 Quality/ Patient Care

The Health and Care Staffing Programme's mission is to support the delivery of safe and high quality care, by enabling Health Boards to deliver effective workload and workforce planning, so that the right people with the right skills are in the right place at the right time. This is in response to the Scottish Government enshrining safe staffing in law through the Health & Care (Staffing) (Scotland) Act 2019 (The Act).

This is supported by an evidence base which highlights that where supplementary staffing is in place, that a level of 15% or more supplementary staffing is linked with poor patient outcomes.

2.3.3 Workforce

The HCSPB was established to provide oversight of the implementation of the Health and Care (Staffing) (Scotland) Act.

The purpose of the Act is 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*".

Implementation of the requirements of this Act should have a positive effect on the workforce both in terms of recognising and endeavouring to ensure safe staffing levels are in place but also in providing a requirement to undertake rigorous workload reviews through the application of nationally approved evidence based tools.

Ensuring there are sufficient staff to undertake workload demand should also have a benefit on overall staff welfare.

2.3.4 Financial

There are no direct financial consequences of this paper. However, where staffing level tools indicate a requirement to increase staff capacity this will have a financial consequence to the organisation and will have to be considered in line with the other clinical priorities as part of the budget setting process.

The current financial position within NHS Shetland has the potential to impact upon the Board's progression to full compliance with the requirements of the Act.

2.3.5 Risk Assessment/Management

Workforce is one of the Strategic risks for NHS Shetland.

Risk Assessment and Management is undertaken in line with Healthcare Improvement Scotland (HIS) Risk Management Framework which incorporates the NHS Scotland 5x5 Risk Assessment Matrix. A new Risk Management Matrix will be implemented in 2026/27 as part of the local adoption of the 'A national framework for reviewing and learning from adverse events in Scotland' (Healthcare Improvement Scotland, Feb 2025).

2.3.6 Equality and Diversity, including health inequalities

The Board is committed to managing exposure to risk and thereby protecting the health, safety and welfare of everyone - whatever their race, gender, disability, age, work pattern, sexual orientation, transgender, religion or beliefs - who provides or receives a service to/from NHS Shetland.

An impact assessment specifically for compliance with the Act has not been conducted as adherence to the Guiding Principles should ensure that due consideration has been given to equality and diversity issues.

2.3.7 Other impacts

There are no other impacts to note.

2.3.7 Communication, involvement, engagement and consultation

This paper provides an update on activities in progress to support implementation of the Health and Care (Staffing) (Scotland) Act 2019 and as such reports on activities being undertaken at both a national and local level to progress this agenda.
Regular communication and engagement with staff both locally and nationally has taken place to support these activities.

2.3.8 Route to the Meeting

This paper provides a summary of the Professional Leads and Clinical Workforce Lead's assessment on progress towards compliance with the duties of the Act, including details of some of the key activities being carried out to support implementation of the Act.

Due to the scheduled timing of the NHS Board and it's respective Governance Committee's this report has not been considered at a formal meeting of the Staff or Clinical Governance Committee before being presented to the NHS Board for awareness and Approval of the Annual Report for 2025/26 prior to submission to Scottish Ministers.

2.4 Recommendation

This paper presents the second Annual Report on progress towards compliance with the duties of the Health and Care Staffing (Scotland) Act across NHS Shetland and Health services delivered within the Community Health and Social Care Partnership (CHSCP). This report also forms the internal compliance report for Quarter 4.

Board members are encouraged to reflect on the information provided and to provide guidance on any further information which they feel would be helpful to both provide assurance to the Board, and to support evidencing of compliance with the Act.

This paper is being presented to the NHS Board for:

- Awareness and Assurance
- Decision – Approval to publish the Health and Care (Staffing) (Scotland) Act Annual Report 2025/26 in national template form as set out in Appendix 3.

3 List of appendices

Appendix No 1	Roll out plan for Health Roster/Optima and Safe Care as of 12 March 2026
Appendix No 2	Overall Board Self Assessed levels of assurance against the 10 Duties
Appendix No 3	Full Annual Report on National Reporting Template

NHS Shetland Revised Roll out Allocate e-Rostering update – 12th March 2026:

	Nursing & Midwifery	Allied Health Professionals	Support Services	Bank & Agency	Medics	Organisationally
Number of rosters	52	16	30	8	20	126
Number of rosters live	51	16	30	6	13	116
Number of rosters being progressed	1	0	0	1	2	4
Number of rosters to be implemented	0	0	0	1	5	6
Percentage implemented	98.14%	100%	100%	75%	65%	92.06%

Optima has been implemented to 92.06% of the organisation

KEY CONTACT IN BAU TEAM	Nursing & Midwifery Emma Geddes & Jessika Bartkowicz	AHP Emma Geddes & Jessika Bartkowicz	Support Emma Geddes & Jessika Bartkowicz	Medics Nikola Gatherer
Rolled out	1. Clinical Governance & Risk Team 2. Community ANPs 3. District Nurses Mainland 4. District Nurses Isles 5. Non Doctor Isles Nurses 6. Hospital at Home 7. Infection Prevention & Control 8. CDU 9. Air Ambulance OC 10. Practice Nurses 11. Intermediate Care Service 12. Outpatients 13. Practice Education 14. Hospital Specialist Nurses 15. Learning Disability Services 16. Public Health Vaccination Team 17. Cardiology 18. Ward 3 19. Unst Health Centre 20. Oncology/Macmillan Team 21. Brae Health Centre 22. Public Health Team 23. Public Health – On Call 24. Health Improvement Team 25. Bixter Health Centre 26. Clinical Team Leaders 27. Lerwick Health Centre 28. Scalloway Health Centre 29. Whalsay Health Centre 30. Sexual Health Clinic 31. Theatres 32. Senior Charge Nurses 33. Renal Unit 34. CAMHS 35. Yell Health Centre 36. Psychological Therapies Service 37. Child Protection 38. Paediatric Nursing Staffing 39. School Nursing Service 40. Health Visiting Service	1. Podiatry & Orthotics 2. Pharmacy - Primary Care Team 3. Physiotherapy 4. Nutrition and Dietetics 5. AHP Practice Education Lead 6. Medical Imaging 7. Hospital Pharmacy Team 8. Pharmacy On Call 9. CHSC Management 10. Silver Command Community 11. Audiology 12. Laboratory Services 13. Medical Physics 14. Primary Care Admin 15. Occupational Therapy 16. Speech Therapy	1. Finance Team 2. Finance Heads of Departments 3. Procurement 4. Patient Travel 5. HR Team 6. Staff Development Team 7. Spiritual Care Team 8. Information Governance Team 9. Health & Safety Team 10. Digital Technology 11. HR Heads of Department 12. Estates 13. Board Members 14. Chair 15. Chief Executive Office 16. CEO - Chief Executive 17. Corporate Services 18. Community Nursing Admin 19. Occupational Health 20. Porters 21. Domestics 22. Laundry 23. Catering 24. Facilities – Management 25. Patient Focused Booking 26. Main Reception GBH 27. Medical Records 28. Director of Nursing	1. Dental Team 2. Junior Doctors 3. Unst Health Centre 4. Whalsay Health Centre 5. Scalloway Health Centre 6. Yell Health Centre 7. Brae Health Centre 8. Bixter Health Centre 9. Walls Health Centre 10. Lerwick Health Centre 11. Levenwick Health Centre 12. Psychiatry 13. GP OOH **14. Medical Bank** **15. Medical Agency**

	41. ADP Support Team 42. Ward 1 43. Maternity 44. Silver Command Acute – On Call 45. Community Psychiatric Team 46. Dementia Services 47. Substance Misuse Recovery Service 48. MAPA 49. Forensics - On Call 50. A&E 51. Walls Health Centre **52. Community Nursing Bank** **53. Acute Nursing Bank**		29. Planning, Performance and Projects Team 30. Mental Health Admin 31. **Admin Bank** 32. **Other Bank**	
Plan to go live shortly	1. Levenwick Health Centre **2. Mental Health Bank**			1. Medicine 2. Surgery
				1. GP Joy 2. Paediatrics 3. Obs & Gynae 4. Anaesthetics 5. Clinic Planner **6. IR35**

NHS Shetland Roll out Allocate SafeCare update – 12th March 2026:

	Nursing & Midwifery	Allied Health Professionals	Support Services	Medics	Organisationally
Number of rosters	46	11	3	17	77
Number of rosters implemented	23	8	2	0	33
Number of rosters being progressed	3	1	0	0	4
Number of rosters to be implemented	20	2	1	17	40
Percentage implemented	50%	72.72%	33.33%	0%	42.85&

42.85% of the organisation have implemented SafeCare.

NHS Shetland Proposed Roll Out:				
KEY CONTACT IN BAU TEAM	**Nursing & Midwifery** **Emma Geddes & Jessika Bartkowicz**	**AHP** **Emma Geddes & Jessika Bartkowicz**	**Support** **Emma Geddes & Jessika Bartkowicz**	**Medics** **Nikola Gatherer**
Rolled out	1. Clinical Governance & Risk Team 2. Hospital Specialist Nurses 3. Ward 3 4. District Nurses Mainland 5. District Nurses Isles 6. Non Doctor Isles Nurses 7. Hospital at Home 8. Outpatients 9. Sexual Health Clinic 10. Ward 1 11. Maternity 12. A&E 13. Theatres 14. Psychological Therapies Service 15. Public Health Vaccination Team 16. Community ANPs 17. Clinical Team Leaders 18. Health Visiting Service 19. Cardiology 20. Dementia Services 21. Substance Misuse Recovery Service 22. Community Psychiatric Team 23. Learning Disability Services	1. Physiotherapy 2. Medical Imaging 3. Laboratory 4. Podiatry & Orthotics 5. Hospital Pharmacy Team 6. Occupational Therapy 7. Nutrition and Dietetics 8. Speech Therapy	1. Spiritual Care Team 2. Occupational Health	
Work/Training required to implement	24. Paediatric Nursing Staffing 25. School Nursing Service 26. Child Protection	9. Pharmacy - Primary Care Team		
No implementation attempt made so far	27. Infection Prevention & Control 28. CDU 29. Practice Nurses 30. Intermediate Care Service 31. Practice Education	10. Audiology 11. Medical Physics	3. Director of Nursing	1. Dental Team 2. Unst Health Centre 3. Whalsay Health Centre

	32. Oncology/Macmillan Team 33. Public Health Team 34. Health Improvement Team 35. Renal Unit 36. CAMHS 37. ADP Support Team 38. Unst Health Centre 39. Whalsay Health Centre 40. Scalloway Health Centre 41. Yell Health Centre 42. Brae Health Centre 43. Bixter Health Centre 44. Walls Health Centre 45. Lerwick Health Centre 46. Levenwick Heath Centre			4. Scalloway Health Centre 5. Yell Health Centre 6. Brae Health Centre 7. Bixter Health Centre 8. Walls Health Centre 9. Lerwick Health Centre 10. Levenwick Heath Centre 11. Junior Doctors 12. Surgery 13. Psychiatry 14. Paediatrics 15. Obs & Gynae 16. Medicine 17. Anaesthetics

NHS Shetland Roll out Allocate SafeCare <u>February</u> usage update – 12th March 2026:

	Nursing & Midwifery	Allied Health Professionals	Support Services	Medics	Organisationally
Number of rosters	46	11	3	17	77
Number of rosters live	7	5	0	0	12
Number of rosters not live	20	3	1	0	24
Number of rosters to be implemented	19	3	2	17	41
Percentage implemented	13.04%	27.27%	0%	0%	15.58%

15.58% of the organisation are actively and consistently using SafeCare.

NHS Shetland Proposed Roll Out:				
KEY CONTACT IN BAU TEAM	**Nursing & Midwifery** **Emma Geddes & Jessika Bartkowicz**	**AHP** **Emma Geddes & Jessika Bartkowicz**	**Support** **Emma Geddes & Jessika Bartkowicz**	**Medics** **Nikola Gatherer**
Consistently Using	1. Ward 3 2. Outpatients 3. Ward 1 4. Maternity 5. A&E 6. Psychological Therapies Service 7. Theatres	1. Physiotherapy 2. Medical Imaging 3. Hospital Pharmacy Team 4. Laboratory 5. Podiatry & Orthotics		
No usage/inconsistent usage	7. Public Health Vaccination Team 8. Community ANPs 9. Hospital at Home 10. Clinical Team Leaders 11. Health Visiting Service 12. Sexual Health Clinic 13. District Nurses Mainland 14. District Nurses Isles 15. Non Doctor Isles Nurses 16. Hospital Specialist Nurses 17. Clinical Governance 18. Cardiology 19. Paediatric Nursing Staffing 20. School Nursing Service 21. Child Protection 22. CAMHS 23. Dementia Services 24. Substance Misuse Recovery Service 25. Learning Disability Services 26. Community Psychiatric Team	6. Occupational Therapy 7. Speech Therapy 8. Nutrition and Dietetics	1. Spiritual Care Team	
	27. Infection Prevention & Control 28. CDU 29. Practice Nurses 30. Intermediate Care Service 31. Practice Education	7. Audiology 8. Medical Physics 9. Pharmacy - Primary Care Team	1. Director of Nursing 2 Occupational Health	1. Dental Team 2. Unst Health Centre 3. Whalsay Health Centre

	32. Oncology/Macmillan Team 33. Public Health Team 34. Health Improvement Team 35. Renal Unit 36. ADP Support Team 37. Unst Health Centre 38. Whalsay Health Centre 39. Scalloway Health Centre 40. Yell Health Centre 41. Brae Health Centre 42. Bixter Health Centre 43. Walls Health Centre 44. Lerwick Health Centre 45. Levenwick Heath Centre			4. Scalloway Health Centre 5. Yell Health Centre 6. Brae Health Centre 7. Bixter Health Centre 8. Walls Health Centre 9. Lerwick Health Centre 10. Levenwick Heath Centre 11. Junior Doctors 12. Surgery 13. Psychiatry 14. Paediatrics 15. Obs & Gynae 16. Medicine 17. Anaesthetics

NHS Shetland Revised Roll Allocate e-Rostering usage – 12th March 2026:

	Nursing & Midwifery	Allied Health Professionals	Support Services	Bank & Agency	Medics	Organisationally
Number of rosters	52	16	30	8	20	126
Number of rosters used	49	15	30	6	11	111
Number of rosters live not used	2	1	0	0	1	4
Number of rosters to be implemented	1	0	0	2	8	11
Percentage Used	94.23%	93.75%	90%	75%	55%	88.09%

*Roster is classified as being used if users have logged in and made any changes within the system within the last 4 weeks (not including leave approval) If no activity is recorded that means that at least one roster is out of date, therefore the roster is not being used.

NHS Shetland Roll Out:				
KEY CONTACT IN BAU TEAM	**Nursing & Midwifery** **Emma Geddes & Jessika Bartkowicz**	**AHP** **Emma Geddes & Jessika Bartkowicz**	**Support** **Emma Geddes & Jessika Bartkowicz**	**Medics** **Nikola Gatherer**
Live Used	1. Clinical Governance & Risk Team 2. Community ANPs 3. Hospital at Home 4. District Nurses Mainland 5. District Nurses Isles 6. Non Doctor Isles Nurses 7. Infection Prevention & Control 8. CDU 9. Air Ambulance OC 10. Practice Nurses 11. Intermediate Care Service 12. Outpatients 13. Practice Education 14. Hospital Specialist Nurses 15. Public Health Vaccination Team 16. Ward 3 17. Unst Health Centre 18. Oncology/Macmillan Team 19. Brae Health Centre 20. Public Health Team 21. Public Health – On Call 22. Health Improvement Team 23. Clinical Team Leaders 24. Scalloway Health Centre 25. Whalsay Health Centre 26. Sexual Health Clinic 27. Renal Unit 28. CAMHS 29. Yell Health Centre 30. Psychological Therapies Service 31. Health Visiting Service 32. Ward 1 33. Maternity 34. Silver Command Acute – On Call 35. Community Psychiatric Team 36. Dementia Services	1. Podiatry & Orthotics 2. Pharmacy - Primary Care Team 3. Physiotherapy 4. Nutrition and Dietetics 5. Medical Imaging 6. Hospital Pharmacy Team 7. Pharmacy On Call 8. Laboratory 9. Medical Physics 10. Audiology 11. Primary Care Admin 12. Speech Therapy 13. Occupational Therapy 14. CHSC Management 15. Silver Command Community	1. Patient Travel 2. HR Team 3. Staff Development Team 4. Information Governance Team 5. Health & Safety Team 6. Digital Technology 7. HR Heads of Department 8. Estates 9. Community Nursing Admin 10. Porters 11. Domestics 12. Laundry 13. Catering 14. Facilities – Management 15. Patient Focused Booking 16. Main Reception GBH 17. Director of Nursing 18. CEO - Chief Executive 19. Chief Executive Office 20. Corporate Services 21. Occupational Health 22. Planning, Performance and Projects Team 23. Board Members 24. Procurement 25. Spiritual Care Team	1. Brae Health Centre 2. Walls Health Centre 3. Whalsay Health Centre 4. Yell Health Centre 5. Scalloway Health Centre 6. Unst Health Centre 7. Junior Doctors 8. Dental Team 9. GP OOH 10. Levenwick Health Centre 11. Bixter Health Centre **12. Medical Bank** **13. Medical Agency**

	37. Substance Misuse Recovery Service 38. Forensics - On Call 39. A&E 40. MAPA 41. Child Protection 42. Cardiology 43. Senior Charge Nurses 44. Walls Health Centre 45. ADP Support Team 46. Learning Disability Services 47. Bixter Health Centre 48. Paediatric Nursing Staffing 49. School Nursing Service **50. Community Nursing Bank** **51. Acute Nursing Bank**		26. Medical Records 27. Chair 28. Finance Team 29. Finance Heads of Departments 30. Mental Health Admin 31. **Admin Bank** 32. **Other Bank**	
Live Not Used	50. Theatres 51. Lerwick Health Centre	16. AHP Practice Education Lead		12. Lerwick Health Centre
Not Live	52. Levenwick Health Centre **2. Mental Health Bank**			13. GP Joy 14. Surgery 15. Psychiatry 16. Paediatrics 17. Obs & Gynae 18. Medicine 19. Anaesthetics 20. Clinic Planner **1. IR35**

NHS Shetland Revised Roll out RosterPerform update – 12th March 2026:

	Nursing & Midwifery	Allied Health Professionals	Support Services	Bank & Agency	Medics	Organisationally
Number of rosters	52	16	29	9	20	126
Number of rosters live	33	0	3	0	0	36
Number of rosters being progressed	0	0	0	0	0	0
Number of rosters to be implemented	20	16	26	9	20	91
Percentage implemented	63.46%	0%	10.34%	0%	0%	28.57%

28.57% of the organisation are using RosterPerform.

NHS Shetland Revised Roll out eJobPlan update – 12th March 2026:

	Number of Job Plans	Number of Signed Off Job Plans	Number of Job Plans Awaiting 1st Manager Sign Off	Number of Job Plans Awaiting 1st Clinician Sign Off	Number of Job Plans Awaiting 2nd Sign Off	Number of Job Plans In Discussion	Number of Unpublished Job Plans	Percentage implemented
Medics	17	1	0	1	1	11	3	5.88%

5.88% of the Medics have a signed off eJobPlan.

Signed Off Job Plans – Signed off by a relevant consultant as well as Pauline Wilson and Kirsty Brightwell

Job Plans Awaiting 1st Manager Sign Off – Job Plans awaiting sign off by Pauline Wilson

Job Plans Awaiting 1st Clinician Sign Off - Job Plans awaiting sign off by the relevant consultant

Job Plans Awaiting 2nd Sign Off – Job Plans awaiting sign off by Kirsty Brightwell

Job Plans In Discussion - Consultants are reviewing the job plans and discussing any changes that are needed

Unpublished Job Plans – Job Plans on which we are awaiting guidance

NHS Shetland Revised Roll out eRota update – 12th March 2026:

	Number of Rotas	Number of Created Rotas	Number of Live Rotas	Number of Junior Doctors in eRota	Number of Monitoring Exercises carried out	Number of Rotas interfaced to Optima	Percentage implemented
Medics	15	15	2	16	2	0	0%

0% of the Medics are using eRota.

NHS Shetland Revised Roll out BankStaff update – 12th March 2026:

	Bank & Agency
Number of rosters	9
Number of rosters live	0
Number of rosters being progressed	0
Number of rosters to be implemented	9
Percentage implemented	0%

0% of the organisation are using BankStaff.

Decision needs to be made on whether the bank and agency units can be condensed. If not, a named person should be responsible for each of them as access to BankStaff needs to be limited.

Board Reporting Template Overview	**Level of Assurance**
Summary	Reasonable
Chapter 12IA : Duty to ensure appropriate staffing	Reasonable
12IB – Duty to ensure appropriate staffing: agency worker	Reported separately
12IC – Duty to have real-time staffing assessment in place	Reasonable
12ID – Duty to have risk escalation process in place	Reasonable
12IE – Duty to have arrangements to address severe and recurrent risks	Reasonable
12IF – Duty to seek clinical advice on staffing	Reasonable
12IH – Duty to ensure adequate time given to leaders	Reasonable
12II – Duty to ensure appropriate staffing: training of staff	Substantial
12IJ – Duty to follow the common staffing method	Substantial
12IL – Training and Consultation of Staff – Common Staffing Method	Substantial
Planning and Securing Services*	Limited

*relates to healthcare provided by a private or 3rd sector provider, another Health Board or through a National agreement, where assurance of their compliance with the Guiding Principles and Duties of the Act will be sought from the providers, in most cases the local Exec Officers (Medical and Nurse Directors) will not be the accountable officer

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

Appendix 3

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.

HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – SHETLAND HEALTH BOARD ANNUAL REPORT 2025/2026

Report approval

1. The box below should be completed by the person signing off the report. An electronic signature is acceptable.
2. 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 in the boxes below.

Name of organisation:	*Shetland Health Board*
	Professor Kathleen Carolan
	Director of Nursing and Acute Services
	28 April 2026
Location where report is published:	*[hyperlink] to be inserted before submission to SG*

GUIDANCE ON USING THIS TEMPLATE

Purpose

This guidance has been developed to support relevant organisations in the completion of the below template which will form their annual report detailing compliance with the requirements of the Health and Care (Staffing) (Scotland) Act 2019 (the Act). Completed reports must be returned to hcsa@gov.scot by 30 April 2026.

Additional resources can be accessed here: Health and Care (Staffing) (Scotland) Act 2019: statutory guidance - gov.scot

If you require further assistance or have any queries, please contact hcsa@gov.scot.

Summary Section

3. The summary asks for an overview 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. You will be asked to provide an assurance level in respect of your overall compliance with the Act. Definitions for these assurance levels can be found at point seven.

4. Following receipt, the Scottish Ministers must collate reports from relevant organisations 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 should be comprehensive and pertinent to the staffing of the health service. To enable this, please complete the questions contained in the reporting template in sufficient 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.

   Individual duties / requirements

5. Following the summary section, the template seeks detail on individual duties/requirements of the Act in turn, asking relevant organisations to provide an assessment of compliance, and to provide details. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act. Relevant organisations should provide detail to explain the assurance level in respect of the Duty, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus.

   Evidence could, for example, include details of the organisational structures, systems and/or processes being used.

6. The duty description contains the legislative wording of the Act, outlining the duty requirements.

7. As outlined at paragraph 3, the template requests an overall level of assurance with regard to the relevant organisation's compliance with the Act/Duties, using the assurance categories as detailed below:

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.

8. 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. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to complete this with an appropriate level of detail.

9. 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. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to provide an appropriate level of detail.

ANNUAL REPORTING TEMPLATE

Summary

Please answer the following questions, to provide an overall assessment of how the organisation has carried out its duties under sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the National Health Service (Scotland) Act 1978 (inserted by section 4 of the Act), and in line with Sections 1 and 2 of the Act : Guiding principles for health and care staffing and Guiding principles etc. in health and care staffing and planning.

Please advise how the information provided in this report has been used or will be used to inform workforce plans.
The information contained within the 2025/26 Annual Report will be used to inform local workforce planning across the organisation. This is achieved by drawing on intelligence gathered through implementation of the Common Staffing Method, alongside the further development and formalisation of governance and planning structures that support the duties of the Health and Care Staffing (Scotland) Act. Across the Board, annual service planning has been deliberately aligned with budget setting, including agreement of funded establishments, and with broader workforce planning processes. As a result, the outputs from the various systems and governance structures that support delivery of the Act provide essential evidence and intelligence to inform workforce decisions. Workforce planning is further informed through the systematic use of real-time staffing tools, Common Staffing Method outputs, Datix adverse event and risk management processes, and feedback from staff gathered through these mechanisms. This is complemented by feedback from patients and the public, including Comments, Care Opinion submissions, and Complaints. Together, these sources enable a more comprehensive understanding of how workload and staffing levels impact on patient safety, quality of care, outcomes, and staff wellbeing across services within the NHS Board and the Community Health and Social Care Partnership. In particular, data generated through the Common Staffing Method and the use of SafeCare—especially professional judgement and red flag reporting—provides objective evidence of service demand and workforce pressures. This evidence is used to support workforce planning decisions and, where necessary, to underpin business cases for additional resource investment. The Act is not considered in isolation. Workforce intelligence derived from these processes is reviewed alongside other performance, quality, safety, and governance information to ensure a rounded and proportionate approach to planning.

Progress in implementing the Act is reported routinely through established governance routes. Updates are provided to the Health and Care Staffing Programme Board, with escalation to the Board's Staff Governance and Clinical Governance Committees. In addition, formal quarterly internal compliance reports have been embedded within the NHS Board business programme since April 2024, with the first report presented to the Board in June 2024.

Since implementation of the Act, increased use of SafeCare (where in place) and the Datix adverse event and risk management system has strengthened the organisation's ability to identify and record staffing challenges in a structured and objective way. Enhanced reporting allows services to assess whether staffing pressures represent enduring risks and, where appropriate, to record these on the Risk Register. These risks are then reviewed as part of subsequent workforce planning cycles. This approach has improved organisational visibility of workforce challenges and enabled more timely escalation and assurance than was previously possible.

Please provide information on how your compliance to the Health and Care Staffing Act has led to improved outcomes for service users and workforce

In line with the requirements of the Health and Care Staffing (Scotland) Act, NHS Shetland can provide assurance that implementation of the duties has contributed to improved outcomes for both service users and the workforce, consistent with the requirements of the Health and Care Standards (Scottish Government, 2022).

Compliance with the Health and Care Staffing Act has strengthened the Board's ability to deliver safe, high-quality, person-centred care. The systematic use of nationally approved staffing tools and application of the Common Staffing Method have improved understanding of service demand and patient acuity, enabling staffing decisions to better reflect local need. Enhanced real-time staffing assessment, supported by SafeCare where implemented, has improved the organisation's ability to identify, mitigate and escalate staffing risks in a timely way, reducing the potential impact on patient safety and quality of care. This supports service users' experience of care that is safe, effective, and tailored to their needs (Health and Care Standard 1).

Implementation of the Act reinforces the importance of patient voice in workforce planning and service delivery. Patient feedback, including Care Opinion, Complaints, and Voiced Care concerns recorded through SafeCare, where available, is considered alongside staffing and workload information. This ensures that workforce planning and staffing decisions take account of people's experiences thus supporting the delivery of responsive services, contributing to service users feeling listened to and involved (Health and Care Standard 2).

The Act has both strengthened confidence in the workforce delivering care and in professional assurance by ensuring that staff are appropriately trained, supported and deployed. Reduced reliance on agency staffing and increased use of NHS Bank and substantive staffing arrangements have improved continuity of care, workforce stability and team cohesion.

Clear expectations around training, appropriate skill mix and access to clinical advice combined with processes for escalating concerns, ensure staff delivering care are supported to practise safely and within their competence, reinforcing patient confidence in those who care for them (Health and Care Standard 3).

For staff, compliance with the Act has reinforced wellbeing, inclusion and the professional voice. Formal routes for raising concerns, recording professional judgement and escalating risks have strengthened psychological safety and supported a culture of openness. Improved workforce stability, clearer leadership arrangements and more consistent recognition of training and leadership time contribute to more sustainable working environments and support staff wellbeing, in line with the guiding principles underpinning the Act.

Compliance with the Act has enhanced organisational transparency, consistency and assurance in staffing decisions. Formal governance arrangements, including quarterly compliance reporting, routine risk escalation through Datix and SafeCare and structured oversight through Board committees, provides assurance that staffing decisions are informed by clinical advice and aligned with the guiding principles set out in legislation. During the reporting period, there were no decisions taken in conflict with clinical advice. This supports confidence in NHS Shetland as an organisation committed to safe staffing and continuous improvement (Health and Care Standard 4).

Improved real-time staffing assessment oversight through structured safety huddles, supported by SafeCare where implemented, has contributed to safer and more supportive care environments with improved situational awareness and co-ordination across services. Increased situational awareness enables services to respond collectively to staffing pressures, supporting safe practice across wards, departments and community settings (Health and Care Standard 5).

Overall, while implementation of all systems remains a work in progress across all services, compliance with the Health and Care Staffing (Scotland) Act has led to demonstrable improvements in workforce assurance, risk management and governance, contributing to safer care for service users and improved support and wellbeing for staff. Across all five Health and Care Standards, compliance with the Act has reinforced the 5 principles which should shape all care and support, namely, dignity and respect, compassion, inclusion, responsive care, and wellbeing. Staff wellbeing is better supported through clearer escalation routes, improved workforce stability, and greater recognition of leadership and training time. In turn, this supports a compassionate, engaged workforce capable of delivering high-quality care for service users. **Ref Health and Social Care Standards: *My support, my life (Scottish Government, 2022)***

Health and Care Staffing Act Health Board Duty Compliance Assurance Levels
Please complete the table below with your Health Boards compliance assurance level for each duty.

DUTY	COMPLIANCE ASSURANCE LEVEL
Duty 12IA: Duty To Ensure Appropriate Staffing	Reasonable Assurance
Duty 12IC: Duty To Have Real-Time Staffing Assessment In Place.	Reasonable Assurance
Duty 12ID: Duty To Have Risk Escalation Process In Place.	Reasonable Assurance
Duty 12IE: Duty To Have Arrangements To Address Severe And Recurrent Risks.	Reasonable Assurance
Duty 12IF: Duty To Seek Clinical Advice On Staffing.	Reasonable Assurance
Duty 12II: Duty To Ensure Appropriate Staffing: Training Of Staff	Substantial Assurance
Duty 12IH: Duty To Ensure Adequate Time Given To Clinical Leaders.	Reasonable Assurance
Duty 12IJ: Duty To Follow The Common Staffing Method (CSM)	Substantial Assurance
Duty 12IL: Training And Consultation Of Staff	Substantial Assurance
Planning And Securing Services	Limited Assurance
PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE	
Reasonable Assurance	

Duty 12IA: Duty to ensure appropriate staffing

Duty Description	**2 Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. **Duty 12IA: Duty to ensure appropriate staffing.** (**1) It is the duty of every Health Board and the Agency 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— (a) the health, wellbeing, and safety of patients, (b) the provision of safe and high-quality health care, and (c) in so far as it affects either of those matters, the wellbeing of staff. (**2) In determining what, in a particular kind of health care provision, constitutes appropriate numbers for the purposes of subsection (1), regard is to be had to—** (a) the nature of the particular kind of health care provision, (b) the local context in which it is being provided, (c) the number of patients being provided it, (d) the needs of patients being provided it, and (e) appropriate clinical advice.

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

There are structures and processes in place, in all areas, to ensure there is the ability to assess staffing requirements in real-time, and to escalate and seek support from leaders and managers. Whilst different approaches are taken to realtime staffing assessment, across different disciplines and services, across the NHS Board and Community Health and Social Care Partnership area all disciplines/areas have a mechanism by which they can assess their staffing requirements and an escalation route via their line management structure if required.

All staff are represented at the HCSA Programme Board which provides oversight, and receives assurance through self-assessment reporting and updates. Due to the key responsibilities of the HCSA Programme Board, progress to date has been reported to both the Clinical Governance Committee (CGC) and Staff Governance Committee (SGC). Workforce is one of the strategic risks for NHS Shetland and therefore it is important that both Standing Committees have an understanding of the work of the programme board and ongoing progress towards implementation, and overall compliance, with the requirements of the Act.

Across the organisation there is variation in the processes used, and mechanisms for being assured of compliance, across the broad range of service and professions within the organisation, however, with the implementation of eRostering, and roll out of SafeCare, this is helping to create a consistency of approach and an ability to demonstrate compliance through a range of reporting functions available within this product.

Sign posting occurs to national resources to support staff understanding of the Act, and to inform how in their roles they can support the Board meet its legislative duties, to ensure there is appropriate staffing for the health, well-being and safety of patients, and wellbeing of staff.

The systems and processes in place within the Board require the leaders, managers, and decision makers to have due regard to the kind of healthcare provision. For nursing and midwifery professions within the in-patient setting, this is achieved through the use of staffing level tools, within the overall common staffing method, to determine appropriate staffing levels to provide an establishment, and staff requirement for each shift which considers the kind of healthcare provided which within local services is very generic in nature requiring staff to have a broad generalist skill base. The staff on individual shifts will then apply professional judgement to determine whether this staffing level is sufficient, or if there is a need to escalate concerns due to a change in the acuity of the patient demand leading to the need for additional staffing.

Whilst the CSM is not a requirement for use in other professions, locally the Executive Management Team have agreed that the structure provides a helpful framework in workforce planning and is being promoted to other service areas who wish to use it.

There is a robust process of workforce planning in place considering demand, capacity, activity and quality that also considers the kind of healthcare provision, and on an ongoing basis the professional leads, clinical teams and managers will review and consider changes in service that may require adjustments to be made to staffing requirements, skill mix, or service capacity. There are, therefore, systems and processes in place to support future workforce planning, as well as to consider any immediate and medium terms changes that may create a risk or change, to ensure appropriate staffing provision is in place at all times.

The current Health and Social Care Integrated workforce plan is published on our website and can be viewed at shetland-health-and-social-care-integrated-workforce-plan-2022-25. Our workforce plan for 2025-2028 remains in draft at this time. We are awaiting updates to national guidance for longterm planning, in the interim we have a local annual review process linked to the service and financial planning cycle.

Following a review of service demand and staffing levels, as part of the annual cycle of service, workforce and financial planning, any subsequently identified need for additional resources is submitted as Business cases for consideration by the Executive Management Team.

Service planning is the responsibility of local managers, engaging with local teams and services to ensure local context is recognised, considered and had due regard to when considering staffing requirements. For services using the Common Staffing Method, consideration of the local context in which services are delivered is integral to this process. As noted above, we are promoting the use of the CSM across services as a Framework for workforce planning. This then feeds into wider system workforce planning approaches, and will ensure local context is reflected in staffing establishments and models.

The workforce requirements reflect the activity, or number of patients being cared for by a person or a service. These are considered in real-time as part of real-time assessment to reflect variation in demand and activity, to ensure staffing meets any change in patient acuity.

Realtime staffing assessment and dynamic risk assessment both support consideration of the numbers of patients requiring the service, as well as the staffing available to support delivery of the service. Full implementation of SafeCare across all clinical services will support the formal recording of these assessments and any action taken.

Where already implemented SafeCare data will be considered as part of any service or performance review going forward, with any risks or impact on patient quality and safety being escalated and considered through clinical and staff governance forums as appropriate. In due course, SafeCare data will inform all levels of workforce planning, and establishment setting.

The service and workforce planning processes consider speciality specific information reflecting the specific needs of patients within individual services. On a day to day basis, real-time staffing assessment and dynamic risk assessment is embedded in practice, taking into account patient acuity as part of the requirements of service provision and will ensure that any changes to patient needs can be captured, and any risk to providing appropriate staffing to meet the needs of the real-time demands can be identified, mitigated or escalated for support.

Clinical advice is readily available within all functions, with arrangements in place to enable clinical advice on a 24/7 basis via an oncall system. The majority of our real time staffing assessments will have clinical advice automatically incorporated as a result of working in predominantly professionally led and managed services across both NHS Board and CHSCP. Where this is not the case, Managers and leaders are aware of the need to seek advice, and are supported to ensure they seek relevant clinical advice to inform and support decision making.

The guiding principles for health and care underpin healthcare planning and delivery, and reflect the ways of working within the Board. Within workforce planning in current services, use of CSM or Six Step methodology, there is a requirement to consider a range of measures, data and feedback that relates to quality of services (complaints, patient feedback), Adverse events, and staff feedback (iMatter, whistleblowing) all of which will help inform whether or not we are paying due regard to the guiding principles.

The principles are also reflected in the Board's approach to delivering person centred care, using a human rights based approach, reflecting engagement and feedback from staff, thus providing a holistic whole systems approach when considering workforce requirements, for the purposes of ensuring high quality safe healthcare with the best possible outcomes for patients, and in relation to the principles of the Act, due consideration of the wellbeing of staff.

Monitoring Compliance with this duty and escalation, when required, is undertaken in practice with escalation occurring within clearly defined management structures in both the NHS Board and CHSC Partnership. Currently there is variation across the organisation in both the processes and the monitoring, and therefore once eRostering and SafeCare is fully rolled out across the organisation the Board will have more reliable and consistent mechanisms in place for monitoring compliance and addressing any areas of risk, concern or non compliance across both the Acute sector and CHSC Partnership.

Please provide Information on your methods of monitoring compliance with Duty 12IA
Work was progressed in 2025-2026 across the NHS Board and Community Health and Social Care Partnership (CHSCP) to develop an integrated workforce plan for 2025-2028. This remains in draft at this time. The draft workforce plan has been used to inform discussion across services, and to support service planning and development. The workforce plan outlines a range of initiatives to enable effective recruitment, to attract staff to the Board, to value, support and develop staff and ensure the most efficient and effective use of staff to meet the needs of patients. The Staff Governance Action plan 2025-2026 outlined actions to progress activities in the Five Pillars of the Workforce Journey, namely Plan, Attract, Retain, Employ, and Nurture. The same approach is being taken to the Action Plan for 2026-2027. Work has been undertaken to promote NHS Shetland as an employer of choice by creating a brand identity that highlights the 'personal' in the employment relationship, with adverts being updated to improve online presence, and staff stories being collated and added to the recruitment pages on the NHS Board website. The Communications team are increasing the profile of posts available locally by regularly running features on social media to encourage consideration of NHS careers. A working group has developed a focus on recruitment to Consultant level posts in order to support the Board's ongoing work in creating a more sustainable service with locally based Consultants appointed on substantive contracts to help reduce both our reliance on and cost of service models, operating with supplementary staffing via Bank or Agency contracts. During 2025-2026 for those medical staff who provide a regular commitment to working in Shetland on a rotational basis, work has been taken forward to secure these working arrangements on a Bank contract basis. There is a robust programme of workforce planning in place, which is aligned to the Board's financial and service planning processes, with annual reviews being conducted by all services. The outputs from the processes in place across the organisation to support meeting the requirements of the Act, eg outcome of applying the Common Staffing Method with due consideration being given to a range of safety and quality data from SafeCare, complaints, adverse events and risks, are all used to inform service's future workforce plans. Work scheduled to commence in 2025-2026 to review and update our Volunteer Policy and processes has been delayed due to capacity issues. However, in order to refocus on recognition of the added value that volunteers bring to the services provided to patients across the organisation, this work has been rolled forward into the Staff Governance Action Plan for 2026-2027. NHS Shetland has to date recruited and sponsored a number of roles for international new starts, becoming one of our biggest source of new nursing recruits with to date 13 Acute nursing post holders plus 2 Theatre Nurse/ODPs filled with 2 leavers. An additional 3 international graduates will be in the pipeline by mid 2026, starting as HCSWs Band 4 moving to Band 5 after successfully completing the OSCE. Radiology – had 1 international recruit who subsequently left and went to another NHS Board in Scotland.

We work collaboratively to fund the North of Scotland International Recruitment (IR) Hub who support the recruitment process and 3 weeks preparation for OSCE in Grampian. Visa, relocation, and onboarding, is handled through the local Shetland recruitment team with OSCE co-ordination through the IR Hub. There are also a number of other roles within nursing, AHP and Healthcare Science who have been sponsored by NHS Shetland without the requirement of OSCE preparation. Mid 2025, the UK Government implemented tighter immigration restrictions including higher salary thresholds, stricter English language requirements and longer residence settlement waits in an aim to reduce net migration and reforming the visa system. These changes also include increased compliance for employers.

During 2025-2026 work has continued to promote support worker roles locally by raising awareness through schools / providing work experience / and through attendance at Local careers fairs and working closely with the Local DYW team who support local co-ordination of events to promote employment opportunities for all staff groups. The Board has collaborated with our local College to develop and deliver a Modern Apprenticeship route for Band 2/3 roles to provide a structured career development framework for Health Care Support Workers and promote roles with universities to provide professional work placements.

We are also actively engaged with the Armed Forces Talent Programme, and directly with the career Transition Partnership who support resettlement for those leaving the armed forces; unfortunately, we were unable to attract any applicants to the funded placements offered.

Within Nursing and AHP services there is a continued focus on planning / 'growing our own' models with developing Assistant practitioner roles at band 4 and with increasing the scope of the role for some Healthcare support workers working in Primary Care. Three primary care HCSWs are upskilling through the Modern Apprentice route from March 2026. Assistant Practitioner (Band 4) posts have already been introduced in the Out Patient Dept to support undertaking technical aspects of care for patients

Through the implementation of the erostering programme, complete with an integral staff bank module (in due course), we will be able to review our Staff Bank capacity to ensure that this remains a viable option for identifying supplementary staffing when needed. We feel that this will enhance our overall Bank processes, as well as help in the maintenance of a healthy staff bank which can be called upon to fill resource gaps at short notice.

NHS Shetland has implemented the policy for retire and return, where we have offered flexible, fixed term and/or substantive contracts post retirement thus retaining high levels of experience and expertise within local services. The number of employees choosing this route in 2025/26 equates to 9 (7 x returning to Bank with 2 to part time posts), 8.49% as opposed to 7 employees (2 x Bank and 5 x part time positions) in the previous year, equating to 6.79%.

In terms of current agency and Locum spend these are recorded organisationally and monitored at both head of service level and standing committee of the NHS Board, with overall costs reported to NHS Board level. Overall Agency/ Locum spend in 2025/26 is approx 23% less than spend in 2024/25, with £2,309,259 spent in comparison to £3,015,986. There was a 29% reduction in Agency spend in nursing and midwifery over the same time period, with spend reducing from £752,543 in 2024/25 to £532,511 in 2025/26.

In both the NHS and Community Health and Social Care Partnership (CHSCP) there are robust processes in place for the authorisation of spend on Agency or Locum staffing. Any request for Agency/Locum staff requires Exec Director Level sign off either in the Acute sector or the CHSC Partnership.

However it has to be noted that securing agency or locum staff maybe necessary in order to enable us to provide safe care in terms of having right number of staff, with right skills in the place across the organisation at all times. As highlighted above a positive shift to engage supplementary staff on a "Bank" basis is now the norm as opposed to utilising Locum rates. Agency requests may still be required to support last minute gaps in service which have not been able to be planned for in advance.

Throughout 2025-2026 organisational monitoring has enabled NHS Shetland to report a nil return for all 4 quarters when reporting against the duty on Agency Spend for any individuals costing 150% of a substantive contract.

All leavers have the opportunity to have an exit interview to understand reasons for leaving and opportunities to reduce staff leavers. However, the number of staff taking up this offer remains low at 24% of leavers, therefore a focused piece of work is being undertaken to review this process.

There is an expanding range of facilities / activities across the organisation to support staff wellbeing. This has included funding a fulltime Spiritual Care lead, re-establishing the Health and Wellbeing Group under their leadership, appointment of 2 TRiM managers, to enable access to TRiM assessments for staff who have been exposed to traumatic events in the workplace; successful appointment to the Occupational Health Nurse Manager vacancy; progressing work across the organisation to respond to the 3 national directives to reduce the working week, provide paid mandatory training time and to review Band 5 to Band 6 roles within nursing; aligned to the Scottish Government Staff Wellbeing Framework, the Spiritual Care Service delivered 107 confidential one-to-one staff support sessions and 16 facilitated staff group support sessions, supporting psychological safety, early intervention, reflective practice, and a compassionate workplace culture, particularly during periods of loss, high pressure, and organisational change.

Within the organisation there are wider support mechanisms available for staff such as access to confidential contacts, support through the organisational learning and development team and management or self referral to local Occupational Health services as required.

Within NHS Shetland, there continues to be a focus on how to bring together more closely patient quality and safety data, alongside staffing information. Through effective clinical governance structures there are established structures in place to review patient quality and safety information, and patient outcomes, feedback and patient experience data.

The Chief Nurse (Corporate) as Clinical Workforce Lead helps to build the links between the clinical quality, safety and risk data with the workforce data, enabling the triangulation of the information with the intelligence gathered via the structures put in place to comply with the duties of the Act. It is anticipated that with the further roll out of SafeCare across the NHS Board and CHSCP, along with the move to a new enhanced system of healthcare governance, through implementation of the Healthcare Guardian risk and incident management system during

2026-2027, that it will be possible to have an enhanced level of transparency and reporting in place in the future. This should assist with the early identification of concerns and any trends appearing within services, thus enabling timely consideration to be given to measures to address this.

At a Board level, the Chief Nurse (Corporate) is the Chair of the local Health Care Staffing Programme Board. The Programme Board also has representation from all those with professional lead roles, across the organisation. Once the opportunities to more formally triangulate quality and safety data, and outcome measures with workforce data, as more staff are onboarded to SafeCare, this will be formally reported to the Programme Board and onwards through the Clinical Governance and Staff Governance Committees to the NHS Board via the quarterly internal compliance report.

Within N&M, quality data is supported by the Excellence in Care programme, and the Care Assurance and Improvement Resource (CAIR) Dashboard of care measures which brings together, and helps triangulate nationally agreed measures with workforce data at a ward level. This process is embedded in local nursing and midwifery structures to ensure this information is reviewed and any areas of improvement identified. Following the gap in data gathering in 2024-2025 as a result of a key staff vacancy, data gathering in 2025-2026 has resumed and has been extended to other areas of nursing and midwifery practice eg School Nursing & Midwifery.

There are other processes whereby quality and safety is reviewed to understand causes, for example, through the use of Care Opinion, Adverse Event reviews, both at local dept/service level and organisationally via Significant Adverse Event Reviews (SAER).
As a Board we can monitor adverse events that have staffing identified as a contributing factor – a number of adverse events with a staffing theme have been recorded over the last 12 months and risks added to specific departmental registers where there have been severe or enduring gaps in staffing.

There have been no major, or severe harms reported through our adverse event reporting that is related to staffing. There are a number of examples of where the use of SafeCare and the processes of the Act has helped identify and address specific risks to patient care because of staffing, however we are unable to attribute any change in outcomes, at this time, to these actions. Patient feedback opportunities have also increased because of the Act, however it is too early to determine any change made as a result of the Act at this time.

A focus for the next year will be to better understand the clinical benefits and impact on patient outcomes as the duties of the Act, and digital systems put in place to support these duties, are more embedded and can assist with more robust data analysis.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, application of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level of risk.	This should describe how the success, achievement or learning could be used in the future. For example, continue the roll out of eRostering across the organisation, using learning from areas that have already implemented.
Effective Health and Care Staffing programme Board	With broad representation from across all services and professional disciplines, as well as clinical governance and risk, excellence in care, and eRostering to ensure key interdependencies are recognised and programmes mutually supportive, and to build improved intelligence and information to evidence impact and outcomes for patients and staff as a result of the HCSA.	To continue to review membership, structure and context of the PB meetings and seek feedback from members to ensure it remains effective and responsive to the needs of the organisation.
Nursing and Midwifery - Awareness raising of HCS Act and Staffing Level Tools	Preparation for staffing level tool runs has increased the number of staff and areas across the workforce who have had some awareness raising in relation to the Health and Care Staffing Act and also familiarisation with the Common Staffing Method and use of the tools and reporting /review process in practice. This has enabled services locally to include the results from the staffing level tools in their business cases submitted into the organisation's service and financial planning cycles.	Annual rolling programme of staffing level tool runs in place. This will ensure compliance with the requirements of the Act to undertake the Common Staffing Method on an at least annual basis whilst also ensuring a better distribution of the timing of tool runs across the year in order that the workforce lead can support the training and output from the tools in a timely way whilst also ensuring that staff have the results to use in service and workforce planning.
Reduction in Agency Spend	Year on Year reduction on Overall Agency/ Locum spend is evidenced. In 2025/26 approx 23% less spend than in 2024/25, with £2,309,259 spent in comparison to £3,015,986. There was a 29% reduction in Agency spend in nursing and midwifery over the same time period, with spend reducing from £752,543 in 2024/25 to £532,511 in 2025/26.	Continue to ensure that there are good governance arrangements in place to monitor authorisation and spend on Agency staffing across all disciplines in both NHS Board and Health and Social Care Partnership services

	Nil return for all 4 quarters against the requirement to report on Duty 12IB: Duty to ensure appropriate staffing: agency workers for year 2025/2026	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with recruiting a particular staff speciality or recruitment in a remote / rural location.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in recruiting in a particular speciality or remote / rural location, the relevant organisation may have investigated retire and return schemes or upskilling and career development for existing staff. It may also have looked at how the service could be redesigned.
Impact of reduced working week	The impact of the RWW has been significant in terms of reviewing rosters and working patterns, but additionally the impact on updating rosters has affected the roll out of eRostering and SafeCare as key enablers to the Act and Act compliance. Any further changes required to be made to the rosters at local level will continue to have the potential to further impact implementation and roll out of these systems and hence also impact the Board's ability to demonstrate and monitor compliance, as well as have access to more qualitative data to consider impact on patient outcomes.	
Development of web page to support all staff	To build sustainability the Board is in process of developing a web page that provides a range of information about the Act, access to internal an external resources to support staff as a refresher, or reference for new staff / staff changing roles who will therefore have a different level of responsibility or requirements to support the Board meet the duties	To make webpage available to staff by end of June 2026 and then continue to update, refine and seek feedback on the content and use of web page to ensure it is meeting the needs of staff and leaders within the organisation.

	off the Act. Due to capacity issues this action has been delayed from 2025-2026 into 2006-2027	
Recruitment and Retention of staff across all professional disciplines is a challenge	Within this remote and rural island setting recruitment and retention has become a significant challenge across most services. This applies to both core hospital services and to community services, especially in the more remote areas and in the non-doctor island setting where a single resident Registered Nurse has traditionally been the point of access to healthcare in this setting.	Various actions have been progressed to address the staffing challenges across the services eg In terms of recruitment, International recruitment has been pursued with success. The Board has opted to invest in a "grow your own" approach to developing the workforce of the future with a mixture of redesigned posts, introduction of assistant Practitioner posts at Band 4, Modern Apprentices, Open University route to professional Registration. Redesign of service models on outer islands to have rotational GP contracts with postholders who have a substantive post elsewhere but work in Shetland for a number of weeks per year, split over a number of sessions thus providing some regular continuity of practitioner for the local population whilst also bringing a wider range of skills into these remote locations. This model is working well as opposed to the traditional single handed GP approach. GPs who participate in this arrangement have been secured through the GP Joy initiative. Redesign of the non-doctor island services has moved this service provision from a resident Registered Nurse to a resident healthcare support worker with a visiting professional service and a greater use of technology to access support and consultations. Recruitment to the healthcare support worker posts has been easier as these positions are generally filled by someone who already resides within this community and thus this creates a new opportunity for an islander and overall enhances the local economy. Within the Hospital sector rotational models are also in place for Consultant

		Physicians, ED Consultants and Obs & Gynae Consultants. The Strategic Workforce Risk has also been subject to recent review to ensure that all controls in place to mitigate this risk are recorded and that there is active focus on new areas of activity to support recruitment eg positive testimonials from staff working in rotational models to support our attraction strategy

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the real-time assessment of its compliance with the duty imposed by section 12IA.** **(2) The arrangements under subsection (1) must, in particular, include—** (a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to— (i) the health, wellbeing, and safety of patients, (ii) the provision of safe and high-quality health care, or (iii) in so far as it affects either of those matters, the wellbeing of staff, (b) a procedure for the notification of any such risk to an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, (c) a procedure for the mitigation of any such risks, so far as possible, by such an individual, and a requirement for that individual to seek and have regard to appropriate clinical advice, as necessary, in carrying out such mitigation, (d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c), (e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b), (f) training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (e), and (g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12IC.

Systems for Realtime staffing are in place within both the Acute sector and Community Health and Social Care Partnership (CHSCP) to enable real-time staffing assessment to identify risk to patient safety, quality and outcomes.

All areas operate dynamic risk assessment either through their safety huddles or directly through their line management structures in response to unplanned absences/vacancies which impact on staffing levels. Many of these structures were initially informal and therefore demonstrating compliance was limited where there was no digital system or process in place. In 2024-2025 the Board made the decision to prioritise SafeCare in order to create a single organisational system for real time staffing assessment, mitigation and escalation going forward.

SafeCare is the agreed platform and approach to support compliance with this duty, and implementation has continued across services throughout 2025-2026. SafeCare has now been rolled out to acute adult in-patient nursing areas, Accident & Emergency, Outpatients, Theatres, Midwifery, Psychological Therapies team and some AHP teams. Targeted support is in place to support some of the healthcare scientist workforce and the remainder of the AHP workforce. Following successful roll out in these areas the focus will be on healthcare services within the wider Community Health and Social Care Partnership from 1 April 2026.

Where SafeCare is not yet in place, teams can escalate issues of concern in relation to staffing directly up the line management structure, which are predominantly professionally led and managed structures.

Assurance that safety huddles are in use in practice is gained via the Clinical Workforce Lead's participation in key Directorate level meetings where issues raised from the huddles are considered eg CHSCP management Team, Clinical Professional Oversight Group, Hospital Management Team.

All staff are able to identify a risk caused by staffing levels, however, the process for this still varies between services depending on whether they are onboarded to SafeCare or not.

Any staff member can raise an issue of concern with their Team Leader /Manager via handovers or the safety huddle process. The team leader will assess the staffing available against the planned workload and use their professional judgement to determine whether there is a risk or not. Action will be taken at a local level to address or mitigate any identified risk, where appropriate.

All staff have open access to the Datix system and can record adverse events or raise a risk in relation to safe staffing levels at any time. Where rolled out, red flags are utilised within SafeCare for review, mitigation or escalation of risks at Safety Huddles inclusive of any risk raised by the team without direct access to SafeCare.

Roll out of SafeCare is supporting the recording of the identification, escalation and mitigation of any risk highlighted within one single area, where it is not possible to mitigate the risk then an adverse event report should be made on the Risk Management system, Datix. Reports from SafeCare and Datix can be used to review escalation and mitigation of risk, identifying recurrent risk and hence due consideration should be given to these reports as part of workforce planning. Formal reporting on red flags raised has commenced for areas utilising SafeCare in practice.

In the Acute sector, at a team level, the team leader/SCN will manage risk raised to them, record this on SafeCare and/ or verbally report into the safety huddles, where relevant lead professionals are included. Following the site safety huddle there is a second safety huddle which includes the Board level professional lead, thus escalation of any issues of concern can easily and quickly be brought to the attention of the individual with overall Professional Lead responsibility.

Similar processes exist in other areas of the services and therefore the Escalation structures in place across the organisation enables timely reporting to individuals with lead professional responsibility, some of whom may be present in the site safety huddles or are informed directly through the escalation structure. Within the CHSCP it is planned to be able to go live with having the SafeCare Sunburst information available to inform safety huddle discussions during 2026-2027.

All staff have access to Datix and can raise a risk on there, the Datix system reporting line is generally to the staff members' line manager in the first instance. This provides the first level of escalation to the lead with professional responsibility, first opportunity to mitigate the risk and provide clinical input. Risks submitted with a rating as Severe / Extreme also escalate directly to the executive management team.

In clinical teams where SafeCare is currently utilised, all red flags are reviewed and mitigation agreed within the safety huddle which comprises of professional mangers up to senior Executive level. Generally staff will raise a risk directly with their line manager. An example of appropriate mitigations would be: bringing in additional resource from other areas, redeployment of available staff and/or a re-prioritising of workload for the staff in the area.

Any risk not safely mitigated is escalated onto the Datix system.

The Escalation structures in place provides opportunity for the mitigation of risk by individuals with lead professional responsibility. Most structures are professionally managed and led and therefore ready access to appropriate clinical advice exists. Where clinical advice is not sought or adhered to there is the ability to report this on a Datix adverse event report. To date we have not had any reports of actions taken being contrary to clinical advice provided.

Once SafeCare is in place across the organisation we will be able to systematically ensure that where clinical advice has been sought that this has been provided and monitor whether subsequent actions have taken this into account or not. If decisions taken are contrary to clinical advice provided, as noted above, this should be reported on a Datix adverse event report.

The local flowcharts outline the Escalation structures in place for identifying risk and reporting to the individuals with lead professional responsibility. As most structures are professionally managed and lead there is ready access to appropriate clinical advice.
We are confident that this sub-duty is being met, however in the absence of SafeCare for all services this is not always formally recorded. Once SafeCare is in place, we will be able to ensure that all risks are identified, reported to the individual with lead professional responsibility and a record of appropriate mitigation put in place, is noted.

Awareness raising of the Act and the associated duties placed on the NHS Board has been conducted through articles in Corporate Newsletter, Organisational bulletin, briefing issued as part of Corporate Induction, Team meetings and promotion of the TURAS learning resources.

Through Corporate Induction all new staff are made aware of the structures and processes in place to identify, communicate and report any risks with staffing. We have built the reporting of staffing risks into our organisational Risk Management Policy and procedures. Individuals escalating risks which cannot be mitigated are encouraged to report this on Datix. The Datix system is open to all for reporting, training on use of the system is available for staff via the Clinical Governance and Risk Team
As SafeCare is rolled out to departments, training is provided for the staff team as to how to use the system to record, manage, mitigate and escalate risks, thus supporting the organisation meet the requirements of the duties. The Escalation structures in place provides opportunity for the mitigation of risk by individuals with lead professional responsibility.

Training is available in relation to dynamic risk assessment and in relation to risk management and use of the Risk and Incident Management system, Datix. Briefings have been held for professional Leads, there is access to a suite of resources on TURAS and an Intranet page for

the Health and Care Staffing Act is in development. The roll out of SafeCare will enable us to provide the same, consistent, approach to Realtime staffing across the organisation. Training for teams on how to use SafeCare is provided as part of the introduction of it in their area. Individuals with lead professional responsibility are trained in the place that realtime staffing plays in meeting the requirements of the Act There are ongoing opportunities for professional leads to access additional support via the HCS Programme Board, training resources available and/or via the Board clinical workforce lead (Chief Nurse (Corporate)), to support both individuals and team leaders on how to implement the arrangements in place to comply with this duty.

Considering whether or not individuals with lead professional responsibility have adequate time and resources planned within their job plans / job roles to comply with this duty is currently via Line Management discussion/review at time of Appraisal. Risk management and risk escalation are embedded processes within the organisation. The activity of lead professionals and senior decision makers related to the management of risk and risk escalation is routinely incorporated into their daily work activities, however, there isn't a consistent process in place that seeks assurance that the agreed time and resources were available and/or sufficient to meet these duties. The use of SafeCare, going forward, will enable systematic recording organisationally of any time where lead professionals have had to step into the provision of direct patient care, hence impacting on their leadership time. The frequency of occurrence of this should be considered as part of workforce planning activities.

Please provide Information on your methods of monitoring compliance with Duty 12IC

Professional Leads have been provided with a self assessment template to support quarterly reporting of progress towards compliance within their area of responsibility. An overview of current progress, as understood from the information provided in the self assessment returns received, and from the Clinical Workforce Lead's knowledge of service areas and systems progress, is presented in the quarterly NHS Board report.

The Executive Leadership Team have oversight of areas of compliance and non-compliance, highlighted through the quarterly reports and any required escalation to the Board can happen through this route. This is separate to the escalation of risk up to the Board as appropriate.

Whilst there is a monitoring structure in place it requires self-assessment and reporting, which has limitations, and therefore until SafeCare is in place with a digital monitoring function, we can offer reasonable assurance, reflecting the structures in place but cannot provide substantial assurance that all gaps will be identified, and therefore addressed.

As the use of SafeCare expands, the reports available within this system will be used as the primary source of compliance monitoring.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, areas that have implemented and are using SafeCare are able to accurately record risks that are identified and the mitigation measures implemented, and clinical advice received. Reports extracted from the system are demonstrating an auditable trail of decision-making.	This should describe how the success, achievement or learning could be used in the future. For example, this success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation.
Real Time Staffing	Well defined process in place within the acute sector and supported by an Escalation Framework. Escalation Framework known to staff and successfully trialled in practice. Process also in place within the Community Health and Social Care Partnership but requires formal documentation.	Formal Documenation of the process within CHSCP to be completed
SafeCare roll out and monitoring	All reporting lines are asked to use the self-assessment return to provide an update on progress to feed into the internal quarterly compliance report that goes to the Board. Erostering lead provides details of progress of roll out of Safecare to feed into the quarterly report. The Executive Leadership Team has oversight of areas of compliance and non-compliance, highlighted through the quarterly reports and any required escalation to the Board can happen through this route. As the use of SafeCare expands, the reports available within this system will be used as the primary source of compliance monitoring.	All areas encouraged to showcase activities being progressed in their areas to support realtime staffing and escalation, to support wider team /organisational learning. Continue to support teams with the implementation of SafeCare with escalation to the relevant management structure where there are barriers to implementation.
Path to green	All services will need to have SafeCare rolled out before the Board is comfortable to provide substantial assurance on this duty. Due to the processes in place, as described above, the Board is assured that the systems and processes in place	The systems and processes in place will become more streamlined once SafeCare has been rolled out to all clinical services, facilitating systematic reporting on realtime staffing.

	are functioning effectively however there is variation in processes in the absence of SafeCare.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with encouraging and enabling certain professional groups to use the systems and processes.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in engaging certain professional groups, what measures have been put in place with regard to increasing this such as using professional networks, staff representatives etc.?
All Professional Groups. Dependency on SafeCare roll out and timeline for completion is unclear, but expected to be a further 12 months as a minimum.	Currently there continues to be a mix of formal realtime staffing resources and informal professional judgement being used to inform realtime staffing assessment and escalation. Not all areas have access to SafeCare yet. Implementation is being progressed at the pace that services can manage depending upon capacity as opposed to a strict roll out plan. This continues to impact upon the time taken to move to full implementation which is not anticipated to be until the end of March 2027.	Continue to promote the implementation and use of SafeCare across the organisation, highlighting benefits to be gained from use of the system. Monthly monitoring reports of the implementation and use of SafeCare in practice are being sent to the Exec Directors to gain further management support for the roll out. Targeted support is being offered by the eRostering Lead and Clinical Workforce Lead to some service areas in order to complete full implementation prior to moving on with new areas within the CHSCP
Impact of reduced working week on rosters and eRostering	eRostering has now been rolled out to 92% of areas across the organisation, with 88% of these areas now actively and consistently using eRostering. Whilst this is a very positive position for the organisation overall, the need to now update the system to take account of the reduction in the working week to 36hrs has created considerable additional work for teams and thus has had quite an impact on staff teams across the organisation.	Any future upgrade /change required to be made to the system to implement a national directive should be considered for action at a national, 'Once for Scotland' level to minimise the impact on frontline clinical staffing.

Unclear if medical staff will be onboarded into SafeCare	Medical staff have arrangements in place to ensure there is an assessment of real-time staffing, and structures to address this at different levels. Work is ongoing with the development of the medic specific modules in Optima, and work is required to agree how, and if, SafeCare will be used to support medical staff.	Ongoing engagement with the relevant national EWG and the eRostering national team, local eRostering Programme Board and HCSA programme board to continue with engagement and to streamline processes, once relevant digital solutions are available to staff.
All staff groups	Working in a small remote, rural and island health board means there is limited supplementary staffing available resulting in staff having to work extra at short notice or planned care may have to be rescheduled if staff are not available due to compensatory rest requirements. This is an inherent risk in our system which has to be managed on a regular/ongoing basis.	

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12ID: Duty to Have Risk Escalation Process in Place.

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the escalation of any risk.** (a) identified during the real-time assessment of its staffing levels in accordance with arrangements put in place under section 12IC, and (b)which it has not been possible to mitigate in accordance with the arrangements put in place under that section. **(2) The arrangements under subsection (1) of this duty must include:** a) A procedure for the initial reporting of a risk as described in subsection (1), by an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, to a more senior decision-maker, b) A requirement for any such decision-maker to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, c) A procedure for the onward reporting of the risk, as necessary, to a more senior decision-maker in turn, and a requirement for that decision-maker in turn to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, d) A requirement for the arrangements put in place under paragraph (c) to escalate further in order to reach a final decision on the risk, including in appropriate cases by the reporting of the risk to the members of the Health Board. e) A procedure for the notification of every decision made following the initial report, and the reasons for it, to: (i)any individual who was involved in identifying the risk in accordance with the arrangements put in place under section 12IC(2)(a), (ii)any individual who was involved in attempting to mitigate the risk in accordance with the arrangements put in place under section 12IC(2)(c), (iii)any individual who was involved in reporting the risk in accordance with the arrangements put in place under paragraph (a), (c) or (d) of this subsection, and (iv)any individual who gave clinical advice in accordance with the arrangements put in place under section 12IC(2)(c), or under paragraph (b), (c) or (d) of this subsection, f) A procedure for those individuals to record any disagreement with any decision made following the initial report, g) A procedure for those individuals to be able to request a review of the final decision on a risk (other than a final decision made by the members of the Health Board or the Agency) made in accordance with the arrangements put in place under section 12IC(2)(c) or, as the case may be, paragraphs (b), (c) or (d) of this subsection, h) Raising awareness among staff about the procedures described in paragraphs (a) to (f), i) Training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of healthcare, and other senior decision-makers, in how to implement the arrangements put in place under paragraphs (a) to (h), and j) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12ID.
Realtime staffing assessment and risk escalation processes are in place in the NHS Board and CHSCP. All staff groups have a risk escalation process in place through established operational structures, which are predominantly professionally led and managed. Discussion takes place through safety huddles where any risk identified, which it has not been possible to mitigate, can be escalated up through the line management structure, as necessary. This would currently be done either via the senior professional lead being present in the safety huddle or where necessary via telephone call to the senior professional lead. The full implementation of SafeCare will support individuals in recording realtime staffing assessment, risk mitigation as well as the escalation of the risk if it has not been possible to mitigate the risk. In addition to safety huddles, staff and mangers can also raise a concern regarding appropriate staffing in real time directly to their line manager to provide dynamic risk assessment by the manager of the staffing provision in the area and take action to mitigate any risk identified. Near miss, or incidents of omissions of care can be captured within the adverse event reporting system, DATIX. DATIX also hosts service risk registers where services can capture relevant risks to staffing. Utilising core systems, which staff are already familiar with, to support the recording of any staffing related matter works well, however we are unable to robustly capture and evidence all risk escalations, and associated action / mitigations within our current structures - evidence of compliance with this duty will increase as SafeCare is rolled out fully across the organisation. Safety Huddles have clear processes for reporting of outcomes to senior professional leads (who are often in attendance at Safety Huddles). Unmitigated Real Time Staffing risks are escalated through line management and operational reporting lines, and captured within SafeCare, where available, and reported on DATIX ,as appropriate. Through the Escalation structure there is the ability to report a risk to a more senior decision maker. Silver and Gold command provide an escalation structure during out of hours periods. Any identified risk which cannot be mitigated would be escalated through the Professional lead to Executive level as necessary. Where a level of high risk is recorded this can be escalated directly to the Executive team for action. The risk would then also be reported via the Datix system. Local staff teams are predominantly professionally led and managed and hence escalation of a risk is through a professional management route with clinical advice readily available. This includes professional clinical advice being available from a postholder at Executive level. Where clinical advice is not sought or adhered to there is the ability to report this on a Datix adverse event report. To date we have not had any reports of actions taken being contrary to clinical advice provided. Once SafeCare is in place across the organisation we will be able to systematically ensure that where clinical advice has been sought that this has been provided and monitor whether subsequent actions have taken this into account or not. If decisions taken are contrary to clinical advice provided, as noted above, this should be reported on a Datix adverse event report.

There are clear structures for onward escalation in place 24/7 until this reaches a Board level executive, if required. As above these structures and processes include the requirement to seek appropriate clinical advice.

NHS Shetland has a small, relatively flat management structure and therefore risk escalation from a dept/area is to Chief Nurse/ Head of Service level and then to an Executive Director. Risk escalation can therefore happen very rapidly, if required. Risk Management Strategy supports this escalation process.

The reporting of workforce risks on SafeCare and Datix (where appropriate) supports onward escalation up to executive level, if required, in order to achieve mitigation or elimination of the risk. The levels of escalation are dependent on level of risk identified. Major or Extreme risks and issues are automatically notified at an executive level.

All services have in place Business Continuity plans, service level risk registers and escalation of risks through governance groups up to strategic risk registers, as required, which are reviewed by both Exec and Non-Exec members of the NHS Board. There are existing mechanisms in place to allow rapid escalation through the relevant professional and managerial lines, with appropriate clinical advice, to respond to any urgent concerns, and ensure the appropriate level of seniority and executive decision making. As noted above, the local management structure facilitates this as within 2 escalations issues escalated reach the level where by Board reporting can be done directly by the relevant Professional Lead.

Whilst there is a level of confidence of awareness and compliance with this overarching duty, and that relevant staff provide feedback to those involved in identifying, reporting or mitigating the risk, being able to evidence feedback has been provided in all cases is challenging without the existence of digital systems and technology to support these communications, especially if decision making and feedback span across different shift patterns. Where SafeCare is in place, staff have access to feedback within the system, and similarly DATIX has this inbuilt function, however for all other staff or communications, this is reliant on informal verbal feedback which cannot be evidenced robustly at this time.

Implementation of SafeCare across the Organisation for staffing assessment and risk escalation will create a standardised notification and recording system for all decisions made following an initial report of staffing concerns, clearly identifying where and when clinical advice has been sought and provided, and recording subsequent actions taken.

All staff have the ability to escalate concerns with a staffing decision following the processes outlined above. For services using SafeCare this will be using the red flag functionality, however, for other staff this will be following their operational line management structure.
Audit of compliance is via SafeCare where available, via an adverse event report on Datix, or by exception reporting by staff where there is not yet a systematic formal recording system in place.

If there should be any disagreement with a decision, a Review of the decision can be requested and reported in the DATIX system as an adverse event. While these systems and processes are in place within operational lines and professions; current returns do not allow for 100% compliance and assurance as not all areas have access to SafeCare and Datix adverse event reports are dependent upon staff completion of a report.

The roll out of SafeCare to include identification, mitigation and escalation of risk will support the identification of severe and recurring risks as these will be report generating functions which can be reviewed at the appropriate risk management forums. Reporting has commenced for areas with SafeCare in place.

Awareness of the current process exists amongst staff. It is introduced as part of staff Induction to services and /or at any point if there are any changes either to the process or when SafeCare is implemented in an area then awareness raising and training is put in place for staff as part of the Introduction of these revised system and processes.

Training and support is in place for eRostering and SafeCare. H&S learning modules are available on dynamic risk assessment, Datix modules (Adverse Events and Risk Management) and H&S modules for managers and supervisors are also in place. The Chief Nurse (Corporate)/Clinical Workforce Lead is available for internal engagement sessions and team meetings with professional leads, accountable managers and staff. A dedicated web page is currently in development for the Health and Care Staffing Act to support staff with ready access to key information.

Training modules are on TURAS with signposting by the Chief Nurse (Corporate)/Clinical Workforce Lead and Clinical Governance and Risk Team. This training will be aligned with training and support for general awareness of the Act, and the provision of relevant guidance to support practice.

The Organisational Risk Management Strategy will be refreshed in 2026-2027 and training and awareness sessions will be reviewed at this time as we move forward with implementation of Healthcare Guardian as our new incident and risk management system.

This duty is linked to the work associated with Duty 12IH Adequate time given to leaders. Current provision of "adequate time" is built into Job Descriptions and this will be reviewed as part of annual appraisal reviews, Job plans etc going forward. Risk management and risk escalation are embedded processes within the Board and CHSCP through the use of safety huddles and dynamic risk assessment processes.

Management of Risk and management of risk escalation are both core parts of the activity of Lead Professionals and senior decision makers and hence is incorporated into their daily work activities. There are opportunities via the self assessments, and through the line management reporting arrangements, to raise any issues of concern about relevant staff having adequate time and resources to implement the arrangements, to date no issues have been raised via either route.

Please provide Information on your methods of monitoring compliance with Duty 12IC

Whilst Realtime staffing assessment and risk escalation processes are in place in the NHS Board and CHSCP, these are currently carried out by a variety of processes, most of which do not have an inbuilt data/information capture feature and therefore we are unable to robustly capture and evidence all risk escalations, and associated action / mitigations within our current structures. We anticipate across the organisation, that as SafeCare is rolled out fully our ability to evidence monitoring of compliance with this duty, including escalation of non-compliance, will increase. To date we have been able to review staffing, mitigation and red flags raised within the departments who are active on SafeCare. Reports on compliance will be shared with the Health and Care Staffing Programme Board, with formal escalation of any concerns or non-compliance being made directly to lead Professionals and via quarterly compliance reports to the Staff and Clinical Governance Committees and onward to NHS Board.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, senior decision-makers in paediatric nursing were identified and a chain of escalation communicated to all personnel. Individuals are now much better aware of who to contact during any particular shift in the event that a risk needs to be escalated.	This should describe how the success, achievement or learning could be used in the future. For example, The procedures for identifying the chain of escalation that were used in paediatric nursing are now being trialled and rolled out across other areas.
All professions	There is a risk escalation process in place for both in hours and the out of hours periods which involves contact to and input from Silver and Gold command structures as necessary. This structure exists in both the acute sector and the Community Health and Care Partnership.	
Robust Risk Assessment processes	Risk Assessment is already well embedded within the Board. Having the Chief Nurse (Corporate) / Clinical Workforce Lead as Head of Clinical Governance has enabled adjustments to be made in	Further develop risk assessment processes and ensure that the development of Datix/implementation of Healthcare Guardian

	Datix to provide a risk management system compliant with the legislation	continues to support the requirements of the HCS Act
Pathway to Green	Confident risk assessment and escalation is embedded across all systems, all functions and services. The alignment of risk escalation structures and digital reporting systems will be required to fully comply, and evidence compliance with the Act.	While these systems and processes are in place within operational lines and professions; current returns do not allow for 100% compliance and assurance as not all are documented processes or formally recorded.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating, or giving clinical advice on a risk are notified of decisions made and the reasons for them.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes?
Resource pressures	Time and resources to continue to embed these resources and support practice, as new learning emerges, increased activity with compliance monitoring and reporting.	Continue to support teams with roll out of SafeCare and any changes to practice needed as a result
Lack of standardised approach	Whilst services can provide assurance through a range of processes, a single process is required to facilitate monitoring and reporting.	Ongoing support for eRostering/ SafeCare implementation to enable access to a single system, in order to deliver a single approach to standardised compliance monitoring.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

Duty Summary	**Duty to have arrangements to address severe and recurrent risks.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements to—** (a) collate information relating to every risk escalated to such level as the Health Board or the Agency (as the case may be) consider appropriate in accordance with the arrangements put in place under section 12ID (2), and (b) identify and address those risks which are considered to be either or both— (i) severe, (ii) liable to materialise frequently. **(2) The arrangements under subsection (1) must, in particular, include a procedure for—** (a) the recording of a risk as described in subsection (1)(b), (b) the reporting of any such risk, as necessary, to a more senior decision-maker, including in appropriate cases to the members of the Health Board or the Agency (as the case may be), (c) the mitigation of the risk, so far as possible, and a requirement for appropriate clinical advice to be sought and had regard to in carrying out such mitigation, and (d) the identification of actions to prevent the future materialisation of the risk, so far as possible.

Please provide information on the steps taken to comply with Duty 12IE.

A Formal Risk Management Strategy is in place and used across NHS Board and CHSCP health services. The Risk Management Strategy has an Escalation plan which outlines how risks can be escalated / de-escalated from Dept to Directorate to Organisational to Strategic Level as required. All risks raised on the current Risk management system, Datix, are allocated a rating for impact (severity) and likelihood (anticipated likelihood of recurrence). All Datix Adverse Event reports are reviewed daily by Chief Nurse (Corporate) and Clinical Governance Team and hence any staffing related issues immediately brought to the attention of the Chief Nurse (Corporate) as Clinical Workforce Lead.

Our Risk Management Strategy outlines the risk management process from service to Executive Strategic risk level. Our governance processes include adverse event reviews with clinical input from Chief Nurse (Corporate)/Clinical Workforce Lead which enables early identification and escalation into the line management structure of any significant / severe adverse event (SAER). All risks have mitigations, identified in the form of a range of controls, noted to be in place and are subject to regular review, frequency of which is based on level of severity of the risk.

The governance processes are embedded within operational structures, and are reviewed and reported through governance structures.

Each professional group/ service determines what constitutes a severe risk to their safe service delivery. Staffing level risks can be reported on the Datix system either reporting adverse events where staffing levels have been a contributory factor or as a risk with the potential to impact upon service provision. As outlined in the Risk Management Strategy, all identified severe and recurring risks are reported through the above lines of governance, up to and including to the NHS Board as necessary.

Thematic reports are available from Datix and reports on specific risks can be provided to departments, topic specialist or various governance groups. Severe and recurrent workforce risks will be shared with the Healthcare Staffing Programme Board for awareness and any escalations reported to the Staff and Clinical Governance Committee's and onwards to NHS Board, via the quarterly report, as necessary. Data from SafeCare, reflecting Professional judgement and red flags raised, can also highlight recurring staffing risks and once this is implemented fully across services will be able to provide a comprehensive overview of any severe and recurrent risks identified across all clinical areas.

Together, the Datix and SafeCare systems will provide robust data on severe and recurrent risks identified across both the NHS Board and CHSC Partnership services.

Most of our services are professionally led and managed and hence clinical advice is inherent within the service structure, where this is not the case the "Topic Specialist" section on the Datix form can be used to record clinical advice sought/ provided.

The requirement to seek and have regard to appropriate clinical advice requires to be formally documented on severe risks.
SafeCare can be used to record and report on mitigations in place for risks, along with assurance that clinical advice has been sought. Once implemented fully, SafeCare will be used routinely to record and report on the mitigations in place, along with providing assurance that clinical advice was sought, both of which will strengthen the current process.

Services who currently don't use SafeCare can record any disagreement with clinical advice provided by submitting an adverse event form within Datix. To date there have been no reports of disagreement with clinical advice provided locally.

As the roll out of SafeCare progresses across the organisation a suite of management reports are also being developed which will enable Senior Charge Nurse /Team Leader/ Exec Managers to have readily accessible information in relation to any severe and recurring risk within their service. This information can then be used to inform future workforce planning processes.

Thematic reports are available from Datix and risk specific dashboards are available. Each service area can pull risks specific to their area to provide a localised and operational picture of risk. All risks raised on the Datix system are allocated a rating for impact (severity) and likelihood (anticipated likelihood of reoccurrence). All Datix submissions can be reviewed across functional groups for trends and occurrences.

We can generate reports on the use of red flags through SafeCare and this will be further strengthened as more services are onboarded. Management Reporting to the respective Exec Director on all red flags raised in SafeCare has been in place since January 2026, the wider implementation of SafeCare across the organisation will strengthen the Board's overall awareness of, and response to, recurrent risk.
All risks raised and recorded on Datix are submitted through line management routes to a more senior decision maker for action or onward escalation. All high risks (severe, score of 15 or above) are escalated to executive level decision makers. Organisational or Strategic risks are considered at the Risk Management Group on a quarterly basis. Risk Management Group (RMG) comprises the Executive Management

Team, Chief Nurse (Corporate) and the Clinical Governance and Risk Team. RMG either provide assurance to the Audit and Risk Committee that risks are being managed or they can be escalated to the Audit and Risk Committee and then to the NHS Board as required.

The complete Risk Register is presented to the Audit Committee at it's quarterly meetings and to the NHS Board on a bi-annual basis.
As above, reports on red flags can be generated through SafeCare and this will be further strengthened as more services are onboarded.
Mitigating actions can be recorded on the Datix risk system.

Our Risk Management Strategy outlines the risk management process from service to Executive Strategic risk level. Our governance processes include adverse event reviews with clinical input from Chief Nurse (Corporate)/Clinical Workforce Lead which enables early identification and escalation into the line management structure of any significant / severe adverse event (SAER). All risks have mitigations, identified in the form of a range of controls, noted to be in place and are subject to regular review, frequency of which is based on level of severity of the risk.

The governance processes are embedded within operational structures, and are reviewed and reported through governance structures.

Please provide Information on your methods of monitoring compliance with Duty 12IE

A process is in place to support all relevant professions to provide self-assessment returns to the HCSA Programme Board on a quarterly basis, which in turn are used to inform the internal quarterly compliance report that goes to the Standing Committees (Staff and Clinical Governance) and to the NHS Board.

Whilst adherence to this process has been variable across services, the Executive Leadership Team has oversight of areas of compliance and non-compliance, highlighted through the quarterly reports made to the Board and any required formal escalation to the Board can happen through this route. This is separate to the process for escalation of risk up to the Board, as outlined above, as appropriate.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action

This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, a recurrent risk was identified in the capacity of one laboratory, leading to a delay in testing samples and communicating sample results. Following investigation, the process for booking in samples was streamlined and an admin coordinator was appointed. This has improved performance, and the lab is now meeting its targets.	This should describe how the success, achievement or learning could be used in the future. For example, the organisation is now looking at whether the changes implemented in one lab could be applied to other labs, to improve wider performance.
Success - All professions	Utilising the Board's standard Risk Management Policy and procedures to report workforce risks means that there is an already familiar system in place for reporting of risks. This system is accessible by all staff and thus anyone can report a risk. The NHS Board's full risk register is visible to all staff thus increasing openness and transparency across the organisation.	Continue to promote the active use of Datix Risk for reporting of risks. Support to use Datix is available to individuals and teams from the Chief Nurse (Corporate) & Clinical Governance and Risk Team During 2026/2027 NHS Shetland will be moving forward with the implementation of Healthcare Guardian as a replacement for Datix Risk and Adverse Events. Support will be provided to teams to transition to the use of this new system.
Escalation of Risks	The Clinical Governance and Risk Team have operational oversight of all Risk Registers at Department, Directorate, Organisational and Strategic level. This team reports to the Chief Nurse (Corporate) / Clinical Workforce Lead and therefore any severe or recurring risk reported relating to workforce issues can be easily identified and readily escalated. Clinical Governance and Risk Team work with the Executive Directors/ Professional Leads and are well placed to raise issues of concern in relation to addressing areas of severe and recurrent risk reported eg identification of an issue of concern via the number of Datix Adverse Events reported, lead to the use of the Common Staffing method and the employment of additional staff	Gather and share across the organisation examples of where following health and care staffing reporting, escalation processes has resulted in a positive change in practice.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, collation of information in a particular NHS function has identified a risk that materialises frequently, however identification of actions to prevent future materialisation has not improved the situation.	This should describe what actions have been / are being / will be taken to address the situation. For example, if identification of initial actions to prevent a recurring risk has not improved the situation, further steps may include establishing a working group to investigate and make recommendations, observing practice in the area, interviewing staff, addressing the staff skills mix, allocating additional assistance, redesigning the service etc.
Lack of standardised approach	Whilst the variation in approach to RTS continues across the Board, these variable processes will continue to present a risk to robust and reliable data capture and reporting to ensure all risks are identified and addressed appropriately.	Continue with roll out of SafeCare as a single RTS Resource organisation wide. Ensure that development of the risk management system continues to support the reporting, escalation and monitoring of staffing risks, as we transition from Datix to Healthcare Guardian. Utilise staffing risk reports from SafeCare to inform risks that are drafted to reflect any severe and enduring staffing risk within services.
Potential for negative impact on identification, recording and managing of risks whilst moving forward with a new Risk Management system	Moving to a new electronic system for Risk Management may reduce the reporting of staffing issues and / or risks whilst staff become familiar with new processes within a different system	The Chief Nurse (Corporate) as Clinical Workforce lead and the Clinical Governance & Risk Team are core to the implementation of the new system and will provide training and support for staff to facilitate as smooth a transfer as possible with an aim to prevent any loss of the good engagement experienced in reporting on current systems

COMPLIANCE ASSURANCE LEVEL

Reasonable Assurance

Duty 12IF: Duty to Seek Clinical Advice on Staffing.

Duty Summary	**Duty to Seek Clinical Advice on Staffing.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for—** (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL, (b) recording and explaining decisions which conflict with that advice.

	(2) The arrangements under subsection (1) must, in particular, include— (a) where a Health Board or the Agency (as the case may be) reaches a decision on a matter which conflicts with the clinical advice it has received— (i) a procedure for the identification of any risks caused by that decision, (ii) a procedure for the mitigation of any such risks, so far as possible, (iii) a procedure for the notification of any such decision, and the reasons for it, to any individual who gave clinical advice on the matter, (iv) a procedure for any such individual to record any disagreement with the decision made on the matter, (b)a procedure for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the Health Board or the Agency (as the case may be), on at least a quarterly basis, about the extent to which that individual considers that it is complying with the duties imposed by— (i) this section, and (ii) sections 12IA to 12IE and 12IH to 12IL, (c) a procedure for such individuals to— (i) enable and encourage other employees to give views on the operation of this section, and (ii) record such views in reports made in accordance with the arrangements put in place under paragraph (b), (d) raising awareness among individuals with lead clinical professional responsibility for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (c), and (e) ensuring that such individuals receive adequate time and resources to implement those arrangements. **(3) Every Health Board and the Agency must have regard to the reports received in accordance with the arrangements put in place under subsection (2)(b).**

Please provide information on the steps taken to comply with Duty 12IF.

All services have agreed processes in place that seek and have regard to appropriate clinical advice in making decisions about staffing at all levels from real-time staffing, as part of risk escalation and management, and as part of the wider workforce planning discussions. Most structures within NHS Shetland are professionally managed and led and therefore ready access to appropriate clinical advice exists.

Professional Leads are in place for all services apart from for Healthcare Science, where, whilst there is no Professional Lead there is a Band 8 Diagnostics Care Lead who performs an operational management lead role for this group of staff. In order to support these professions the

Chief Nurse (Corporate)/ Clinical Workforce Lead will continue to work closely with both the relevant individual services and the Diagnostics Care Lead to ensure that the services continue to progress implementation of the duties in the Act.

All Professional Leads are members of our Programme Board, this includes the individual with Line Management responsibility for Healthcare Science also being on the Programme Board in their own right. Processes are in place to support the provision of clinical advice on a day to day basis via safety huddles and use of realtime staffing methods with escalation as necessary within both the NHS Board and Community Health and Social Care Partnership.

In the out of hours periods a 'Silver command' rota is in place in both areas of the service, some of the postholders on this rota can provide appropriate clinical advice. There is also a Gold Command rota in place at Executive Management Level, some of whom are the Professional Leads, and therefore the need for clinical advice might be escalated to this level. As services in Shetland are small scale it is also recognised practice that if issues could not wait until the next working day and specific professional advice was required that the relevant professional leader may be contacted in the out of hours period whether formally oncall or not. Datix Adverse event/Incident reports or a Risk could be raised to record any event where clinical advice has not been sought or adhered to. To date we have not had any reports of actions taken being contrary to clinical advice provided.

The implementation of SafeCare will support the recording and evidencing of clinical advice having been sought and the subsequent outcome of that advice including any disagreement with the advice provided. From the areas which currently have SafeCare rolled out, there have been no records of any decisions / actions taken which have been contrary to clinical advice provided.
If decisions had been taken which were contrary to clinical advice provided, as noted above, this should be reported on a Datix adverse event report.

On any occasion where following an assessment of risk, a decision is made about staffing which conflicts with the clinical advice provided, we would expect there to be dialogue and discussion between the decision maker and the individual providing clinical advice to inform and support the decision making, including considering potential risks associated with different options, however, in the event that a decision is made that conflicts with the clinical advice received, any actual or potential risk will be identified and mitigated so far as possible. A SOP is in development to support this process in practice.

Any risks identified can be recorded via Datix Adverse Events report (for actual event or to report a near miss) or Datix Risk Assessment. Raising a Datix Risk enables the issue of concern to be formally documented, along with all risks arising and mitigation in place. The implementation of SafeCare will enhance recording of any decision which is against clinical advice and provide a single system where this can be recorded, currently any conflict and subsequent risks caused by that decision would be reported via the Datix Risk and Incident management system.

Whilst the organisation has confidence that this practice is followed there is no single mechanism or process of evidencing this practice at present. SafeCare has the ability to capture any conflict with clinical advice and any ensuing risks and mitigation as a result of this (roll out

continues across the organisation at this time), and the DATIX system is also available to report and record any resulting adverse event (both near miss and actual harm) as considered necessary. All staff have open access to use DATIX.

In the event a decision maker makes a decision that conflicts with clinical advice given, the person providing that clinical advice will be notified of this, and the reason for this. In practice, these conversations are usually undertaken as part of the decision making process.
The person providing clinical advice currently has the ability to raise and record their concern through a range of mechanisms, either to a more senior decision maker, through the processes in place to record real-time staffing risk, huddle notes, by using SafeCare or DATIX systems.

If the concern was reported via a Datix Adverse Event then there is the facility within the system for the Investigator to provide feedback to the person raising the report and any other relevant staff member as to the outcome of this. As we move forward with using SafeCare for realtime staffing assessment and escalation there is the opportunity within the system to record clinical advice sought and any decision taken which conflicts with advice provided.

Whilst SafeCare will also enable conflicts with clinical advice to be recorded, until the system is embedded in practice across the organisation, recording conflicts via a DATIX adverse event will enable these issues, should they occur, to be more quickly raised within the organisational structure as the Chief Nurse (Corporate)/Clinical Workforce lead reviews all adverse events submitted on a daily basis, thus enabling awareness and escalation to Executive level in a timely way.

Whilst there is currently variation across the organisation about how and where conflicts can be recorded which makes audit and assurance of compliance difficult to evidence, the use of SafeCare, combined with the development of the Datix system to incorporate recording of clinical advice and the development of a SOP to clearly lay out the steps required to record any conflict with clinical advice given, will meet this requirement.

Within the organisation the individuals with lead clinical professional responsibility, identified as Board level clinicians, are the Medical and Executive Nurse Directors.

The Health and Care Staffing Programme Board (HCSPB) has been in place since March 2022 to provide guidance on the overall strategic direction of the Health & Care Staffing legislation (the ‘Act’) for NHS Shetland. The HCSPB has representatives from all operational and professional structures across the NHS Board and CHSCP and retains oversight of the implementation of the 10 specific duties placed on NHS Shetland. Due to the key responsibilities of the HCSPB, progress towards compliance has been reported to both the Clinical Governance Committee (CGC) and Staff Governance Committee (SGC).

The Clinical Workforce Lead co-ordinates the provision of information, and drafting of the compliance report, to the Medical and Nurse Director to support them in their duties to report to the NHS Board. Internal compliance reports have been made to the Clinical Governance

and Staff Governance Committees, with quarterly reporting to the NHS Board being built into the Board's business programme since April 2024. Should there be a need for any escalation outwith these times then mechanisms are in place to support this.

The organisation has a range of mechanisms in place to support individuals with lead clinical professional responsibility to enable and encourage staff to give views on the operation of seeking clinical advice on staffing. Feedback can be collected from staff via direct communication, feedback at team meetings, communication / reports / self-assessment returns / feedback from operational services directly into the HCS Programme Board, or through direct engagement sessions with professional leads. At an organisational level staff are encouraged to complete the questions in iMatter (annual staff survey) on how well they feel that their views are listened to and acted upon. Over the last 2 years, we have scored highly on the listened to question but slightly less well on the acted upon, which may reflect that we need to be better at providing feedback on issues, and reporting back into teams, going forward.

The reporting function within SafeCare, can be used to get additional views from red flags raised, any voiced staff or care concerns as well as considering reports raised on staffing within the adverse events system. There are also opportunities across the organisation where staff can share and celebrate success as well as report on things that are not going well, this includes the Clinical Governance Afternoons, Clinical Pathways meetings and the annual Excellence in Care event.

Most of the organisational structures are professionally managed and led and therefore ready access to appropriate clinical advice exists. Escalation structures incorporate access to clinical advice across the professions on a 24/7 basis. Where clinical advice is not sought or adhered to there is the ability to report this on a Datix adverse event report.

The Escalation structures in place provide opportunity for the mitigation of risk by individuals with lead professional responsibility. Once Safe Care is in place across the organisation we will be able to systematically ensure that where clinical advice has been sought that this has been provided and monitor whether subsequent actions have taken this into account or not. If decisions taken are contrary to clinical advice provided, as noted above, this should be reported on a Datix adverse event report.

All professions have time to lead built in to their job descriptions or have job plans that can be updated to include adequate time to implement the arrangements. As we move forward with SafeCare roll out, any issues with clinical leaders working clinically to mitigate risk will be able to be systematically monitored and due consideration given as to what impact this has on their ability to lead and implement the duties of the Act. Information available via the Risk and Incident management system, Datix, can also be used to inform whether or not there is adequate time and resources in place to implement the duty as well as to support a review of the impact on patient outcomes where a risk has been identified.

A working group has been in place over the last year, led by Organisational Development, to implement the requirements of the Protected Learning Time Directive. The Once for Scotland 9 core Statutory Mandatory modules are in the process of being implemented for all staff and plans are being developed to support the PLT Assurance reporting requirements. ERostering can support the allocation of Protected

Learning Time for staff, with SafeCare being used to support the recording of Protected Learning Time taken or any factors impacting on the ability to take Protected Learning Time. Whilst recording PLT in SafeCare was recommended during 2025, there has been limited uptake so far and thus the Clinical Workforce Lead will work with the Organisational Development Team to help progress this during 2026-2027.

Work has also commenced on identifying Profession Specific Mandatory training for Agenda for Change staff and this will be rolled out across the Organisation in 2026-2027. All Protected Learning Time going forward should be recorded in SafeCare to help support being able to evidence that protected learning time for both core and profession specific training has been allocated in worktime, in line with the requirements of the Health and Care Staffing (Scotland) Act 2019 and the DL (2025)26.

Please provide Information on your methods of monitoring compliance with Duty 12IF

An overview of current progress, as understood from the information provided in the self assessment returns completed by the Professional Leads, feedback by a range of individuals at service manager level and from the Clinical Workforce Lead's knowledge of service areas and systems progress is presented in the quarterly report to the Clinical and Staff Governance Committees and to the NHS Board in the internal compliance report.

Formal monitoring of compliance with this duty will be supported by the organisational implementation of SafeCare where seeking and receiving clinical advice can be systematically recorded. Any non-compliance or concerns re potential non-compliance can be reported to the person with Lead Professional responsibility for review at any time. A Datix Adverse Event report can be submitted to highlight areas of concern where clinical advice has either not been sought or action taken not in line with the clinical advice provided.

The governance structure of the organisation ensures that the organisation has regard to reports created.

Due to the key responsibilities of the HCSPB, progress to date has been reported to both the Clinical Governance Committee (CGC) and Staff Governance Committee (SGC), which are both standing Committees of the NHS Board.

Quarterly NHS Board internal compliance reports have been built into the Board's Business programme since April 2024, with the first of these reports considered by the NHS Board at their meeting in June 2024.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action

This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, the views of employees included in the reports prepared by individuals with lead clinical professional responsibility for a particular type of healthcare identified a potential improvement in working practices in one area.	This should describe how the success, achievement or learning could be used in the future. For example, the potential improvement is being trialled in the one area and if successful will be rolled out across other areas in the organisation.
Current culture	Strong culture of seeking clinical advice is in place in the organisation. In order to formalise this, a SOP is in development which will outline the management and reporting structure to make it clear to staff where to seek appropriate clinical advice.	Develop communications plan to raise profile of the SOP once completed.
Path to green	All services will need to have SafeCare rolled out before the Board is comfortable to provide substantial assurance on this duty. Due to the processes in place, as described above, the Board is assured that the systems and processes in place are functioning effectively	The systems and processes in place will become more streamlined and robust once SafeCare has been implemented in all clinical services.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, in compiling reports made to the members of the Health Board, there are good mechanisms in place for the Medical Director to enable and encourage medical employees to give	This should describe what actions have been / are being / will be taken to address the situation. For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions.

	their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports.	
Delays to roll out of SafeCare	The challenge of not having all services and professions using the same system is creating variability across both the NHS Board and CHSCP.	A high implementation rate for eRostering has now been achieved across the organisation, currently approx. 90%. Increasing understanding that SafeCare can help managers deliver on the requirements of the HCS Act should positively support good progress to be made in the next 12 months. In the interim all staff can continue to access the operational and professional structures in place to support practice in their own area/discipline. Datix is available to all staff organisationally to record any associated adverse events.
Ability to record and report on all activity	There are robust structures and processes in place to support this duty, however there continues to be no consistent method for recording and reporting on this in the absence of full roll out of SafeCare	Continue to promote and support SafeCare implementation across the organisation, articulating the role that SafeCare plays in supporting delivery of the requirements of the Act.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IH: Duty to ensure adequate time given to clinical leaders.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must 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, including, in particular, time—** (a) to supervise the meeting of the clinical needs of the patients in their care, (b) to manage, and support the development of, the staff for whom they are responsible, and (c) to lead the delivery of safe, high-quality, and person-centred health care.

Please provide information on the steps taken to comply with Duty 12IH.

The organisation uses established workforce systems, including SSTS, eESS, TURAS and Health Roster, to identify roles and individuals holding lead clinical responsibility. Leadership responsibilities are explicitly reflected in job roles, titles and Job Descriptions, ensuring clarity of accountability.

Leadership time is formally built into all relevant Job Descriptions and varies according to role and service context, ranging from a percentage of time being allocated to being 100% supernumerary, such as Senior Charge Nurse posts. Job planning for medical staff is in progress, however challenges have been faced with using eJobplan due to some of the unique features of our roles, assistance was sought nationally from RL Datix to assist with this.

Leadership activity and displacement by clinical workload can be monitored through Optima Allocate and, increasingly via SafeCare, as it is rolled out across the organisation. Using SafeCare will support the systematic monitoring of time for leadership and supervision activities across the organisation.

Actual Leadership time and expectations are reviewed through annual appraisal and job planning processes. Where clinical leadership time is felt to be insufficient and has the potential to impact on patient and/or staff safety this can be highlighted through the organisation's risk management structure with any adverse impacts reported via Datix. Any untoward event occuring either through a lack of time for leadership or supervision can also be reported via the adverse incident system, Datix. In tandem with Duty 12IC and 12ID, the impact on patient outcomes is routinely reviewed when risks or adverse events are identified, in line with the National Framework for Reviewing and Learning from Adverse Events in NHS Scotland (Healthcare Improvement Scotland, 2025).

The scale of our services helps support close working with line managers, in predominantly professionally led service models, so raising issues of concern regarding lack of time and resources to support clinical leadership time can be easily done.
Annual appraisal provides a structured mechanism for reviewing leadership capacity and resource sufficiency. While organisational appraisal completion rates are currently low, targeted improvement actions are in place.

Rates of completion of Appraisal and of Job Planning reviews can be monitored via TURAS and eJobplan (currently implementing). Challenges experienced with implanting eJobplan have been raised nationally.

Annual appraisal provides the opportunity for Managers to review with staff the current capacity within their role to undertake their clinical leadership responsibilities. Organisationally as we move forward with the use of SafeCare we will be able to more systematically monitor the time clinical leaders have to undertake their leadership role and be able to monitor how often the leadership duties have been superseded by the need to pick up a clinical caseload to mitigate clinical risk. Where SafeCare is already in place this is currently being monitored in practice. The output from Appraisals and monitoring data from SafeCare will inform our organisational position on whether all relevant staff do have the time and access to resources to support them discharge their leadership responsibilities. Discrepancies identified will require to be addressed via the organisational Workforce Planning processes.

Appraisal outputs, alongside SafeCare data, will inform assurance on leadership capacity and any required mitigations. The further roll out of SafeCare, will support the ability to monitor this more systematically across disciplines, moving forward. Until SafeCare is rolled out to all clinical services, any concerns with regards to staff having adequate time to lead will be reported on by Professional Leads.

Leadership time is explicitly considered within:

- Workforce planning using the six-step methodology
- The Common Staffing Method
- Staffing level tools, appraisal data, workload information and quality indicators

Where gaps are identified, actions are taken through workforce planning, job planning, or service redesign to protect leadership capacity.

Workforce planning through the six step methodology and Common Staffing Method takes cognisance of outputs from staff appraisal completion rates, workload and activity of all staff (staffing levels, levels of redeployment, non-caseload holding time of clinical leaders), identified risks and patient outcomes.

The time needed for clinical leadership should be considered whilst undertaking the Common Staffing Method. The output from staffing level tools will provide evidence on whether there is adequate leadership time available and if not the requirement for additional time should be discussed with the individual and built into future workforce planning. Professional leads discuss and agree with line managers the level of time and resource required to discharge their responsibilities and clinical workload as a core component of annual appraisal meetings.
All professions have time to lead built in to their job descriptions or have job plans that can be updated to include adequate time to implement the arrangements. As we move forward with SafeCare roll out, any issues with clinical leaders working clinically to mitigate risk will be able to be systematically monitored and due consideration given as to what impact this has on their ability to lead and implement the duties of the Act.

Information available via the Risk and Incident management system, Datix, can also be used to inform whether or not there is adequate time and resources in place to implement the duty as well as to support a review of the impact on patient outcomes where a risk has been identified.

A working group has been in place over the last year, led by Organisational Development, to implement the requirements of the Protected Learning Time Directive. The Once for Scotland 9 core Statutory Mandatory modules are in the process of being implemented for all staff and plans are being developed to support the PLT Assurance reporting requirements. ERostering can support the allocation of Protected Learning Time for staff, with SafeCare being used to support the recording of Protected Learning Time taken or any factors impacting on the ability to take Protected Learning Time. Whilst recording PLT in SafeCare was recommended during 2025, there has been limited uptake so far and thus the Clinical Workforce Lead will work with the Organisational Development Team to help progress this during 2026-2027.

Work has also commenced on identifying Profession Specific Mandatory training for Agenda for Change staff and this will be rolled out across the Organisation in 2026-2027. All Protected Learning Time going forward should be recorded in SafeCare to help support being able to evidence that protected learning time for both core and profession specific training has been allocated in worktime, in line with the requirements of the Health and Care Staffing (Scotland) Act 2019.

Please provide Information on your methods of monitoring compliance with Duty 12IH

The organisation is developing a formal mechanism for monitoring compliance with this duty, and escalation of non-compliance (when this cannot be adequately met). Each team leader in conjunction with their line manager must discuss, agree and document what is appropriate time for their clinical and non clinical functions.

Currently this can be monitored through various mechanisms eg TURAS reports, LearnPro completion, SafeCare and Datix (adverse events & risks). A process to monitor Protected Learning Time for both core Statutory Mandatory modules and Profession Specific PLT will be progressed as part of the work to meet PLT Assurance reporting requirements.

A mechanism for the systematic monitoring of time for leadership will be achieved through the use of SafeCare (currently in roll out across the organisation).

The Professional Leads and Executive Management Team have oversight of areas of compliance and non-compliance. Any escalation required can be highlighted to the Board through the quarterly compliance report.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action

This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project was a determination of time and resources for different team leaders, and feedback so far has been positive.	This should describe how the success, achievement or learning could be used in the future. For example, the positive outcome experienced as a result of the working group has led to this model being extended to other AHP areas and trialled to see applicability.
Policies, systems and processes in place	Robust Organisational policies, systems and processes in place for facilitating and monitoring of Clinical leaders time.	Continue to develop audit and compliance framework
Path to green	All services will need to have SafeCare rolled out before the Board is comfortable to provide substantial assurance on this duty.	Due to the processes in place, as described above, the Board is assured that the systems and processes in place are functioning effectively. The monitoring systems and processes will become more streamlined and robust once SafeCare has been rolled out to all services.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the process in place to identify the roles, and therefore individuals, with lead clinical professional responsibility for a team of staff does not consistently identify who these individuals are, and therefore sufficient time and resources for these individuals to discharge their responsibilities has not been considered.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the process in place to identify the roles, and therefore individuals, does not consistently identify who those individuals are, what measures have been taken to address this? This could involve working with all staff groups, clinical areas, and teams to identify job titles / roles, utilising HR processes, and information and or utilising eRostering to identify team leaders etc.

Annual Appraisal	Recorded appraisal rates are low within NHS Shetland and this is a current area of focus for the organisation. If we are agreeing that discussions of whether or not staff have access to appropriate time and resources to support them in their leadership duties should be built into the annual appraisal process unless we ensure that annual appraisal is conducted there will be no regular opportunity to review this duty between staff and manager.	Develop monitoring process (audit and compliance framework) to check compliance with both this duty and that it has been considered as part of the annual appraisal conversation – will be progressed as part of work to meet PLT Assurance reporting requirements

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12II: Duty to ensure appropriate staffing: training of staff.

Duty Summary	**In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that its employees receive—** (a) such training as it considers appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b), and (b) such time and resources as it considers adequate to undertake such training.

Please provide information on the steps taken to comply with Duty 12II.

All employees attend Corporate Induction and have a local departmental Induction when commencing employment with the NHS Board. As part of the Induction pack information is provided regarding the Health and Care Staffing Act via a Briefing paper which includes links to further sources of information including the TURAS e-learning resources. Training in relation to Legislation, Common Staffing Method and use of Staffing Level Tools is provided for relevant staff groups prior to tool runs being undertaken.

Organisationally there is a process in place to develop a Corporate Training Plan for all staff. This was trialled on a 3 year basis over the last period but has been revised to a 2 year timeframe going forward in order to provide increased flexibility to support the current redesign of services.

A Schedule of Mandatory and essential training for all NHS functions and professional groups in the organisation is in place and is being reviewed as part of the work to implement the Protected Learning Time Directive. The 9 core statutory mandatory modules have been adopted in line with NHS Scotland guidance and work continues to review and agree Profession specific mandatory training. Compliance levels with mandatory training and induction completion is monitored.

Discussion re completion of mandatory and essential training is expected as part of the annual appraisal and PDP process, monitoring of which is through line managers, Organisational Learning and Development with quarterly reports made to the Staff Governance Committee. Annual Appraisals are conducted across the organisation, however, monitoring data indicates that our appraisal and PDP completion rate is low. This is currently a focus for action across the organisation.

There is a small Practice development function with Practice Education Facilitators in place for nursing and midwifery and for AHPs, through a regional approach. These core resources are small and there is an emphasis within the overall organisation that staff within clinical roles support the education and development of a variety of students/ learners across the professions. Within medicine there is a dedicated admin support role who helps support and co-ordinate education and training for junior doctors.

There is also a Clinical Development Fellow whose role is partly to support learning and development within clinical teams. Whilst there is a commitment to support staff training across the organisation, current service pressures means this is challenging.

The Staff Governance Standards highlight that both Employers and staff have a responsibility to ensure that they adhere to regulatory standards and keep themselves up to date. Training requirements for all staff, based on professional or service needs, are identified at dept/service level and then fed into the overall Corporate Training Plan. Training needs recorded on TURAS include recording their priority level of Mandatory, Essential or Developmental. All Managers, including Executive Directors, can see individuals and teams compliance on training through TURAS Line Manager Reporting function and are responsible for performance management of individuals.

Staff time for training is challenging and resources are limited and therefore bids to alternative funding mechanisms, both locally and nationally, are made to supplement core funding for staff training and development. Where training needs are identified as Essential for role or service development these are funded through the training plan if identified and agreed as part of the proposed service development.

The Executive Management Team consider and agree the Corporate Training Plan priorities annually and this is then funded from the core training budget, +/- any supplementary funding attracted. As previously noted, dedicated resources to support inhouse education are limited and therefore there is an expectation on staff within key clinical roles to provide education and development opportunities for colleagues and learners.

PDP completion is monitored through TURAS platform along with completion of mandatory and essential training at one to one meetings between managers and staff within all professions.

Good links exist with external Higher Education Institutes and training needs are discussed with them through the Strategic NMAHP group and the Medical Education Governance Group.

Training agreed through the Corporate Plan has a time and resource commitment allocated to it. Over the last year challenges have been experienced in release of staff time to train due to workforce /service pressures. If staff are unable to attend training on the day it is the responsibility of the individual/dept to book on to another course - as our services have relatively small staff numbers this means this is relatively easy to manage at dept level with escalation up the management structure as necessary.

As noted in Duty 121H a working group has been in place over the last year, led by Organisational Development, to implement the requirements of the Protected Learning Time Directive. The Once for Scotland 9 core Statutory Mandatory modules are in the process of being implemented for all staff and plans are being developed to support the PLT Assurance reporting requirements. ERostering can support the allocation of Protected Learning Time for staff, with SafeCare being used to support the recording of Protected Learning Time taken or any factors impacting on the ability to take Protected Learning Time. Whilst recording PLT in SafeCare was recommended to managers across services during 2025, there has been limited uptake to date and thus the Clinical Workforce Lead will work with the Organisational Development Team to help progress this during 2026-2027.

Work has also commenced on identifying Profession Specific Mandatory training for Agenda for Change staff and this will be rolled out across the Organisation in 2026-2027. All Protected Learning Time going forward should be recorded in SafeCare to help support being able to

evidence that protected learning time for both core and profession specific training has been allocated in worktime, in line with the requirements of the Health and Care Staffing (Scotland) Act 2019.

In terms of online access to mandatory training staff can access TURAS online from a variety of devices and locations. Staff are enabled to complete their mandatory training at a time and location that is convenient for them with some staff areas already providing a standard 7hrs (day) per annum for staff to complete their mandatory training. Once data is more readily available on whether or not allocated training time is being achieved this can be reviewed and due consideration given as to what this means in terms of the need for time to complete mandatory training being built into department workforce plans going forward, as required. Staff competency and capability is part of both Six Step methodology and Common Staffing Method in workforce planning; as is review of completion rates of training to identify future workforce need for training resource and time.

Please provide Information on your methods of monitoring compliance with Duty 12II

Core Mandatory and Statutory training for staff are clearly identified in the Organisation's Training Matrix which is available on NHS Shetland's TURAS pages. Approved Corporate Training, including mandatory training, is monitored via the Organisational Learning and Development Dept, the Learning and Development Team provide regular reports on compliance to relevant Committees and governance groups eg Area Partnership Forum and the Staff Governance Committee.

Once data is more readily available via Allocate Optima & SafeCare this will help evidence compliance with this duty, where non-compliance is identified it is expected that this will be escalated through the management structure, placed on departmental risk registers (as required) and reported to the NHS Board as part of quarterly reporting.

The routine use of Allocate Optima & SafeCare going forward will enable us to formally record study/ training time scheduled and to monitor and report on study time actually achieved as protected time. During 2025-2026 staff have been encouraged to start recording study/ training time in Optima in order to support monitoring in line with the protected learning time directive, however data entry to date has been limited and additional briefings have been issued via the Corporate Newsletter to raise the profile of the importance of recording this time. The Business as Usual team, eRostering and Clinical Workforce Leads are supporting the sharing of this message organisationally with any team contact they have.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, the psychology department in conjunction with HR, has just completed a project to promote more accurate capturing of information relating to continued professional development for psychology colleagues. Feedback from employees is that they have found the new system much easier to use and are now recording relevant CPD.	This should describe how the success, achievement or learning could be used in the future. For example, AHP colleagues have now expressed interest in the new system and are undertaking a project to establish whether they could implement something similar.
All disciplines	We are fortunate to have a training plan process in place which is accessible to all across the organisation. The move to undertaking this on a bi-annual basis will hopefully better support services to plan and develop new staff skills and competencies over a 2year period which will also support succession planning in the workforce. This is very important as we have a predominantly mature workforce across the organisation	
Path to green	Achieved. All services have agreed processes in place that ensures that all employees receive such training as considered appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b) and such time and resources as considered adequate to undertake this training. There is a strong training culture in the Organisation and robust monitoring of all mandatory and essential training requirements and compliance is in place, including escalation of non-compliance (when this cannot be adequately met).	Monitoring processes in place and data shared with Staff Governance Committee on a quarterly basis

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, clearly defined processes and procedures exist for some groups of staff, e.g. nursing and midwifery, but do not exist for other groups of staff, e.g. healthcare scientists.	This should describe what actions have been / are being / will be taken to address the situation. For example, if procedures and processes are not in place for healthcare scientists, please list the measures which need to be put in place to address this, such as working with HR and healthcare scientist representatives to define an appropriate training programme, assess training needs of employees and plan for required training to be undertaken.
Consistency of application across all professions in all clinical settings	Whilst there are systems and processes in place, further work could be undertaken to strengthen these and ensure consistency of approach across all professional disciplines and in all clinical settings.	Continue to work with sub-groups and operational leaders to seek assurance that these systems and processes are in place, identifying any gaps or challenges, and promoting the use of Health Roster & SafeCare across services to evidence compliance with this duty.

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance

Duty 12IJ: Duty to follow the common staffing method.

Duty Summary	**(1)In relation to health care of a type mentioned in section 12IK, a Health Board or the Agency (as the case may be) must, no less often than at the frequency specified in regulations by the Scottish Ministers, use the common staffing method set out in subsection (2).** **(2) The common staffing method means that a Health Board or the Agency (as the case may be)—** (a) uses the staffing level tool and the professional judgement tool as prescribed in regulations under subsection (3) and takes into account the results from those tools, (b) takes into account, in so far as relevant, any measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H (1) by the Scottish Ministers (including any measures developed as part of a national care assurance framework), (c) takes into account— (i) its current staffing levels and any vacancies, (ii) the different skills and levels of experience of its employees, (iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care, (iv) 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 including, in particular, those to which this section does not apply, (v) the local context in which it provides health care, (vi) patient needs, (vii) appropriate clinical advice, (viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides, (ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE, (x) comments by patients, and by individuals who have a personal interest in their health care (for example family members and carers within the meaning of section 1 of the Carers (Scotland) Act 2016), which relate to the duty imposed by section 12IA, and (xi) comments by its employees which relate to the duty imposed by section 12IA, (d) identifies and takes all reasonable steps to mitigate any risks, and (e) having followed the steps described in paragraphs (a) to (d), decides what changes (if any) are needed as a result to its staffing establishment, and to the way in which it provides health care.
Please provide information on the steps taken to comply with Duty 12IJ.	

During 2025-2026 all areas, where there are speciality specific staffing tools in place, have conducted these in line with the regulations (2 weeks per annum). However, this year we have experienced considerable difficulty in data retrieval via BOXI reporting and the Healthcare Staffing Programme Staffing Level Tool Compliance Dashboard is not reporting an accurate reflection of the tool run activity undertaken across local services.

Support for accessing the staffing level tool data has been sought from HIS Healthcare Staffing Programme Analysts. The challenges experienced this year have been reported to both our SSTS provider, NHS Grampian, and to the Healthcare Staffing Programme regarding the inaccuracy of the Compliance Dashboard information. Challenges with retrieval of the staffing level tool data has meant that the Common Staffing Method for all relevant services has not been completed prior to the 31 March 2026 and work remains ongoing at this time.

Support for the use of the Staffing level tools is in place via the Chief Nurse (Corporate)/ Clinical Workforce Lead. This includes support for preparation, running the tool, reviewing & quality assuring the data as well as the provision of education and support for reporting on each tool run. The HIS Quality Assurance checklist is used to guide the tool runs and there is a standardised reporting template in use to report on the outcome of the tool run which ensures that all other aspects of the Common Staffing Method have also been given due consideration.

The Clinical Workforce Lead ensures that staff have the access to the most current resources from HIS and staff can access training support both via the electronic resources available via the Healthcare Staffing Programme website, as well as in person via the local Clinical Workforce Lead. Due to the scale of the local service, training and support is provided on a service by service basis, immediately prior to the scheduled tool runs being carried out. A record of staff trained is kept along with the training resources used.

A Staffing Level tool programme is in place to support the use of speciality specific tools in relevant areas of practice locally. Both the Professional Judgement tool and/or Quality Tool are also used as part of relevant tool runs. The results from the tool runs are then considered in the formal report as part of applying the Common Staffing Method. The Clinical Workforce Lead is part of the national Workforce Leads collaborative and works closely with peers and HIS colleagues to ensure that local staff are aware of any updates and/or recent developments in relation to the staffing level tools.

Following discussion at our Executive Management Team in January 2026 it was agreed to support the use of the Common Staffing Method as a workforce planning framework across all clinical areas. A SOP is in development to support staff in accurately undertaking all aspects of the Common Staffing Method.

Common Staffing method requires consideration to be given to funded establishment, actual staffing (including current vacancies), level of supplementary staffing being used and Predicted Absence Allowance versus Actual absence. Information to inform this section of the CSM report is available from budget reports, and from both the SSTS BOXI and Health Roster reporting functions.
With the Common Staffing Method there is a requirement that relevant local quality measures such as clinical quality data (falls, pressure ulcers), complaints, adverse events reports as well as the Excellence in Care measures are taken into account as part of the use of the

Common Staffing Method. The Chief Nurse (Corporate) portfolio includes oversight of Clinical Governance (Quality, Safety, Risk), Care Assurance including Excellence in Care, Health Care Staffing and Patient experience and therefore is well placed to support areas with the co-ordination and provision of quality of care information to be considered as part of the application of the Common Staffing Method.

When recording the outcome of the Common Staffing Method a standardised reporting form is used. This reporting form seeks information on a range of factors, as follows:

- Workforce data - Real time staffing risk assessments, escalations and/or any identified enduring risks. Data to inform this is available through realtime staffing resources in use, via SafeCare and through reports from the Adverse event and risk reporting system, Datix.
- Workforce characteristics - consideration of skill mix, experience of employees and age profile of employees.
- Local context is very important in our remote, rural and island setting. Staff are encouraged to use this section to describe local context within their service. Examples given include: skill mix, missed care results, psychological safety results, imatter scores, staff experiences, age profile of employees, capacity and demand, supplementary staffing usage, PAA v actual, etc.
- Patient dependency and needs, both current and unmet, are considered with due consideration being given to quality issues raised through patient feedback and formal complaints. There are various mechanisms in place to enable patients to provide feedback on their experiences of care eg comments, Care Opinion posts, complaints processes, all of which are considered as part of the triangulation in the CSM.
- Assessments by HIS or local measures of quality will be taken into consideration. Training provided for staff prior to the Tool run highlights the importance of giving consideration to the results of any recent audit or scrutiny reports with examples of such reports provided. The standardised reporting template expects the reports considered as part of the Common Staffing Method to be listed.
- Risk assessment & prioritisation: Identification, escalation and mitigation of risks - use of realtime staffing assessment, identification of risks and whether these were mitigated or escalated checking that staff understand the internal reporting, escalation and prioritisation process; has clinical professional advice/ guidance sought where required?
- Decision making, recommendations and next steps taking into account various factors which may be relevant eg service redesign or service/roster or skill mix required including has professional advice/ guidance been sought from clinicians and workforce planning colleagues?
- Is staffing appropriate to provide safe, high quality care? Does this report identify that an SBAR is required for this location?

The Common Staffing Method expects the staff team to have been actively involved in Team discussions as part of the prep for undertaking staffing level tool runs and reviewing the subsequent output as a Team provides an opportunity for staff to feed their comments into the process. In addition to the opportunities specifically related to undertaking the tool run, general staff feedback available through mechanisms such as iMatter, staff comment schemes, whistleblowing, should be recorded and used to inform the overall outcome of the Common Staffing Method.
If the Output from the Common Staffing method suggests additional resources are required, to meet safer staffing requirements, an SBAR would then be presented to the Director of Nursing and approval sought to proceed to developing a Business case for onward consideration

by the Exec Management Team. Through this process the output of the Common Staffing Method would be used to inform future establishment levels or to support/drive service changes as necessary.

Business cases are then submitted to the Executive Management Team for consideration as part of the annual budget setting process. This enables an organisational overview to be taken of all requests submitted, with a multi-professional review then being conducted, informed by the organisation's Professional Leads. In addition, Individual Business cases can be presented to the Executive Management Team at any point in the year upon identification of the need for additional staffing resources.

Support for staff undertaking the staffing level tool runs and completing the Common Staffing Method Reporting Template is provided by the Chief Nurse (Corporate)/Clinical Workforce Lead and/or Chief Nurse for that clinical area. All accountable managers are asked to provide assurance by responding to all prompts on the Common Staffing Method reporting template.

Please provide Information on your methods of monitoring compliance with Duty 12IJ

All reporting lines use the self-assessment return to report on use of the Common Staffing Method. This is also incorporated into the internal quarterly report that goes to the Board.

The Executive Leadership Team has oversight of areas of compliance and non-compliance, highlighted through the quarterly reports and any required escalation to the Board can happen through this route. Whilst there is a separate process for escalation of risk up to the Board, any risks noted in relation to health care staffing will also be highlighted in the Board quarterly compliance report.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action

This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, application of the common staffing method in adult inpatient provision identified some areas where the staffing establishment needed to be changed, and some areas with potential for service redesign. These changes are now in progress and will be trialled to monitor the outcomes.	This should describe how the success, achievement or learning could be used in the future. For example, following completion of the trials regarding changes in staffing establishment and service redesign, decisions will be taken about their formal adoption. A summary of this exercise could then be used as case studies to inform training for staff about the use of the common staffing method.
CSM & Staffing Level Tool Programme	Annual programme of Staffing Level Tool runs and CSM application in place.	Continue to build on current practices and consider how best the outputs provide additional assurance to the HCSA Programme Board. Encourage running of staffing level tools earlier in the business year in order that results can be used to directly inform the annual service, workforce and financial planning cycle.
Nursing	Use of the Common Staffing Method has provided objective evidence to support the development and submission of Business cases to support the need for additional staffing in 2 clinical areas, general medical ward and accident and emergency dept.	Showcase examples as an illustration of the positive impact of using the Common Staffing Method to undertake an objective review of staffing levels in an area, illustrate the appropriate engagement of staff within the overall process, outlining the entire process and successful achievement of additional investment. This would be very positive for the teams involved whilst also demonstrating the Common Staffing Method in action and merit of the application of the CSM in practice.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel.	This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provision and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc.
Capacity to Support all duties of the Act	There is limited time from the Clinical Workforce lead (equivalent of 1 day, 7hrs, per week) to support awareness raising, support the development of activities to demonstrate compliance with the Act, and to also support all tool runs undertaken, therefore continued further progress may be slow and there is also the potential that progress made to date may be lost over time through capacity constraints within both the workforce lead capacity and overall service capacity.	Ensure all duties are built into Induction and annual training programmes to ensure consistency and an ongoing legacy. Existing structures eg morning huddle will be used to keep staff aware of their responsibilities

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance

Duty 12IL: Training and consultation of staff

Duty Summary	**In complying with the duty imposed by section 12IJ, every Health Board and the Agency must—** (a) encourage and support its employees to give views on its staffing arrangements for the types of health care described in section 12IK, (b) take into account and use any such views it receives to identify best practice, and areas for improvement, in relation to such staffing arrangements, (c) train employees (including, in particular, employees of a type mentioned in the third column of the table in section 12IK (1)) using the common staffing method on how to use it (d) ensure that those employees receive adequate time to use the common staffing method, and (e) provide information to employees engaged in the types of health care described in section 12IK about its use of the common staffing method, including about— (i) the results from using the staffing level tool and the professional judgement tool under paragraph (a) of section 12IJ (2), (ii) the steps taken under paragraphs (b), (c) and (d)] of that subsection, and (iii)the results of its decision under paragraph (e) of that subsection.

Please provide information on the steps taken to comply with Duty 12IL.

Educational sessions are held for all relevant staff on the application of the Common Staffing Method, including completion of the staffing level tools, immediately prior to undertaking a tool run. The Clinical Workforce Lead provides the training on the Staffing level tools and Common Staffing Method, with access to the resources on the Healthcare Staffing Programme website also brought to staff attention at this time. A record of attendance at all training sessions held is kept by the Clinical Workforce Lead.

As part of the preparation for staffing level tool runs there is an opportunity for staff, as individuals and as a staff team, to consider staffing issues directly relevant to their area of practice and to ensure that these are taken account of when completing the tool run.

Staff involvement throughout the application of the Common Staffing Method is encouraged and can be evidenced via a number of sections on the standardised reporting template eg Section 3 "comments by staff", Section 4 "iMatter, employee experience", Section 5 "staff engagement and feedback", Section 7 "how are staff consulted during this process & how are staff informed during this process". Section 7 also requires an explanation and rationale for decision making to be reported on and shared amongst staff.

Staff Consultation takes place through face to face team meetings with discussions held on the outcome of the staffing tool run providing an opportunity for the staff team and SCN to interact with the Chief Nurse, Clinical Workforce Lead and to seek specialist support from the organisational workforce lead (HR) as necessary. The outcome and feedback from all local management meetings should feed into future workforce plans.

A generic Briefing for all staff has been issued which outlines key information on the Act and provides easy access to both the HIS Healthcare Staffing Programme and TURAS eLearn resources, via QR codes. In addition, a regular section on various aspects of the Health and Care

Staffing (Scotland) Act has been placed in the Corporate Monthly Newsletter to assist with wider awareness raising of the Act and to help increase understanding of how SafeCare can support teams evidence compliance with the requirements of the Act.

No issues with regards to available time to complete the Common Staffing Method have been raised to date.

The outcome of staffing level tool runs should be shared with staff, clarifying the next actions to be taken with regards to reporting the outcomes and the use of the Common Staffing Method to inform the department/service workforce plans going forward. It is expected that the outcome of the tool run would be shared within the context of a department/ Team meeting to allow for transparency and for staff to be made aware of the outcome. Due consideration is given as to the most appropriate meeting for the discussing and sharing of the Emergency Care tool outcome to take account of the multi-professional nature of this tool.

Outcomes from tool runs are shared with the Chief Nurse for the area and any areas where additional staffing resource is required is brought to the attention of the Director of Nursing/Director of Nursing and Director of Community Health and Social care enabling workforce information to inform the annual budget setting process. For the Emergency care tool, results would be shared with the Chief Nurse and the Associate Medical Director (Acute) prior to escalation to Director of Nursing who is also the lead Director for Acute & Specialist Services. Section 5 of the standardised reporting template, expects how results will be cascaded to all staff within a ward/team to be confirmed.

Please provide Information on your methods of monitoring compliance with Duty 12IL

The Clinical Workforce Lead will monitor the training and consultation of staff in the Common Staffing Method process when used across relevant service areas, ensuring due process has been carried out and reporting activity undertaken to the Health and Care Staffing Programme Board and subsequently to the Standing Committees of the NHS Board (Staff Governance and Clinical Governance) and to the NHS Board it's self as part of the quarterly report.

Any non-compliance will be escalated to the Director of Nursing for management oversight and action.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, key personnel who were very experienced in using the common staffing method were engaged to train and mentor other personnel involved in the process.	This should describe how the success, achievement or learning could be used in the future. For example, those key personnel have now decided to meet regularly in a forum to discuss shared learning and to ensure the common staffing method is used consistently across all relevant areas in the organisation.
Path to green	Achieved.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, issues were identified with a lack of training on the CSM for personnel in emergency care provision due to time constraints.	This should describe what actions have been / are being / will be taken to address the situation. For example, arranging and delivering training; the provision of mentoring from experienced personnel; or the adoption of job planning which ensures adequate time is available for designated personnel to undertake training on the common staffing method.
Ensure staff have formal opportunities to feed into processes	Initial consideration was given to developing an eForm to support staff to give feedback on staffing issues, however, experience over 2025-2026 has demonstrated that staff/ teams raise questions directly to Clinical Workforce Lead when tool runs are in progress and that staffing challenges experienced in practice are reported on Adverse Event reports and therefore this action is not being	

	progressed currently. Will be revisited if evidence supports a lack of feedback from staff	
Capacity to support all duties in the Act	There is limited time from the Clinical Workforce lead (equivalent of 1 day, 7hrs, per week) to support awareness raising, support the development of activities to demonstrate compliance with the Act, and to also support all tool runs undertaken, therefore further progress may be slow and there is also the potential that progress made to date may be lost over time through capacity constraints within both the workforce lead capacity and overall service capacity.	Ensure all duties are built into Induction and annual training programmes to ensure consistency and an ongoing legacy. Existing structures eg morning huddle will be used to keep staff aware of their responsibilities

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance

Planning and Securing Services

Duty Summary	**Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. (2) In planning or securing the provision of health care from another person under a contract, agreement or arrangements made under or by virtue of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to— (a)the guiding principles for health and care staffing, and (b)the need for the person from whom the provision of health care is to be secured to have appropriate staffing arrangements in place.

Please provide information on the steps taken to comply with section 2(2) of this Duty.

The NHS Board's Primary Healthcare service model is predominantly an NHS Board directly provided salaried service. Only one of the 10 General Practices is an Independent Provider. Work will be progressed with the Service Manager for Primary Care regarding ensuring that this practice is required to confirm that they are abiding by the Guiding Principles and have appropriate staffing arrangements in place. Contracts exist with a number of Special Health Boards where services are provided at a national level, there are also a range of shared care pathways in place with other Boards eg via NECU and further pathways will be developed to take account of future subnational arrangements. The Director of Finance will review these alongside national contracting.

A statement to be added to tender documents, service specifications and Service Level Agreements which reference the need to have due regard to the Guiding Principles and to have appropriate staffing arrangements in place is in the process of being drafted. Discussions will be held with the Director of Finance, as responsible Director for commissioning, and relevant members of the Procurement team, to establish a process by which this statement is built into any procurement and/or commissioning process going forward.

Please provide Information on your methods of monitoring compliance when planning and securing services

Process not yet in place and therefore no formal monitoring of compliance at this time.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, when procuring from private hospitals, the organisation has incorporated the requirements of the Act into the tender process.	This should describe how the success, achievement or learning could be used in the future. For example, the learning from tendering with private hospitals is now being used to implement arrangements in other types of procurement.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may have been difficulties in planning or securing services in a speciality area due to a lack of assurance around the appropriateness of staffing arrangements.	This should describe what actions have been / are being / will be taken to address the situation. For example, engaging with service providers to ensure that they understand what information and assurance is required, seeking alternative service providers etc.
Guiding Principles & Staffing assessment in place	Inclusion of the Guiding Principles and confirmation of appropriate staffing in place needs to be built in to future commissioning processes	Work with the Director of Finance and other Procurement Colleagues to finalise wording to be included in all relevant future contracts that requires the provider of all commissioned services to confirm their compliance with the Act as part of the commissioning process with no contracts awarded to companies/services who do not state their compliance with the requirements of the Act
		Work with the Service Manager Primary Care to aim to have the requirement to evidence this built into the service contract with the only Independent Provider GP practice

Practitioner / Independent Contractor Services	Lack of statutory authority to require staffing information from independent contractors, particularly in dental and general practice services.	Continued collaboration and updated national guidance from Scottish Government required to strengthen compliance and ensure equitable service provision across Scotland

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