

NHS Orkney
Health and Care (Staffing) (Scotland) Act 2019
Annual Report 2025/26

Submitted and approved by Orkney NHS Board 30 April 2026



HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 - NHSO ORKNEY ANNUAL REPORT YEAR 2¹ 2025/26

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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 Orkney
Report authorised by:	Dave Harris
	Director of People and Culture
	1 April 2026
Location where report is published:	<i>[hyperlink]</i>

¹ 1 April 2025 to 31 March 2026

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.

1. The Act covers **808 employed staff** (389.14 WTE), an increase of 10 (7.89 WTE) from Y2 Q2, accounting for **70.6%** of the total workforce, including personnel within the Integrated Joint Board where NHS Orkney remains the employer.
2. Workforce planning is a capacity issue due to vacancy and financial pressures across the organisation, including the freezing of some vacancies.
3. The Common Staffing Method (CSM) was followed at the required frequency by 17.39% of the six types of health care listed in duty 12IK applicable to NHS Orkney. This was for several reasons, including leadership capacity and incomplete structures.

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

1. Integrating patient quality and safety data with staffing information is still under development. Clinical governance reviews patient outcomes, feedback, experience, and safety data, but combining this with workforce insights is not fully implemented at local levels. At Board level, integration occurs through clinical governance representation in the Operational People Group and professional lead roles. For nursing and midwifery, this process is supported by the Excellence in Care (EiC) programme and CAIR Dashboard, which combine national care measures with workforce data at service/ward level.
2. Quality and safety are also examined via systems like Care Opinion and incident reviews, including those identifying staffing as a factor; however, limited data is available for trend analysis. No moderate or severe harm linked to staffing has been reported in adverse event data. Improving understanding of the clinical benefits and patient outcomes associated with staffing and digital support systems will be a key focus next year, as data collection and analysis frameworks are further developed.
3. The Excellence in Care (EiC) submission rate has increased from 35% in Q1 to 55% in Q3. However, until the inclusion of overtime, excess coverage, and support from bank and agency staff data, it is unlikely that this percentage will improve.

4. Anxiety, stress, depression, or other psychiatric illness were the main causes of staff sickness in Q3, making up 27.39% of lost hours; roles covered by the Act saw a comparable figure at 28.41%.
5. In Y2 Quarters 1–3, NHS Scotland Once for Scotland investigations found no cases related to staffing capability or capacity, and complaints rarely referenced staffing, with one complaint in Q2 referenced perceived staffing pressures, which was not substantiated upon review. Significant Adverse Events (SAER) did not highlight staffing or training issues, except for one Q1 recommendation on training. Incident reports varied by quarter (seven in Q1, three in Q2, four in Q3 and 10 in Q4) but consistently included a small number of cases related to staff shortages, skill mix, and training qualifications. These incidents spanned various service, such as outpatient clinics, ophthalmology, administrative support, radiography, and inpatient care, and resulted in operational challenges like delayed appointments, reduced service capacity, increased workload, and, on occasion, heightened patient safety risks. Notably, several incidents recorded each quarter did not fall under the Health and Care Staffing Act's remit. No whistleblowing concerns tied to staffing or training were reported at any point during the year. The anonymous reporting form launched during the previous year received minimal submissions, none of which pertained to staffing or training matters. Overall, while staffing and skill mix issues were documented throughout the reporting periods, there was limited evidence to suggest these directly contributed to adverse outcomes or significant events within the organisation.

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	Limited Assurance
Duty 12IC: Duty To Have Real-Time Staffing Assessment In Place.	Reasonable Assurance
Duty 12ID: Duty To Have Risk Escalation Process In Place.	Reasonable Assurance
Duty 12IE: Duty To Have Arrangements To Address Severe And Recurrent Risks.	Limited 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)	Limited Assurance
Duty 12IL: Training And Consultation Of Staff	Limited Assurance
Planning And Securing Services	Reasonable Assurance
PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE	
Reasonable Assurance	

Duty 12IA: Duty to ensure appropriate staffing

Duty Description	<p>2 Guiding principles etc. in health care staffing and planning</p> <p>(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.</p> <p>Duty 12IA: Duty to ensure appropriate staffing.</p> <p>(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—</p> <ul style="list-style-type: none">(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. <p>(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—</p> <ul style="list-style-type: none">(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.
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Please provide information on the steps taken to comply with Duty 12IA.

1. Annual Report to Scottish Ministers, NHS Orkney Board and published on the board website. Board Level Clinician(s) Quarterly Internal Compliance report to Staff Governance Committee and Area Partnership forum.
2. Internal governance committee(s) report template impact assessment includes assessment of impact of the Act under corporate strategy objective people > workforce.
3. Reduced Working Week
NHS Orkney is progressing the implementation of the national Reduction in the Working Week (RWW), which will reduce Agenda for Change (AfC) full-time hours to 36 by 1 April 2026. Work to implement the change is ongoing in line with national policy requirements, with

services developing and submitting plans that outline how they will accommodate the reduction. These plans were approved by the Executive Directors, enabling departments to move forward with local arrangements. Engagement has been continuous with partnership colleagues to discuss departmental plans. In some areas departments are retaining the part time hours, some are recruiting additional colleagues and in other areas they are adjusting how they deliver their service. Overall, services across NHS Orkney have plans in place and are taking agreed actions to support delivery of care while implementing the reduced working week.

4. Recruitment

- a. Attraction: *Where Compassion Meets Adventure* is NHS Orkney's campaign highlighting professional fulfilment, community engagement, and island lifestyle. Launched during the International Island Games, it promotes Orkney as an excellent place to live and work, with an inclusive community, stunning nature, and diverse career options.
- b. International Recruited Staff: 32 individuals recruited (Q4 100% retention rate)

5. Clinical Services Review: Following receipt of the final Clinical Services Review report, several pressing workforce challenges have been identified that require strategic attention:

- a. *Workforce fragility and shortages in critical areas such as Nursing and Midwifery, driven by a limited pool of trained professionals. Persistent gaps in the locum medical workforce, where substantive recruitment has proven difficult, highlight the need for innovative, collaborative solutions across health systems.*
- b. *Leadership instability at the tier below the Executive Team, which undermines continuity, strategic delivery, and operational resilience.*
- c. *Housing constraints, particularly in remote areas, continue to adversely affect recruitment and retention efforts, limiting the ability to attract and retain skilled professionals.*

6. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting.

7. For quarter 3, anxiety, stress, depression, or other psychiatric illness were the main causes of staff sickness, making up 27.39% of lost hours; roles covered by the Act saw a comparable figure at 28.41%.

8. Pharmacy Services conducted an in-year review of skill mix, management and leadership structures and workforce analysis, a bench marking exercise with other island, remote and rural boards, and utilisation of national professional frameworks for staff development and training.

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

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.
2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72% compliance).
3. Statutory and Mandatory training and Appraisal completion has continued to improve during the year, in all key areas reflecting the significant efforts made by teams across NHS Orkney and increased Senior Leadership oversight. As of 31 March 2026:
 - a. eLearning compliance has risen from 78.24% in April to 83.47%
 - b. Resuscitation training (now tracked with new metrics) stands at 51.73%.
 - c. Manual Handling training improved from 54.7% to 71.64%.
 - d. Safety Intervention training increased from 66.07% to 75.36%.
 - e. Appraisal completion has increased from 39.86% to 45.60%.
4. eLearning (Core Statutory and Mandatory Modules only): Compliance remains above 80% with trend holding consistently strong with only minimal variation from the previous quarter.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Optima Health Care roll out	1. NHS Orkney is transitioning to Optima Health Care, including phase implementation of SafeCare for all roles in scope of the legislation.	1. Learning from the roll out and implementation is being used to inform the roll out to other professional groups / services, with feedback to the national team. An implementation plan for eRostering in 2026/27 with a view to implementing across all services and professions by 31 March 2027.

<p>2. Review of skill mix completed to help meet service demands. Training frameworks ongoing and completed for Pharmacy support workers, Pharmacy Technicians and Pharmacists.</p>	<p>2. Pharmacist professional frameworks supporting staff development across the four pillars of pharmacy practice. Pharmacy Support workers undertaking Scottish Vocational Qualification (SVQ) and in-house training to develop specialist roles for Pharmacists and Pharmacy Technicians to meet clinical demand, improve patient care and safety.</p>	<p>2. Upskilling of team members to meet service need and clinical demand. Continued work to complete training which is ongoing Continued re-evaluation of skill mix and service development.</p>
<p>3. Community nursing: skill mix and service review</p>	<p>3. A change in skill-mix and a move to better integrate the mainland teams improving recruitment and retention reducing the vacancy rate from 46% to 23% improving patient care, safety and staff wellbeing.</p>	<p>3. Share the learning across the organisation, specifically with other under-pressure services.</p>
<p>4. Consultant medical staff recruitment</p>	<p>4. A detailed analysis on medical staffing spend was shared with the executive in February, with a programme for improvement leading on from that with a specific action to define the safe staffing establishment for senior medical roles.</p>	<p>4. A consultant recruitment workshop took place in February, resulting in the successful appointment of a fixed-term consultant surgeon, with further and consultant advertisements underway to decrease the reliance on locum staff.</p>

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
<p>1. NHS Scotland: support and intervention framework - NHS Orkney escalated to Level 3</p> <p>2. Roles in Scope of the legislation</p> <p>3. Incomplete clinical leadership structure</p>	<p>1. NHS Orkney is currently at Level 3 escalation under the NHS Scotland Support and Intervention Framework and aims to achieve financial balance over the medium term. Our modelling indicates that reaching a financial balance will require a comprehensive transformation of both clinical and non-clinical services across the system.</p> <p>2. Recruiting across all professional groups to an island Board continues to pose a challenge. Attracting individuals with the depth of experience and breath of skills required for small rural clinical teams is increasingly difficult, plus maintenance of those skills, and the lack of affordable housing only adds to the issue.</p> <p>HR, SAER, incidents, complaints and whistleblowing review recommendation(s) and subsequent action plan(s), are not being triangulated to identify themes nor are the identified areas for learning / improvement, which relate to workforce, being tracked until all actions are completed.</p> <p>3. Capacity is an issue due to leadership instability at the tier below the Executive Team.</p>	<p>1. NHS Scotland Action Plan in place.</p> <p>2. Recruitment campaign: <i>Where Compassion Meets Adventure</i>.</p> <p>HR, SAER, incidents, complaints & whistleblowing review(s) - Triangulation of themes and tracking of learning recommendations and action plans until all actions are completed, a final report written, and recommendation outcomes presented to NHSO equivalent of a Care Governance committee being implemented.</p> <p>3. Clinical Services Review work stream</p>

<p>4. Impact of reduced working week (RWW)</p>	<p>4. The impact of the RWW has been significant in terms of reviewing rosters and working patterns, but additionally the impact on updating rosters has affected the roll out of eRostering and SafeCare as key enablers to the Act and Act compliance. Further changes to the rosters will further impact implementation and roll out of these systems to support the board demonstrate and monitor compliance, as well as have more qualitative data to consider impact and patient outcomes.</p>	<p>4. Monitor success of recruitment across services and teams to the RWW hours shortfall, impact on staff wellbeing and patient outcomes.</p>
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<p>COMPLIANCE ASSURANCE LEVEL</p>
<p>Limited Assurance</p>

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

Duty Summary	<p>(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.</p> <p>(2) The arrangements under subsection (1) must, in particular, include—</p> <ul style="list-style-type: none">(a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to—<ul style="list-style-type: none">(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.	
<ol style="list-style-type: none">1. The aggregated quarterly self-assessment responses (72%) reveal that while most teams (75%) have established processes for documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary significantly. Smaller or specialist teams often struggle with formalising supervision and documentation due to limited staffing and high clinical demands. Common challenges include protecting time for clinical leaders, maintaining thorough documentation, and managing the impact of absences. However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management and team cohesion where these processes are well embedded.2. Standard Operating Procedure (SOP) Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3.3. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting.	

4. Clinical Services Review: Following receipt of the final Clinical Services Review report, several pressing workforce challenges have been identified that require strategic attention, including workforce fragility and shortages in critical areas such as Nursing and Midwifery, driven by a limited pool of trained professionals. Persistent gaps in the locum medical workforce, where substantive recruitment has proven difficult, highlight the need for innovative, collaborative solutions across health systems.

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

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.
2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
<ol style="list-style-type: none"> 1. Path to green 2. SafeCare roll out and monitoring 3. Pharmacy Services - Morning huddles / team discussions now routine; Escalation process defined, SOP in place 	<ol style="list-style-type: none"> 1. All services with roles in scope of the legislation have access to SafeCare and will need to be completing and utilising the data on a consistent basis before NHS Orkney is able to progress to, as a minimum, reasonable assurance on this duty. 2. SafeCare implementation initially saw positive engagement from many teams / services 3. Acute Pharmacists, Primary Care Pharmacy, Pharmacy Technicians discuss staffing and prioritise workload according to clinical / service need and demand; issues or assurance passed to service 	<ol style="list-style-type: none"> 1. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare. 2. Currently within Optima, time to lead is set up differently depending on the unit. A uniform approach across all units to standardise reporting is required. 3. Further improve addition of professional Judgement following roll-out out of SOP.

	lead; SafeCare utilised regularly to inform and add professional judgement.	
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Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Path to green 2. Double-keying 3. Incomplete clinical leadership structure 4. Current SafeCare configuration does not support all elements of duty	1. Clinical leaders need to be encouraged to utilise SafeCare system to capture challenges with staffing in real-time. 2. Double-keying (SSTS, eRostering) continues to cause a significant burden on the Board, requiring dedicated administrative time, or clinical time, to ensure information is correct and up to date. 3. Capacity is an issue due to leadership instability at the tier below the Executive Team. 4. Engage with SafeCare national configuration work and engage with relevant working group(s).	1. Continue to work with clinical leaders to utilise SafeCare. 2. This risk is being managed by the local eRostering programme Board, with escalation to agree governance routes. 3. Clinical Services Review work stream. 4. Engage with relevant working group(s).

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

Duty Summary	<p>(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.</p> <ul style="list-style-type: none">(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. <p>(2) The arrangements under subsection (1) of this duty must include:</p> <ul style="list-style-type: none">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:<ul style="list-style-type: none">(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), andj) Ensuring that such individuals receive adequate time and resources to implement those arrangements.
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Please provide information on the steps taken to comply with Duty 12ID.

1. 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 should have in place governance processes whereby a risk is reviewed by an appropriate professional clinician to ensure clinical advice is provided.
2. Escalation, decisions made and by whom are not consistently being recorded by all roles in scope across the organisation. Analysis of severe and recurrent risk is therefore difficult due to a lack of auditable data overtime to support identification of themes and trends. In addition, the Daily Pressures report, SafeCare, safety huddle(s) and 4pm handover capacity and capability information are not aligned, e.g., number of open beds v surge capacity. Use of SafeCare as single source of organisational capability and capacity, issue escalation, mitigation and management of severe and recurrent risk. Currently multiple documents / reports detailing inconsistent information, for some but not all roles in scope, are in use.

Being able to evidence awareness and compliance with this overarching duty, including feedback to those involved in identifying, reporting or mitigating the risk, feedback has been provided in all cases is impossible without the use of digital systems and technology to support these communications, especially if decision making and feedback span across different shift patterns. Staff should have access to feedback within SafeCare (provided it has been completed), similarly the Integrated Incident and Risk Management Reporting System has this inbuilt function (which is currently not enabled), however for all other staff or communications, this is reliant of informal verbal feedback which cannot be evidenced robustly at this time.

The aggregated quarterly self-assessment responses (72% return) reveal that while most teams (75%) have established processes for documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary. Common challenges include protecting time for clinical leaders, maintaining thorough documentation, and managing the impact of absences. However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management and team cohesion where these processes are well embedded.

3. SOP Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3.
4. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting.

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

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.

2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
<p>1. SafeCare roll out and monitoring</p> <p>2. Path to green</p> <p>3. Pharmacy Services – Formalisation of processes</p>	<p>1. Safe Care implementation initially saw positive engagement from many teams / services.</p> <p>2. All services with roles in scope of the legislation have access to SafeCare and will require to demonstrate effective risk escalation as set out in the legislation before NHS Orkney is able to progress to, as a minimum, reasonable assurance on this duty.</p> <p>3. SOP including escalation to professional lead process in place Team leads have direct access to escalate to professional lead Challenges raised, where necessary, as part of Organisational RAG meeting</p>	<p>1. Currently within Optima, time to lead is set up differently depending on the unit. A uniform approach across all units to standardise reporting is required.</p> <p>2. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare, specifically risk escalation.</p> <p>3. Critical escalation outside of the service, except for the morning RAG meeting, would be to escalate via professional lead to responsible executive director. This process needs to be documented.</p>

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
<p>1. Resource pressures</p> <p>2. Lack of standardised approach</p> <p>3. Pharmacy Services - As a small team often responding to undefined clinical demand / activity within other service areas it can be challenging to assess real time demand.</p>	<p>1. Time and resources to continue to embed these resources and support practice, as new learning emerges, increased activity with compliance monitoring and reporting.</p> <p>2. Variable processes. A clearer process is required to facilitate monitoring and reporting.</p> <p>3. Activity and service demand will be dependent on: Emergency department patient numbers, numbers of admissions and discharges, patient acuity, procurement challenges and number of medicines shortages, activity levels within GP practices, challenges within Community Pharmacies etc.</p>	<p>1. Continue monitoring, adapting, and highlighting risks due to reduced resources now that Scottish Government (SG) funding is no longer available.</p> <p>2. Explore development of Integrated Incident and Risk Management Reporting System and SafeCare to provide reporting, escalation and monitoring of staffing risks.</p> <p>3. Challenges are discussed and managed within teams and escalated throughout the day and in real time. Open door policy for team leads and professional lead facilitates this.</p>

COMPLIANCE ASSURANCE LEVEL

Reasonable Assurance

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

Duty Summary	<p>Duty to have arrangements to address severe and recurrent risks.</p> <p>(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements to—</p> <ul style="list-style-type: none">(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—<ul style="list-style-type: none">(i) severe,(ii) liable to materialise frequently. <p>(2) The arrangements under subsection (1) must, in particular, include a procedure for—</p> <ul style="list-style-type: none">(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.
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Please provide information on the steps taken to comply with Duty 12IE.

1. NHS Orkney continues to further strengthen our approach to risk management, governance, and clinical engagement. Risk jotters have been introduced and made changes to the layout of our Corporate Risk Register to simplify the process.

Escalation, decisions made and by whom are not consistently being recorded by all roles in scope across the organisation. Analysis of severe and recurrent risk is therefore difficult due to a lack of auditable data overtime to support identification of themes and trends. In addition, the Daily Pressures report, SafeCare, safety huddle(s) and 4pm handover capacity and capability information are not aligned, e.g., number of open beds v surge capacity.

All risks raised on the Integrated Incident and Risk Management Reporting System are allocated a rating for impact (severity) and likelihood (anticipated likelihood of reoccurrence) which can be reviewed across functional groups for trends and occurrences (currently unable to confirm this occurs). Risks recorded in the Integrated Incident and Risk Management Reporting System should be a subject matter for Operational Groups, e.g., Clinical Governance, Workforce and Risk Management. Actions should be decided at this level on mitigation requirements to prevent reoccurrence, including escalation if appropriate. Functional groups report all risks into the Risk

Management Group, Operational People Group 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 is used to report risks that occur frequently but did not require escalation into Integrated Incident and Risk Management Reporting System. Together these systems will provide robust data on severe and recurrent risks when properly embedded within the organisation.

The aggregated responses (72%) reveal that 62.5% of respondents have established processes for staff training, documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary significantly. However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management, training compliance, and team cohesion where these processes are well embedded.

2. There is one current risk directly linked to the legislation on the corporate risk register, plus a further nine that are associated with workforce, five of which relate directly to the staffing concerns and the ability to undertake expected duties or training due to these staffing issues.
3. SOP Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3.

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

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.
2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).
3. Corporate risks are reviewed by the Risk Management Group.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Pharmacy Services: Risks recorded daily via SafeCare and Daily RAG; risks proactively managed as part of decision making and prioritisation during morning meetings and throughout the day	1. For example: Challenges with discharge planning and short notice to facilitate an urgent discharge require flexibility within the team and real time workload prioritisation; recurrent risks highlighted during RAG and clinical governance meetings.	1. Improvement in discharge planning processes

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
<p>1. Risk dashboard</p> <p>2. Risk oversight / Management</p> <p>3. Pharmacy Services - Island, Remote and rural location and small team numbers mean there is no pool of staff to call on (agency and</p>	<p>1. Creation of a staffing related risks dashboard, updated monthly prior to the Operational People Group to be considered. This enables senior leaders to be confident and assured that risks are recorded, and plans are in place to mitigate and reduce the risks.</p> <p>2. Risks to be discussed regularly by the Executive Management Team, and Senior Leadership Team and also at the Risk Management Group. Risks to be discussed at service governance meetings, and safety huddle(s).</p> <p>3. When team members are ill during periods of planned annual leave; can leave teams with very low staff numbers. Real time and dynamic risk assessments undertaken. Service demand</p>	<p>1. Operational People Group to consider implementation / the use of a staffing related risk dashboard</p> <p>2. Embed discussing risks at the groups listed.</p> <p>3. Risk is included in risk register. Consideration to use of agency staff where absence is likely to be long term.</p>

<p>substantive team members) when unplanned staff shortages occur.</p> <p>4. Path to green</p>	<p>prioritised and information disseminated to service users as key stakeholders.</p> <p>4. Severe and recurrent risk definitions have been included in the draft risk escalation SOP. To have improved assurance for this duty, SafeCare utilisation, and data analysis is required by all services and professions. This will enable the scrutiny and up to date information required to be confident in the functioning of the system.</p>	<p>4. The Operational People Group to review yellow grading and implement an action plan to transition from yellow > green.</p>
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<p>COMPLIANCE ASSURANCE LEVEL</p>
<p>Limited Assurance</p>

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

<p>Duty Summary</p>	<p>Duty to Seek Clinical Advice on Staffing.</p> <p>(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for—</p> <ul style="list-style-type: none">(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. <p>(2) The arrangements under subsection (1) must, in particular, include—</p> <ul style="list-style-type: none">(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—<ul style="list-style-type: none">(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—<ul style="list-style-type: none">(i) this section, and(ii) sections 12IA to 12IE and 12IH to 12IL,(c) a procedure for such individuals to—<ul style="list-style-type: none">(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. <p>(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).</p>
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Please provide information on the steps taken to comply with Duty 12IF.

1. The aggregated quarterly self-assessment responses (72% return) reveal that while most teams have established processes for documentation of staffing decisions, and real-time risk escalation, the consistency and depth of implementation vary significantly. Smaller or specialist teams often struggle with formalising supervision and documentation due to limited staffing and high clinical demands. Common challenges include protecting time for clinical leaders, maintaining thorough documentation, and managing the impact of absences. However, many teams have adopted adaptive strategies such as using locum staff, shared calendars, and regular safety huddles, which have led to improved risk management and team cohesion where these processes are well embedded.
2. Vacancy Panel (VP) systems and processes, including the savings tracker, do not sufficiently capture data needed for the board to show legislative compliance. A VP Improvement Workshop has taken place, with several actions identified including alignment with the Health and Care (Staffing) (Scotland) Act 2019. Y2 Q1 - Q3
 - i. A total of 129 vacancies were reviewed, with 80 roles (62.01%) falling within the scope of the legislation. Three posts have been rejected, and one was halted mid-recruitment
 - ii. Eight posts have been deferred to seek additional information to ensure posts are fully reviewed
 - iii. Eight posts are currently withheld within the system with the aim of being actioned during January 2026
3. SOP Real Time Staffing and Risk Escalation for Clinical Leaders / Managers v1.3.
 2. The eRostering Officer post was vacant for the first 6-months of the reporting year impacting on NHS Orkney's ability to access and utilise the data held within the SafeCare system. These limitations have affected data extraction, analysis and reporting.
 3. Clinical Services Review: Following receipt of the final Clinical Services Review report, several pressing workforce challenges have been identified that require strategic attention, including workforce fragility and shortages in critical areas such as Nursing and Midwifery, driven by a limited pool of trained professionals. Persistent gaps in the locum medical workforce, where substantive recruitment has proven difficult, highlight the need for innovative, collaborative solutions across health systems.

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

1. NHS Orkney is currently unable to demonstrate the evidence required to confirm compliance with this duty. Essential processes and documentation that would typically underpin assurance, such as systems for identifying and managing clinical advice, recording decisions that diverge from such advice, and implementing appropriate risk mitigation measures, are not yet in place. Furthermore, there are no established procedures for notifying clinical staff when decisions conflict with their advice, nor mechanisms for managing differing clinical opinions.
2. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.

3. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Path to green	1. All services with roles in scope of the legislation will need to have access to SafeCare and completing and utilising the data on a consistent basis, before NHS Orkney is able to progress to, as a minimum, reasonable assurance on this duty.	1. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Engagement with SafeCare 2. Incomplete clinical leadership structure 3. Vacancy Control Panel	1. Challenges with services and professions to utilise SafeCare on a consistent basis, including recording of clinical advice given and by whom. 2. Capacity is an issue due to incomplete clinical leadership structure, specifically at senior operational level. 3. Vacancy panel systems and processes, including the savings tracker, do not sufficiently capture data needed for the board to demonstrate legislative compliance.	1. Operational People Group to secure commitment and support to enable clinical leaders to engage with SafeCare. 2. An up to date organisational and professional structures organogram publication date is to be confirmed. 3. Carry out the actions outlined during the Improvement Workshop, such as drafting a SOP and ensuring alignment with the Health and Care (Staffing) (Scotland) Act 2019.

COMPLIANCE ASSURANCE LEVEL

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

Duty Summary	<p>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—</p> <p>(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.</p>
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Please provide information on the steps taken to comply with Duty 12IH.

1. NHS Orkney is transitioning to Optima Health Roster and SafeCare, which will highlight when clinical leaders work clinically to mitigate staffing risk. Work is in progress to ensure consistency of data capture as currently there is inconsistency within and between services / professional groups, e.g., TL, SCN, SCM etc are not routinely included in clinical rota; being moved into clinical rota to mitigate / as per job description, e.g., 80% time to lead: 20% clinical, or 60% time to lead: 40% clinical etc. Multi-disciplinary (MD) professional judgment staffing level tool will further support implementation and monitoring. The eRostering Officer position remained vacant during the initial two quarters; after successful recruitment, a reset process is currently underway.
2. SOP Adequate Time given to Clinical Leaders (Time to Lead) v0.5.
3. Most of the quarterly aggregated self-assessment responses (72%) indicate clinical leaders have dedicated leadership time, though some lack enough resources. The SafeCare reset will review if their allotted time is sufficient.

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

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.
2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinician(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72%).

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Pharmacy Services: Team leads have in place scheduled team meetings; autonomy to arrange convenient times to undertake annual and interim reviews	1. Pharmacy Senior leadership team meet monthly to discuss service needs and improvements, staffing challenges and skill mix requirements; each member of senior leadership team (SLT) have their own team meetings to discuss and facilitate delivery of quality improvement work	1. Due to the variable nature of clinical service demand, it is challenging to ringfence time for leads to undertake this work. Time is taken when convenient at present.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
<p>1. Policies, systems and processes in place</p> <p>2. Path to green</p> <p>3. Small teams - during periods of absence, team leads are required to undertake clinical workload. This is included within roles and remits but may necessitate rescheduling of leadership duties.</p>	<p>1. Robust Organisational policies, systems and processes are required to be in place for facilitating and monitoring of Clinical leader's time, e.g. SOP and SafeCare.</p> <p>2. SafeCare is available across NHS Orkney. Clinical leaders need to be encouraged to utilise the system to capture challenges with adequate time to lead for clinical leaders.</p> <p>3. Real time and dynamic risk assessments undertaken. Service demand prioritised and information disseminated to service users as key stakeholders. Non-clinical workload re-prioritised.</p>	<p>1. Develop an audit and compliance framework</p> <p>2. Continue to work with clinical leaders to utilise SafeCare; develop and monitor systems and processes.</p> <p>3. Continual challenge within small remote and rural healthcare systems. Teams need to be flexible daily and throughout the day.</p>

COMPLIANCE ASSURANCE LEVEL

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

Duty Summary	<p>In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that its employees receive—</p> <p>(a) such training as it considers appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b), and</p> <p>(b) such time and resources as it considers adequate to undertake such training.</p>
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Please provide information on the steps taken to comply with Duty 12II.

1. Induction: Since the induction refresh in April 2023, NHS Orkney has seen a marked improvement in new starter experience. Earlier baseline data showed that 40% of staff did not feel comfortable or supported on their first day; this has now risen to 98% agreeing or strongly agreeing. Feedback consistently highlights a welcoming environment, clear communication, accessible and relevant training, strong line-manager support, and improved role clarity.

The induction survey, refreshed September 2025, continues to identify areas for further refinement, such as scheduling consistency, digital navigation, timely role-specific training, and clearer communication around session changes. Ongoing developments, including automatic induction booking and enhanced manager guidance on early setup tasks, demonstrate that the induction process is working well overall while still being actively reviewed and improved.

In addition, a separate Internationally Recruited Staff Survey was completed in September 2025 to review the induction, supernumerary support and training experience. 32 staff members who were recruited into direct clinical, indirect clinical or non-clinical support roles were invited to participate. The response rate was 50%; direct clinical care 87.5%, non-clinical support 12.5%, indirect clinical 0%.

2. Protected Learning Time Workstreams

- a. Workstream 1 - National Statutory and Mandatory Transition

The nine Core Statutory and Mandatory modules are scheduled to launch on 2 March 2026, replacing the current mix of local and national modules. NHS Orkney does not anticipate any reduction in overall compliance except as a new mandatory module, OfS Counter Fraud - will be introduced, which has a six-month grace period for completion.

- b. Workstream 2 – Profession and Role-Specific: Workstream 2 continues to make steady progress in establishing a clear NHS Orkney wide picture of Profession and Role-Specific learning requirements. Learning Aids are expected to be submitted by 26 February 2026,

enabling the transition into the next phase of engagement with Subject Matter Experts (SMEs). This structured approach ensures departments remain actively involved and that future training expectations are transparent and well-supported.

- (i) The first phase focuses on gathering departmental Learning Aids, which provide the foundation for a consistent and proportionate training framework.
- (ii) Once received, SMEs will review the content alongside departments to confirm accuracy, update outdated elements, and ensure alignment with national standards, professional guidelines and local operational needs in collaboration with the department manager.

This collaborative model supports relevance, avoids unnecessary training burden, and reflects real service requirements. In total, 155 departments and roles have been identified, with 51 completed to date (32.9%), demonstrating ongoing, measurable progress toward a comprehensive and sustainable training structure across NHS Orkney. It has been identified that the yearly budget allocation for Nursing, Midwifery and Allied Healthcare Professions training is insufficient to support the required essential role specific training. This funding shortfall presents a significant risk to workforce readiness, professional development, and the safe delivery of care, as staff may be unable to access the training necessary to meet clinical standards and statutory obligations. A risk jotter has been completed to formally document and escalate the concern.

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

1. Quarterly Board Level Clinician(s) Internal Compliance reporting to Staff Governance Committee and Area Partnership Forum.
2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 72% compliance).
3. Protected Learning Time Workstream: Approximately 155 departments and roles have been identified, with 51 completed to date (32.9%).
4. Statutory and mandatory training and appraisal are tracked with the People Summary Dashboard, which provides data for quarterly internal governance updates. Performance has improved throughout the year across all areas, due to efforts from NHS Orkney teams and greater Senior Leadership oversight. As of 31 March 2026:
 - a. eLearning compliance has risen from 78.24% to 83.47%
 - b. Resuscitation training (now tracked with new metrics) stands at 51.73%
 - c. Manual Handling training improved from 54.7% to 71.64%
 - d. Safety Intervention training increased from 66.07% to 75.36%

e. Appraisal completion has increased from 39.86% to 45.60%

5. eLearning (Core Statutory and Mandatory Modules only): Compliance remains above 80% (83.47%) with trend holding consistently strong with only minimal variation from the previous quarter.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
<p>1. Path to green</p> <p>2. AHPs - Historic Training Needs Analysis reviewed to identify priority training. Capacity to progress training requirements at the appropriate level within the organisation has been enabled by a Lead AHP (adult) being in post.</p> <p>3. Improved induction and training of medical locums</p>	<p>1. Education Strategy in development, plus review of statutory / mandatory, and essential training underway.</p> <p>2. Lead AHP will continue to liaise with AHP service leads around the professional training needs and any alterations to the Training Matrix.</p> <p>3. Ensure locums, both internal and external, are appropriately trained, experienced, up to date and familiar with NHS Orkney'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 is had.</p>	<p>1. Complete and publish Education Strategy, review of Statutory and Mandatory, and essential training. Monitor compliance via internal governance committees.</p> <p>2. Training Matrix development is ongoing.</p> <p>3. Ongoing monitoring of utilisation and feedback on opportunity for improvement.</p>

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
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<p>1. Path to green</p> <p>2. Process to booking agreed external courses time consuming and people are missing learning opportunities as a result.</p> <p>3. Embedding protected learning time</p>	<p>1. Processes and procedures are in places for some clinical groups of staff but it is unclear who is responsible and accountable for defining what is an essential training programme, assessing training needs and overseeing that the required training has been undertaken and where this is collated and monitored.</p> <p>2. For example, one £30 course took 7 hours to book.</p> <p>3. Work required to ensure staff received protected learning time to complete statutory / mandatory and role specific training / development.</p>	<p>1. Confirm the process and procedures to be completed, including time frame, e.g., annually or 2 yearly etc, and who responsible & accountable for completing underpinned by a policy / SOP.</p> <p>2. Clear streamline board process of identifying training funding.</p> <p>3. The Operational People Group to review yellow grading and implement an action plan to transition from yellow > green.</p>
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COMPLIANCE ASSURANCE LEVEL

Reasonable Assurance

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

Duty Summary	<p>(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).</p> <p>(2) The common staffing method means that a Health Board or the Agency (as the case may be)—</p> <ul style="list-style-type: none">(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—<ul style="list-style-type: none">(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.
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Please provide information on the steps taken to comply with Duty 12IJ.

1. During Year 2, the Common Staffing Method (CSM) was followed at the required frequency by 17.39% of the six types of health care listed in duty 12IK applicable to NHS Orkney. This was for several reasons, including leadership capacity and incomplete structures.
2. Staffing Level Tools – The Common Staffing Method v0.6 2 Feb 25 SOP.
3. Quarterly Common Staffing Method compliance updates to Executive Director of Nursing, Midwifery and Allied Health Professions / Chief Officer Acute Services, Interim Deputy Director of Nursing and Nursing and Midwifery Advisory Committee
4. Locally developed resources have been created to support teams, e.g. Common Staffing Method Report template and staffing level tools aide memoir(s), which include the requirement for staff consultation/engagement in local staffing level tool runs (before, during and after), and training utilising the Health Improvement Scotland (HIS) Healthcare Staffing Programme (HSP) learning resource(s).

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

1. Board Level Clinician(s) Quarterly report to Staff Governance Committee and Area Partnership Forum.
2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 62.5% compliance).
3. Quarterly Common Staffing Method compliance updates to Executive Director of Nursing, Midwifery and Allied Health Professions / Chief Officer Acute Services, Interim Deputy Director of Nursing and Nursing and Midwifery Advisory Committee.
4. Staffing Level Tools – The Common Staffing Method v0.6 2 Feb 25 SOP was circulated to relevant professional group for comment via internal governance groups and published.
5. Training on the CSM and staffing level tools, which incorporates preparatory education sessions, engagement with services and feedback sessions for all staff involved in the CSM including role specific delivery is available as group (face to face or via Teams) and 1:1 session(s). Uptake to date has been limited. All familiarisation sessions include training specific to the CSM. A log is kept of all staffing level tool familiarisation, staffing level tool run dates and reports received.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
<p>1. Local Common Staffing Method report template</p> <p>2. Staffing Level Tools – The Common Staffing Method v0.6 2 Feb 25 Standard Operating Procedure (SOP)</p>	<p>1. Section 5 of the locally produced CSM reporting template: Staff Engagement and Feedback - 'describe how results will be cascaded to all staff within your wards/teams.</p> <p>2. SOP has been published.</p>	<p>1. Review how staff engagement and feedback is being collated and informing workforce planning.</p> <p>2. Update SOP to include Staffing Level Tool run dates for 2026/27.</p>

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
<p>1. The Common Staffing Method (CSM) compliance</p>	<p>1. The CSM was followed at the required frequency by 17.39% of the six types of health care listed in duty 12IK applicable to NHS Orkney. This was for several reasons, including leadership capacity and incomplete structures.</p> <p>Certain staffing level tools fail to capture the complexities specific to remote, rural, and island boards, especially in wards where there are multiple specialties and staff roles. For example, categories like adult in-patient, maternity, and small wards overlook single-room layouts; additionally, the adult inpatient specialist staffing tool does not align its</p>	<p>1. Need to understand the barriers to staff engaging with the CSM and staffing level tool(s) run(s) to progress and embed into business as usual.</p> <p>Review local CSM report template prompts to capture limitations of specialist staffing level recommended whole time equivalent (rWTE), and where suitable, propose an extra multiplier for single room situations².</p>

² For example, Shelford Staffing Tool add 0.075 rWTE per room.

<p>2. Nursing and Midwifery Practice Education</p>	<p>sub-specialties with multi-speciality wards. This misalignment leads to data being entered repeatedly across various sub-specialties, such as medical and surgical.</p> <p>2. Nursing and midwifery education currently have no direct contribution to the delivery of training / education of the CSM or staffing level tools.</p>	<p>2. Discuss with nursing and midwifery practice education.</p>
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<p>COMPLIANCE ASSURANCE LEVEL</p>
<p>Limited Assurance</p>

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

1. The completion of the locally produced reporting template follows each tool run, incorporating the CSM. The teams / services are encouraged to share the report with all staff following completion to allow for transparency, and for 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. All clinical leaders with responsibility for the completion of the CSM are encouraged to hold face to face feedback sessions in keeping with line management role and responsibilities. Section 5 of the locally produced CSM reporting template: Staff Engagement and Feedback - 'describe how results will be cascaded to all staff within your wards/teams. This includes the Emergency Department staff running the Emergency Care Provision tool (nursing and medical staff). The HIS HSP quality assurance self-assessment template prompts team leaders/ managers to seek feedback from staff on the CSM and training. Staff involvement is also encouraged and evidenced via the locally produced CSM reporting template.
2. Although nursing and midwifery education currently have no direct face to face contribution to the delivery of training / education of the CSM or staffing level tools, appropriate levels have been identified on all training passports for all registered staff.

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

1. A quarterly update is provided to the Executive Director of Nursing, Midwifery and AHPs / Chief Officer Acute and the Interim Deputy Director of Nursing / Lead Midwife on a quarterly basis highlighting areas of good practice and concern. This is incorporated into the quarterly Board Level Clinician(s) Internal Compliance report that goes to Staff Governance Committee.

2. Operational clinical leaders / managers are required to complete a quarterly Act self-assessment. The responses underpin the quarterly Board Level Clinicians(s) Internal Compliance report to the Staff Governance Committee. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q3 62.5% compliance).
3. The Executive and Senior Leadership Team has oversight of areas of compliance and non-compliance, highlighted through the quarterly Board Level Clinician(s) Internal Compliance report reports and any required escalation to the Board can happen through this route.
4. Agenda item on the Nursing and Midwifery Advisory Committee and Area Partnership Forum.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
1. Path to compliance	1. Staff induction includes 'Introduction video: Knowledge and Skills Framework for Health and Care Staffing in Scotland'.	1. Embed informed, skilled, enhanced and expert level into role specific training.
2. Local Common Staffing Method report template	2. Section 5 of the locally produced CSM reporting template: Staff Engagement and Feedback - 'describe how results will be cascaded to all staff within your wards/teams.	2. Review how staff engagement and feedback is being collated and informing workforce planning.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
1. Engagement / ownership by clinical leaders	1. Issues with capacity were identified across all staff groups, plus lack of engagement by clinical leaders.	1. Understand the barriers preventing senior clinical leaders for taking responsibility for embedding duty 12IL into BAU.
2. Nursing and Midwifery Practice	2. Nursing and midwifery education currently have	

Education	no direct contribution to the delivery of training / education of the CSM or staffing level tools.	2. Discuss with nursing and midwifery practice education.
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COMPLIANCE ASSURANCE LEVEL

Limited Assurance

Duty Summary	<p>Guiding principles etc. in health care staffing and planning</p> <p>(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.</p> <p>(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—</p> <ul style="list-style-type: none"> (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.
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Please provide information on the steps taken to comply with section 2(2) of this Duty.

1. Commencing end of January 2025 a short life working group was set up to oversee the governance of service level agreement (SLA), contract and memorandum of understanding (MoU). This group undertook a review of our systems and processes to incorporate the duty and requirements of the Act.
2. Three yearly Combined Practice Inspections of local NHS contracted dental practices.

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

1. All agreements are currently managed by the Procurement function, which routinely reviews them as new agreements are established and existing agreements are updated or renewed, e.g. dermatology is in development; ophthalmology, ENT, rheumatology, and orthopaedics are under review. Baseline details are being established and as SLA documents are developed, refreshed and formalised, the Act regulations are being integrated to ensure compliance and consistency.
2. Independent Sector SLAs: Updated wording is being added as documents are refreshed this year to align with Act standards and regulations.
3. Combined Practice Inspections framework to review local NHS contracted dental practice(s).

Planning and Securing Services

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
<p>1. Procurement engagement. Procurement colleagues are now engaged in the implementation of the Act. Continue to develop and monitor Awareness of this requirement within the Act</p>	<p>1. All contracts, tenders, SLA and MoU where services are secured from 3rd party providers NHS Orkney considers the guiding principles of the Act. As a board we are currently setting up a new SLA which will ensure that the agreement reflects the Act and the duties placed.</p>	<p>1. Continue To work with colleagues from Finance and Procurement Team to update any other agreements as they are refreshed and transitioning to business as usual into planning groups.</p>

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
<p>1. Potential risk of Board being unable to secure a health care provider that meets the specification reflecting the requirements of the Act but can offer a minimum essential service.</p>	<p>1. Board will need to agree with the provider to deliver elements essential to maintain patient safety and service provision, noting that some aspects of the contract cannot reflect the original specification. The Board will need to be assured that the provider can provide appropriate staffing for the services within scope of the contract and make explicit any compromise to the original specification.</p>	<p>1. To monitor patient outcomes and impact of the gap between service specification and delivery. Continue to work with any provider in this situation to look at options to further strengthen the provision of healthcare through monitoring and due diligence processes. Continue to build on or amend current processes to ensure compliance with this Duty.</p>

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance