Appendix 2 **HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – NHS Golden Jubilee ANNUAL REPORT 2025 (Q4/Q1/Q2/Q3)**

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:	*NHS Golden Jubilee*
Report authorised by:	*AnneMarie Cavanagh*
	Executive Nurse Director
	January 2026
Location where report is published:	*[hyperlink]*

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.
Summary on how the information within this report has/or will inform future workforce plans/planning. Examples include - but not limited to: • Impacts and outcomes of real -time staffing assessment on workforce/workload planning • How the outputs of the Staffing Level Tools and the application of the CSM have informed you workforce planning activity. • Impact of the Health and Care Staffing Act has led to safe and efficient staffing.
Please provide information on how your compliance to the Health and Care Staffing Act has led to improved outcomes for service users and workforce
As set out in the legislation, compliance with the Act should support the outcomes from the Health and Care Standards. Therefore, you should demonstrate/consider how implementation of the Act contributes to achieving these Standards This should include - but not be limited to - information in relation to patient safety and quality of care measures and outcomes, patient feedback, staff wellbeing measures, and adverse event reporting; what this information has shown and any trends; and any actions taken as a result.

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	Substantial Assurance
Duty 12IC: Duty To Have Real-Time Staffing Assessment In Place.	Substantial Assurance
Duty 12ID: Duty To Have Risk Escalation Process In Place.	Substantial Assurance
Duty 12IE: Duty To Have Arrangements To Address Severe And Recurrent Risks.	Substantial Assurance
Duty 12IF: Duty To Seek Clinical Advice On Staffing.	Reasonable Assurance
Duty 12II: Duty To Ensure Appropriate Staffing: Training Of Staff	Reasonable 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	Substantial 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.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

2 Guiding principles etc. in health care staffing and planning

The Board maintains a Recruitment and Retention Strategy- this is overseen by the People and Culture work stream, supporting a large range of initiatives to recruit new talent to our Board. Examples of initiatives include streamlined recruitment processes to ensure rigor for agreeing new posts with timelines to progress through advert and appointment. There are some difficult to appoint to specialist roles and clinical leads work closely with Human Resources Recruitment team and in some cases with the Communications team to achieve appointments and retention of new staff. Turnover rates are closely monitored and reported. Leavers are offered an Exit Interview for valuable information on their experience in post. The Board continue to support Retire and Return and this is reviewed in a role-by-role situation to ensure appropriate and right for the member of staff and the Board going forward.

Work to review supplementary staffing continues and close monitoring of use of Agency Staff and Bank Staff- we will continue to review Staff Bank opportunities at NHS Golden Jubilee over 2026 and scope for growing our own Staff Bank for clinical professions.
We work closely with the local Higher Education Institutions (HEIs) and Further Education (FE) Colleges to offer clinical placements for students, and this supports our opportunities to attract new talent to work at NHSGJ. Work is ongoing to build on the existing Modern Apprentice opportunities at GJ and to continue to provide a structured career pathway for Health Care Support Workers. We continue to work with the Armed Forces Talent Program, a local Developing the Young Workforce Board and NHS Scotland Academy.

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,
There are processes in place and established SOPs in all areas to ensure there is ability to assess staffing requirements in real time, escalation and seek support from leaders and managers.

(b) the provision of safe and high-quality health care,
There is clear monitoring of quality of care provided. There are established clinical governance structures in place to review patient care quality and patient safety information, patient outcomes, feedback and patient experience data. Triangulation with outputs from staffing level tool runs are within the Common Staffing Method information gathering. Analysis of this is proving useful. We continue to scope the opportunities to share quality metrics data that is collected and ensure that this is mapped to patient experience and patient outcomes. Within nursing dept there is the Care Assurance Information Resource (CAIR) dashboard in place, and we are planning to test other electronic platforms to display our data. This will be a priority into 2026. There are other processes for monitoring quality and safety in place: Viewpoint/ Care Opinion, Datix reviews, Local and significant adverse event reviews. We continue to monitor adverse events that have staffing noted as a contributing factor.

(c) in so far as it affects either of those matters, the wellbeing of staff.
The Staff Wellbeing Service continues to offer support to staff at their time of need and this is embedded within the Board. This is well promoted within the Board. Occupational Health team are increasingly proactive in supporting staff wellbeing at work through various initiatives. There is a planned series of Spiritual Care drop-in sessions for all staff to participate in.

(**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,
Systems are in place that require Board leaders, managers and decision makers to have regard for the healthcare being provided and the knowledge, skills and experience required to deliver the care required. The Nursing profession run the Staffing Level Tools (SLT) twice per year and detailed analysis is enabling decision making by key leaders to ensure that there are the correct numbers of staff available for

patient care. The Common Staffing Method (CSM) is applied and reported in nursing. Clinical leads continue to use their professional judgement on staffing levels and skill mix. Any operational challenges are shared at the twice daily Hospital wide Huddle for raising should there be gaps and mitigations in place. CSM is not in use in other clinical professions at GJ however there is workforce planning in place reviewing anticipated clinical activity, demand, capacity and quality that considers the kind of healthcare provision and on an ongoing basis the professional lead, clinical teams and managers will review and adjust staffing levels or skill mix according to need.

(b) the local context in which it is being provided,
Service planning is the responsibility of local managers who alongside clinical and operational teams acknowledge the context and consider this when reviewing staffing requirements. In areas using CSM this is integral to the process, and the structured approach and methodology is recommended for other services to support service planning that is inclusive of a broad range of considerations. This supports wider workforce planning approaches, ensuring that local context will be considered in staffing establishments and models.

(c) the number of patients being provided,
Workforce requirements reflect the activity or number of patients being cared for, or a service. These are considered in real time as part of a real time assessment to reflect the variation in demand and activity, to ensure that staffing meets any change in patient activity, demand and acuity.

(d) the needs of patients being provided for,
Service and workforce planning processes consider speciality specific information reflecting the person-centred needs of patients within individual services. On a day-to-day basis, real time staffing assessment is embedded in practice, ensuring that any changes to patient needs can be captured and any risk to providing appropriate staff to meet the needs of the real time demands can be identified, mitigated or escalated.

(e) appropriate clinical advice.
Clinical advice continues to be available within all areas. There are out of hours arrangements in place to ensure clinical advice 24/7.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.
Compliance is monitored through reporting to the Confirm and Challenge divisional meetings, Staff Governance Group, Clinical Governance and Risk Management Committee, Staff Governance Committee (non-executive director chair) and Clinical Governance Committee (non-executive director chair) and this ultimately reported to the Board via these governance routes. These groups meet quarterly and the internal HCSA reports are tabled at these meetings.

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. Implementation of erostering	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. There is a planned roll out of erostering and this includes implementation of Safe Care over 2026. So far this is being well received by clinical teams. roll out was delayed with the first reduced working week coming into force	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. Ongoing roll out of erostering over 2026. Timetable reviewed to fit with Reduced Working Week from April 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. Impact of Reduced Working Week (RWW).	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. Ongoing planning for the impact of RWW with clinical teams and mitigations for this/ changes to shifts. This has caused delays with the roll out of eroster and Safe Care but is timetabled for this year.	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. Significant preparation work in place to mitigate RWW including opportunities for additional clinical roles where clinical care may be impacted by RWW. This includes both service delivery and role reviews.

COMPLIANCE ASSURANCE LEVEL
Substantial 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.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.
All clinical professions have agreed processes in place to enable real time staffing assessments to identify risk to patient safety, quality and outcomes. We are rolling out eroster and Safe Care in 2026/27 however many areas already have this in place and embedded. This system

will be our digital approach to documenting real time staffing assessments, risk logs and mitigations. All staff are able to identify a risk caused by staffing levels, the process for escalation varies per clinical speciality until we have full implementation of Safe Care. The red flags system within Safe Care will enable escalation by any member of clinical staff for review, mitigation or escalation of risks identified at Hospital Huddles.

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,
Systems and processes vary across services and in general manual reporting into team safety huddles or hospital wide huddles. There is a Board wide SOP on risk escalation, with clear lines of reporting per profession. This is in place until all professions are using Safe Care. Datix system provides the first level of escalation to the lead with professional responsibility, and the first opportunity to mitigate the risk and provide clinical input. Severe risks may be escalated directly to executive directors. All staff have access to Datix and can raise a risk by this means, they are able to provide details of the exact risk or concern as it relates to staffing.

(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,
Self-assessment returns from operational reporting lines have provided assurance that appropriate clinical advice is sought. In the SOP on risk and risk escalation, local processes and charts are in place setting out who to seek appropriate clinical advice from each service. We are meeting this duty however there may be some gaps in recording of escalations until Safe Care is embedded.

(d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c),
Line managers are familiar with the escalation routes available to them.

(e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b),
All new staff to the organisation are made aware of the structures and processes in place to identify, communicate and report any risks with staffing- this is within local induction procedures. Staff have regular communication with line managers and opportunities to escalate real time staffing concerns.

(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.

There continues to be a profile of this: access to information on the Act within the hospital web pages. Line managers have access to the Healthcare Staffing Lead Nurse and Associate Nurse Director (corporate)for ongoing support, and training packages for staff when required. Staff are encouraged to complete the TURAS training resources available. Self-assessment surveys allow us to monitor whether individuals with lead professional responsibility have adequate time and resources planned within their job plans/ job roles to comply with this duty.
Please provide Information on your methods of monitoring compliance with Duty 12IC
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance. All reporting is via the self-assessment templates in use, and these are returned quarterly to the Healthcare Staffing Lead and Associate Nurse Director (Corporate). Internal quarterly reports are collated and tabled at Clinical Governance and Staff governance groups. Executive leadership have oversight of the areas of compliance and noncompliance through the quarterly reports. As the use of Safe Care expands, the reports available from this system will be used for governance reporting.

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.
Safe Care roll out and monitoring	There is a timetable in place for full roll out of Safe Care and this will digitalise and standardise the reporting of real time staffing, the escalation documentation and mitigations.	Ongoing implementation of eroster and Safe Care.

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. Reliance on Safe Care roll out and timeline to spring 2027.	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. No teams have access to Safe Care yet however this will be available from April 2026 for further roll out.	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.? Planning for transfer of hospital huddles to Safe Care format as soon as possible with support of operational managers.

COMPLIANCE ASSURANCE LEVEL
Substantial 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.	
Please provide information to demonstrate compliance. Information submitted here should outline how systems & processes take account **<u>of all of the points</u>** detailed in the duty description above by providing detail for each consideration. **(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.** (b) 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**.**	

All professions have a risk escalation process in place through established operational structures, following agreed SOPs. This is supported by TURAS RTSR where these are in place and available as part of this process. However, for staff that do not have a digital system to record these activities, these are captured through huddle communications or email documentation. Safe Care will be implemented in 2026.

In addition to safety huddles, staff and managers can raise a concern regarding appropriate staffing in real time directly to their line manager. This provides dynamic risk assessment by the manager regarding the staffing provision 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 risks related to staffing.

These systems function 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 require SafeCare being fully rolled out in 2026.

(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,

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 this may be reported on DATIX as appropriate. Where a level of high risk is recorded this can be escalated directly to the Executive team by line managers.

The risk escalation SOP clearly sets out the process that needs to be followed and individuals with lead professional responsibility are trained in their responsibilities under the Act.

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,

Escalation of a risk is through operational lines of management or professional lines, depending on the service structure. Where it is not the case that escalation follows a 'professional' line of seniority, services have in place governance processes whereby a risk is reviewed by an appropriate professional clinician to ensure clinical advice is provided.

The risk escalation SOP details the need to seek appropriate clinical advice and provides details of whom to seek this advice from. The SOP is kept as a live document to keep it accurate and up to date. Staff have been supported with training in the duties of the Act, and the requirement to seek, and have regard to appropriate clinical advice is part of the training. Where risk or an adverse event has been captured within DATIX, recorded. There is the ability to report and / or record where this has not occurred, and if there is concern about whether appropriate clinical advice has been sought with decision making through operational and professional structures and subsequent reviews of Datix reports.

b) 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,

There are clear structures for onward escalation 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. These systems and processes are in place, however there is less formal recording of these. The Board has confidence in the risk escalation SOP, which sets out the requirement to escalate and seek clinical advice through professional lines, and this is monitored through Datix/ self-assessment returns. Safety huddles, and clear communication lines evidenced by self-assessment returns. There are existing mechanisms in place to allow rapid escalation through the relevant professional and managerial routes, with appropriate clinical advice, to respond to any urgent concerns.

c) 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.

There are clear structures for onward escalation 24/7 until this reaches a Board level executive, if required. The reporting of workforce risk in Datix has the capacity for onward escalation up to executive level if required to achieve mitigation or elimination of the risk. The levels of escalation are dependent on level of risk identified. Severe (service critical) 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 members of the relevant organisation. 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.

d) 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,

As above, whilst there is a level of confidence about 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 the feedback has been provided in all cases. This is a challenge without the use of digital systems and technology to support these communications, especially if decision making and feedback span across different shift patterns. When SafeCare is in place,

staff will have access to feedback within the system, and similarly DATIX has this inbuilt function, however for all other staff or communications, at present this is reliant of informal verbal feedback which cannot be evidenced robustly at this time.

e) A procedure for those individuals to record any disagreement with any decision made following the initial report.

When services are on board with SafeCare, this will be using the red fleg functionality however as Safecare is not available yet, staff follow the operational structures in place as detailed within the relevant SOPs.
Audit of compliance will be via SafeCare once this is available, self-assessment feedback, or by exception reporting by staff where this has not been achieved. 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 recorded. The roll out of SafeCare and the upgrade to include identification, mitigation and escalation of risk will support the identification of severe and recurring risks together with trend analysis information. There will be a report generating function for review at the appropriate risk management fora.

f) All staff have the ability to escalate concerns with a staffing decision following the processes outlined in 12ID(1).
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,

As above, all staff can escalate concerns with a staffing decision following the processes outlined in 12ID(1). When services are onboarded to SafeCare this will be using the red fleg functionality however other staff will be following the operational structures in place as detailed within the relevant SOPs. Audit of compliance will be via SafeCare where available, self-assessment feedback, or by exception reporting by staff where this has not been achieved.
Disagreement or reviews can be included in the DATIX system or the interim internal Escalation Document. While these systems and processes are in place within operational lines and professions; current returns do not effectively facilitate being able to demonstrate substantial compliance and assurance as not all are documented processes or recorded. The roll out of SafeCare and the upgrade to include identification, mitigation and escalation of risk will support the identification of severe and recurring risks and the trend analysis, as these will be report generating functions for review at the appropriate risk management forums.

g) Raising awareness among staff about the procedures described in paragraphs (a) to (f),
As above, all staff have the ability to escalate concerns with a staffing decision following the processes outlined in 12ID(1).

h) 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),

ERostering and SafeCare training is delivered as and when services are onboarded, H&S learning modules on risk assessment are available, Datix modules and H&S modules for managers and supervisors are currently in place. The HCSA implementation team

previously delivered internal engagement sessions with accountable managers and professional leads, and the Lead Nurse for Safe Staffing and Associate Nurse Director are available for support and advice. Training and awareness session requirements will be reviewed on completion of any future updates to risk management processes and risk management systems and rolled out as appropriate for compliance with the duty.

i) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

This duty is linked to the work associated with Duty 12IH Clinical Leadership time. Current provision to ensure adequate time is established through staff PDPs, Appraisal Reviews, Job Planning, and time built into Job Descriptions. Risk management and risk escalation is a well embedded process within the Board both using Safety Huddles and dynamic real time staffing assessment.
The activity of lead professionals and senior decision makers related to management of risk escalation, and management of risk is routinely incorporated into daily work activities. Please see Duty 12IH.
Self-Assessment returns from operational clinical leads have provided the necessary assurance of the application of this duty regarding providing adequate time to implement the duty.

Please provide Information on your methods of monitoring compliance with Duty 12ID
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance. Self-Assessment returns from all service leads for all professions and functions which are submitted to the HCSA lead to demonstrate either compliance with the duty or any gaps which need addressed. Decision support documents for RTS concerns are real time however where used, they are reviewed on a weekly basis and a non-requirement to escalate is noted where 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?	This should describe how the success, achievement or learning could be used in the future.

Robust Risk Assessment processes	Risk Assessment is already well embedded within the Board. Good engagement from governance colleagues to support use of Datix.	Continued availability of training opportunities around risk assessment/mitigation/escalation using DATIX risk management system to support specific HCSA requirements
Pathway to green agreed	Confidence that risk assessment and escalation is embedded across all systems in use, all functions and services including the communication with all staff, which is planned. The alignment of risk escalation structures and digital reporting systems will be required to fully comply, and evidence compliance with the Act.	Actions as listed above 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 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 resources, provide training and support practice, as new learning emerges, increased activity with compliance monitoring and reporting.	Continue to monitor, flex, and highlight any risks with reduced resources.
Lack of standardised approach	Whilst services can provide assurance through variable processes a single process is required to facilitate monitoring and reporting, and this will	Ongoing support for eRostering implementation to enable access to a single system, to deliver a consistent approach to monitoring and reporting.

	become available with the continued implementation of ersoster and Safecare.	
Interdependency with digital systems	Roll out of e Roster and SafeCare is timetabled. It is impacted by the requirement of the eRostering Team to implement the associated changes to meet the AfC reduction in the working week for all staff members and rosters. SafeCare implementation planned for following the final reduction in working hours.	Continue to re-evaluate impact once roll out and implementation of the eRoster and SafeCare are complete.

COMPLIANCE ASSURANCE LEVEL
Substantial 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.	

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

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),

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. These Datix reviews are a subject matter for operational Health and Safety groups and Clinical Governance groups. Actions are decided at this level on mitigation requirements to prevent reoccurrence, including escalation if appropriate.

Functional groups report all risks into the Health and Safety committee and/or the clinical governance committee when appropriate. Also, each service area can pull risks specific to their area to provide localised and operational pictures of risk.

SafeCare has the function to raise an alert where there is a risk to staffing. This will be used to report risks that occur frequently but did not require escalation into Datix, when it is rolled out. Together these systems will provide robust data on severe and recurrent risks.

Until SafeCare is implemented there remains variation in processes.

(b) identify and address those risks which are considered to be either or both—

(i) severe,

(ii) liable to materialise frequently.

All identified severe and recurring risks are reported through the above noted lines of governance. Thematic reports are available from Datix.

It is for each area to assess severity and/ or recurring risk within their local context, using the national guidance and frameworks that exist. Each professional group/ service will determine what constitutes a severe risk to their safe service delivery within these frameworks. This has been clearly identified for all areas, as part of the development of the risk escalation SOP.

All severe risks are recorded within the Datix system as high level risks. H&S groups review all Datix submissions for trends. There will be trend analysis available through wider use of SafeCare planned in 2026. This will provide more reliable information to support the identification of recurrent risk within the system.

(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),

Thematic reports are available from Datix and risk specific dashboards are available. Each service area can pull risks specific to their area to provide 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 are currently unable to capture the spectrum of mitigated risks that occur frequently, however implementation of SafeCare will enable this which will strengthen the Board's awareness and response to recurrent risk.

(c) 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),
The Datix system allows for application of mitigating actions to be applied with involvement of clinical advisors being recorded through inclusion of the clinical advisor (when the risk is not being mitigated by a clinical professional) in the Datix communication channels. This requirement has been included in the escalation risk management SOP and the Datix system for all professional lines and functions through the work of the Clinical Governance and Risk Management Steering Group. SafeCare will be used to record and report on mitigations in place for risks, along with assurance that clinical advice has been sought. It will strengthen the current process described above. Services are not currently using SafeCare and therefore seek clinical advice and record this locally, and this is audited through the self-assessment returns that are returned quarterly.

(d) 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,
The Datix system allows for application of mitigating actions to be applied with involvement of clinical advisors being recorded through inclusion of the clinical advisor (when the risk is not being mitigated by a clinical professional) in the Datix communication channels. This requirement has been included in the escalation risk management SOP and the Datix system for all professional lines.

(e) the identification of actions to prevent the future materialisation of the risk, so far as possible.
Our governance processes include robust Adverse Event Reviews relevant to the reported severity, including significant adverse event reviews (SAER) for specific severe events to mitigate the risk of reoccurrences. These processes are well embedded in the Risk Management Strategy Framework, which lays out the process management of risk from service level to Board strategic level risks. 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

All reporting lines use the self-assessment returns to report to the Staff Governance Group and Clinical Governance and Risk Management Groups, and onto the Staff Governance Committee and Clinical Governance Committee. This is 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. This is separate to the escalation of risk up to the Board 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.
Risk dashboard	Dashboard of staffing related risks has been created and is updated monthly. This enables senior leaders to be confident and assured that risks are recorded, and plans are in place to mitigate and reduce the risks.	Continue to promote the use of the dashboard
Risk oversight group	Risks discussed regularly within Directorates and also at-risk oversight/risk exec group. Risk manager supports managers to ensure risks are managed and reviewed appropriately and within timescale. Risks also a standing agenda item on Directorate clinical governance groups. Risks also highlighted at daily site huddle and escalated using existing frameworks.	Maintain the focus on discussing risks at the groups listed.
Path to green	Severe and recurrent risk definitions have been established along professional lines and included in the risk escalation SOP. To have full assurance for this duty, we require SafeCare to be rolled out to all services and professions and this will enable the scrutiny and up to date information required to be confident in the functioning of the system. In the interim, self-assessment reports are used for assurance quarterly and this system is functioning well.	Roll out of Safe care in 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. Lack of standardised approach Ability to record and report on all activity	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. While the variation in approach to RTS and recording risk has been agreed within the Board, it creates extra work and complexity to have different services using different methods. Services provide assurance through internal reporting / self-assessment feedback to CCGRMG, however the variable processes present a risk to robust and reliable reporting and data capture to ensure all risks are identified and addressed appropriately. There are robust structures, processes and SOPs in place to support this duty, however there is no consistent method for recording and reporting on this in the absence of SafeCare (linked to above).	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. Continue development of Datix system to provide reporting, escalation and monitoring of staffing risks until implementation of *SafeCare.*

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.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

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.

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. This is clearly embedded within the relevant Standard Operating Procedures (SOPs) in place and supported through ways of working and role modelling in the organisation.

Professional leads are in place for all services to support or provide professional advice with real-time staffing decisions and address any risk escalation and oversee workforce monitoring and planning at operational level and corporate level within their areas of responsibility.

The organisation operates a model of Triumvirate service management: this consists of Nursing Lead, Service/Operations Lead (inclusive of all professions and functions within the services) and Medical Lead to ensure all service decisions are jointly discussed and agreed - the triumvirate structure provides professional oversight of all professions in scope, with the exception of professions which are managed through those professional structures.

A designated professional lead for Out of Hours is in place; however, all managers are aware of the need to seek appropriate clinical advice from the most relevant professional staff available. The professional lead is available to support these conversations and decision making, if it is not within their own scope of practice. Currently there is a lack of consistency about if, and how, this is recorded for assurance purposes. The ongoing implementation of eRostering and SafeCare will improve the ability to record the advice sought, and provide a consistent approach across the organisation, which will be more reliable and auditable.

The Risk Management Policy includes the importance of recording when clinical advice has been sought. Decisions which conflict with that advice are recorded and explained, however this may be within huddle notes, e mails, or other local system in place, in addition to verbal feedback and communications. Review of this policy is due in 2026 and as part of this review this duty will be made more explicit and reference to the legislation.

(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,

The SOPs in place include an assessment of risk in the event of a decision about staffing conflicts with the clinical advice sought and include steps that should be followed to record any conflict with clinical advice given.

We would expect there to be dialogue and discussion between the decision maker and individual providing clinical advice to inform and support the decision making, including 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.

Whilst the organisation has confidence that this practice is followed, supported by the Risk Management Policy in place and awareness / training of decision makers, there is no single mechanism or process of evidencing this practice at present. Once SafeCare is in place this will capture any conflict with clinical advice and any ensuing risks and mitigation because of this. The DATIX system is also available to report and record any resulting adverse event (near miss and actual harm) if considered necessary. The internal clinical decision support tool for RTS also has the facility to record clinical advice and any conflict of opinion.

(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,

The SOP in place requires that in the event a decision maker makes a decision that conflicts with clinical advice given that the person providing that clinical advice will be notified of this, and the reasons for this. In practice, these conversations are usually undertaken as part of the decision-making process, however there is a process for feedback if not a conversation. The person providing clinical advice 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 or DATIX, by e mail communication or other local processes including the clinical decision support tool.

There is variation across the organisation about how and where this is recorded which makes audit and assurance of compliance difficult to evidence, however there will be functionality within SafeCare to support this in duie course for all services. Disagreements or concerns would be recorded within these processes to ensure this is auditable and any actions, feedback or further risk assessment can be captured.

(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,

Within the organisation the individuals with lead clinical professional responsibility are the executive medical and nurse directors.

The Clinical Governance and Risk Management Group and Staff Governance Group monitor compliance through quarterly reports of the combined self-assessment returns that are received from the relevant leaders/ managers.

A report is prepared on behalf of the Executive Medical and Nurse Directors outlining the extent to which the organisations is complying with the duties, and this is reported through the CGRMG, SGG and associated Committees and onto the Board as required by the Act This occurs on a quarterly basis as routine.

(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),
The systems and processes developed by the organisation include mechanisms for individuals with lead clinical professional responsibility, to enable and encourage staff to give views on the operation of seeking clinical advice on staffing. Staff are encouraged to share and document these views to allow these to be considered in the quarterly reports to the Board, and to record those views in the reports to the members of the board of the relevant organisation.

There are a range of ways that this feedback is collected from staff, and in many cases, this will be reflected in compliance monitoring of the different duties in a report, for example, as detailed in 12IC, 12IH, 12IJ, 12IL. Other feedback includes via direct communication, communication / self-assessment returns / feedback from operational services , iMatter feedback or direct engagement sessions with professional leads.

(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

The organisation has robust systems and processes in place to raise awareness among individuals with lead clinical professional responsibility for a particular type of health care in how to implement the arrangements in this duty. Clear communication lines already exist and to raise awareness and currently access to the Lead Nurse for Safe Staffing is open for all professional leads and their Teams.
Information sessions and training for individuals with lead clinical professional responsibility are currently provided as required and access/completion of the Turas modules is highlighted and encouraged.
During training and information sessions the requirements and processes of this duty have been highlighted to comply with this duty.
Engagement sessions with accountable managers and professional leads have taken place and access to the Lead Nurse for Safe Staffing is open.

(e) ensuring that such individuals receive adequate time and resources to implement those arrangements.

The organisation has robust systems and processes to ensure that individuals with lead clinical professional responsibility for a particular type of health care receive adequate time and resources to implement the arrangements.

This duty is linked to implementation of Duty 12IH. Eroster and RTSRs include information on clinical leaders working clinically. Most relevant profession have allocated time for clinical leadership e.g. senior charge nurse and medics via job planning however formal discussions are encouraged during annual reviews and PDPs.

These systems are monitored through operational processes to identify any reduced provision of supervision time. This will be improved by the wider roll out of eRostering. In addition, and in tandem with Duty 12IC and 12ID, reviews should identify risks through risk management systems and processes and review the impact on patient outcomes where a risk is identified.

(2) **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).**
The organisation's systems and processes include means for the organisation to have regard to the reports received, with reporting via a standing committee of the Board. The governance structure of the organisation ensures that the organisation has regard to reports created e.g. clinical governance, staff governance and risk.

Please provide Information on your methods of monitoring compliance with Duty 12IF
The organisation has clearly defined mechanisms for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met). Self-Assessment returns from all service leads for all professions and functions are submitted to inform the internal quarterly reports with an assessment of compliance via highlighting gaps, and any action required / in place to address areas of non-compliance or where processes required to be strengthened/improved. The feedback from the operational delivery leads is then incorporated into the internal quarterly report to the organisation. Clinical Governance Committee has oversight of areas of compliance and non-compliance, highlighted through the quarterly reports and any required escalation to the Board occurs through this route. This is separate to the escalation of risk to the Board 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, the views of employees included in the reports prepared by individuals with lead clinical	This should describe how the success, achievement or learning could be used in the future.

Current culture, strengthened by a new Board Strategy	professional responsibility for a particular type of healthcare identified a potential improvement in working practices in one area. The organisation has a culture of supporting staff to seek clinical advice. This has been strengthened through the webpage, local education and open access to the Lead Nurse for Safe Staffing, to make it clear to staff where to seek appropriate clinical advice.	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. Further embed this through the communication plan and the Board's strategic direction.
Path to green	All services will require 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.	Monitoring through the self-assessment returns presents an effective way of seeking assurance from the system. The systems and processes in place will become more streamlined once SafeCare has been implemented in all services. The governance processes, reporting and committees also provides an effective means of monitoring progress and compliance.

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 their views, but the mechanisms for seeking the views of other professional groups for which they	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.

	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 onboarding to SafeCare	The challenge of not having all services and professions using the same systems is creating variability. The timeline for go live of Safecare across all clinical areas necessitates the continuation of interim processes which mean assurance and reporting is inconsistent and not as transparent or reliable as the organisation would like.	Continue to support and promote eRostering implementation and articulate the interdependency between the Act and eRoster. Mitigation of risk is via good governance and engagement with all services through self-assessment returns, which are in use quarterly. Staff can continue to access the operational and professional structures in place to support practice. Datix is available to all staff to record any associated adverse events.
Ability to record and report on all activity	There are robust structures, processes and SOPs in place to support this duty, however there is no consistent method for recording and reporting on this in the absence of SafeCare (linked to above).	As above

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.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

(a) to supervise the meeting of the clinical needs of the patients in their care,

The organisation has robust systems and processes which include time and resources for individuals to supervise/coach the meeting of the clinical needs of patients , to manage, and support the development of the staff for whom they are responsible, and to lead the delivery of safe, high-quality and person-centred health care.

Through the measures outlined above, as well as line management and professional leadership support at all levels, all clinical leaders are supported to have the time and resources to undertake these roles or seek support and highlight risks where this is not sufficient. Clinical leaders working clinically to mitigate risk can be monitored through eroster,and RTSRs and can identify reduced provision of supervision time. This will be improved by the further roll out of eRostering and SafeCare. In addition to this and in tandem with Duty 12IC and 12ID, the impact on patient outcomes is routinely reviewed where a risk is identified.

(b) to manage, and support the development of, the staff for whom they are responsible,

There are clearly defined systems and processes in place to ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties. however, opportunities to develop/update audit and compliance framework are continuously reviewed. Where appropriate Job Descriptions are inclusive of leadership role. Eroster and RTSRs highlights clinical leaders working clinically to mitigate risk. Generic MDT professional judgment and RTSRs will further support implementation and monitoring.

(c) to lead the delivery of safe, high-quality, and person-centred health care.
Job Planning is in place in some professions to support this. Assurance through eroster for monitoring of non-patient facing activities in professions such as AHP, HCS etc is being captured as part of the roll out. Where monitoring of professions is mainly via one-to-one meetings, PDPs and annual appraisal, the conversation and agreement is recorded.
SCN are identified as non-case holding as much as possible during staffing level tool runs to provide accurate information of direct patient facing care demand and quality assurance of the data entry.

Please provide Information on your methods of monitoring compliance with Duty 12IH
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance. Self-Assessment returns from all service leads for all professions and functions are submitted to inform the internal quarterly reports with an assessment of compliance via highlighting gaps, and any action required / in place to address areas of non-compliance or where processes required to be strengthened/improved. The feedback from the operational delivery leads is then incorporated into the internal quarterly report to the organisation. Clinical Governance Committee and Staff Governance Committee have oversight of areas of compliance and non-compliance, highlighted through the quarterly reports and any required escalation to the Board occurs through this route.

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.
Workforce planning groups aware of this duty and requirements of the Act	Divisional Groups are aware of the requirements from this duty across services, inclusive of the requirement of adequate time for clinical leaders e.g. the Nursing Workforce and Governance group reviews all staffing level tool run outputs and facilitates discussion around all leadership roles, activities and time availability.	Continue to monitor progress and support all professions with awareness raising and discussion to ensure there is good knowledge and confidence regarding this duty.
Policies, systems and processes in place Path to green	Robust Organisational policies, systems and processes are in place for facilitating and monitoring of Clinical leaders' time and this is kept under continuous review.	Continue to develop audit and compliance framework

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	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

Path to green	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. 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.	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. Monitoring through the self-assessment returns presents an effective way of seeking assurance from the clinical leads. The systems and processes in place will become more streamlined once SafeCare has been rolled out to all services.

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.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

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.

Training on legislation delivered at each tool implementation – leads, seniors and clinical staff with responsibility to implement are invited to attend a rolling programme on the run up to Staffing Level tool runs.
The TURAS resources are available to all staff involved in Staffing Level tool runs and completion is strongly encouraged. There has been consideration of making these modules mandatory at the appropriate level however this this has been stepped back due to NHS Scotland wide additional Statutory Mandatory training due to start in April and Reduced Working Week coming in April also.
Annual appraisal on TURAS monitored for completion of PDPs.
Robust system in place to monitor compliance with mandatory and essential training for all NHS functions and professional groups through TURAS and this is reported by Human Resources dept to wider hospital line managers and directors.

In house education teams for professions monitor and provide extensive educational support through Clinical Education department and identified development, learning facilitators in clinical professions to deliver outcomes of Training Needs Assessments, development plans and meet identified new knowledge and skills requirements. All employees undergo induction and orientation. Currently there is open access to the Safe Staffing Lead Nurse for all professions.

Training within the organisation is clearly determined along the lines of Mandatory, Essential and Development requirements for each profession and role. All training is supported with protected time to complete, and all training requirements, resources and protected time is agreed within PDPs. Different professions have different set national training curriculums. These are supported through professional lines and training needs analysis, funding and expert support e.g. clinical educators and medical supervisors, mentors.

Please provide Information on your methods of monitoring compliance with Duty 12II
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance. Assurance of compliance with this duty is monitored through: PDP, for compliance levels with mandatory and induction training for all staff within scope. Essential training is monitored through PDPs and self-assessment returns. This is reported through Staff Governance Committee on a regular basis.

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.
Induction training of medical locums	To ensure locums, both internal and external, are appropriately trained, experienced, up to date and familiar with the Health Board's systems and processes. Specific induction material has been developed, and a checklist is now available to ensure a conversation on experience and training levels takes place.	Ongoing monitoring of utilisation.
Path to green	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 through self-assessment returns.

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 process in place, there is further work 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, and identify any gaps or challenges, and include any additional evidence to support compliance with this duty. There will be improved reporting on training and education time with roll out of eRoster.

COMPLIANCE ASSURANCE LEVEL
Reasonable 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.	

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

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,

SLTs are run twice per year at NHSGJ as a minimum. There is clarity on the clinical areas running only the Professional Judgement tool or a combination of this alongside clinical profession tool. We extended Professional Judgement Tool run to wider clinical areas in most recent tool run and this provided valuable information.

(f) 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),

A CSM template document is used on completion of SLTs. This was transferred to an electronic format however reverted to paper document meantime. There were meetings with SCNs and CNs for preparation for the tool run. There were meetings with the CNMs on completion of the last run of the tools to review CSM.

A range of quality measures (ie CAIR and SPSP data) is used alongside SLT outputs to complete the triangulation within CSM and input to workforce plans.

(c) takes into account—

(i) its current staffing levels and any vacancies,

This is included in the CSM reporting template- this includes funded establishment, actual establishment, vacancies, PAA and actual absence.

(ii) the different skills and levels of experience of its employees,

This is included in the CSM reporting template section 4: local context consider skill mix, experience of employees and age profile of employees.

(iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care,

Pre tool run prep sessions are timetabled ahead of the planned run. All training is recorded locally to provide assurance for this duty.

(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,

All reports are submitted to Nursing Workforce Assurance Group- CSM only applies to Nursing profession at GJ. This group will review and scrutinise outputs of the CSM reports.

(v) the local context in which it provides health care,
This is included in standardised reporting template, and local training.

(vi) patient needs,
This is included in the CSM reporting template- this includes review of complaints, feedback forms, changing acuity levels and demand levels. Patient need is considered for both current and unmet need.

(vii) appropriate clinical advice,
This is included in the CSM reporting template- section 6 Risk assessment and prioritisation, section 7- decision making. All accountable managers are asked to provide assurance by responding to the prompts provided.

(viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides,
Included in standardised reporting template and included in local training. Recent inspections by HIS are included for review within the CSM process. This duty is cross covered within quality measures and context elements of triangulation.

(ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE,
Included in standardised reporting template and included in local training. Section 6 risk assessment and prioritisation, includes the need to report on real-time staffing risks, mitigations, escalation of risk and guidance sought regarding risk. Includes data on severe and recurring risks from Datix submissions.

(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,
Included in standardised reporting template and included in local training. Section 3 Quality Measures- patient complaints and comments. Includes reports from Viewpoint, Care Opinion and social media.

(xi) comments by its employees which relate to the duty imposed by section 12IA,
Included in standardised reporting template and included in local training.

(d) identifies and takes all reasonable steps to mitigate any risks,

Included in standardised reporting template and included in local training. (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. Included in standardised reporting template and included in local training Section 7- staff are supported to make their recommendations and next steps considering the factors listed and any others which may be relevant. CSM documents are reviewed alongside additional workforce information available on vacancies/ skill mix/ occupancy/ quality metrics and turnover rates.
Please provide Information on your methods of monitoring compliance with Duty 12IJ
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance. Use of self-assessment returns are reported at Nursing workforce Governance Group meeting- this is chaired by Associate Nurse Directors.

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.

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.

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.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

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,

Staff involvement is encouraged and evidenced via the standardised CSM reporting template and there are opportunities to lead on the staffing level tool run data collection, quality control and reporting.
The CSM documentation prompts senior charge nurses and clinical nurse managers to seek feedback from staff on results obtained. There are planned SLT runs however CNMs are encouraged that these can be run at additional periods if required by them and their teams.

(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,

Staff involvement is encouraged and evidenced via the standardised reporting template. Section 7: decision making, recommendations and next steps identifies and records how information will be reported on and shared amongst staff. Included in standardised reporting template and included in local training - Sections 3 "comments by staff, Section 4 "iMatter, employee experience", Section 5 "staff engagement and feedback, Section 7 asks for information on "how are staff consulted during this process & how are staff informed during this process".

Consultation also takes place through face-to-face team meetings and their outcomes and /or general annual staff survey results, and real time feedback during tool runs. All outcomes feed into workforce plans and local management meetings.

(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
Local face to face or teams training sessions are delivered as part of the preparation for any tool run and relevant staff are required to attend these sessions. Staff are encouraged to complete TURAS learning resources. Bespoke sessions can currently be arranged for clinical areas as requested.

(d) ensure that those employees receive adequate time to use the common staffing method,
This will be assessed using the same methods as set out in 12IH - through using Optima Health Roster and SafeCare, and informal methods until SafeCare is rolled out to all services.

(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.
The completion of the standardised reporting template follows each tool run incorporating the CSM. The services are expected to share the report with all staff following completion to allow for transparency and staff to be made aware of outcomes. This is a specific step within the preparation and education elements of the staffing Level Tool run process. Clinical Nurse Managers with responsibility for the completion of the CSM are expected to hold face to face feedback sessions/alternative in keeping with line management role and responsibilities. Section 5 of reporting template: describe how results will be cascaded to all staff within a ward/team.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.
CSM outputs are tabled at the Nursing Workforce Assurance Group. Completion of tool runs is incorporated into the internal quarterly report that goes to the 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. Path to green	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. Achieved	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. Embedding processes and timetable for SLT runs within the Board and timetabled pre SLT training sessions to support staff for accuracy of data collection and collation of CSM documentation.

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. No specific challenges	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.

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.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

(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.

The guiding principles and appropriate staffing arrangements are considered when planning and delivering services. Processes are well established in NHSGJ regarding service level agreements with health boards, associated reporting and monthly review. In addition, the

requirements of the Act, delivery and/or procurement of health care services from another board considers costs and specific clauses, scope of service, data protection, compliance with legal obligations etc whenever an SLA or other agreements are signed. NHSGJ provides services for patients from across Scotland which includes supporting boards by delivering some national services and planned procedures in relation to reducing elective waiting times.
Please provide Information on your methods of monitoring compliance when planning and securing services
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance. This is monitored and reported as per business as usual as part of the overall board governance.

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. *The introduction of a Supplementary Staffing Register has enabled us to support staff work more flexibly. The register is made up of retire and return members of staff at Band 3 and Band 5 grade who are fully aware of their roles and responsibilities. We have also opened up this register to year 3 student nurses who are on placement with the option of remaining on the register after their placement ends. This was an additional support of filling shifts when we were unable to have a 'Bank' facility like other health boards.*	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. *To continue to develop the SSR and to have conversations to widen the membership*

Awareness of this requirement within the Act	As part of general awareness raising, communication and training to support implementation of the Act, we are ensuring staff are aware of this duty, and how it applies to all contracts, agreements and arrangements. Meeting held by Workforce Lead with Head of Planning & Performance/Commissioning Team.	To work with colleagues from the Commissioning Team to identify any potential future contracts, agreements or arrangements within their service, and how they will consider the guiding principles and appropriate staffing when planning and securing services from 3rd party providers.
Procurement engagement	Procurement colleagues engaged in the implementation of HCSA.	Continue to develop and monitor

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. All clinical professions	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. The need for formalised processes to demonstrate full compliance with this duty is acknowledged however all SLA services are delivered under the board governance arrangements including meeting the duties of the ACT	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. The actions falling out of this work continue to become business as usual processes.

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance