NHS Orkney
Health and Care (Staffing) (Scotland) Act 2019
Annual Report 2024/25

Submitted and approved by Orkney NHS Board 24 April 2025

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

Section 12IM of the National Health Service (Scotland) Act 1978 ("the 1978 Act") as inserted by section 4 of the Health and Care (Staffing) (Scotland) Act 2019 ("the 2019 Act") requires all Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), to publish, and submit to Scottish Ministers, an annual report setting out how they have carried out their duties under sections 12IA (including how the relevant organisation has had regard to the guiding principles in section 2 of the Act), 12IC, 12D, 12E, 12F, 12IH, 12II, 12IJ and 12IL of the 1978 Act (all inserted by section 4 of the 2019 Act).

Section 2(1) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when carrying out the section 12IA duty to ensure appropriate staffing, to have regard to the guiding principles for health and care staffing in section 1 of the Act. Section 2(3) of the 2019 Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this requirement. Section 2(4) of the 2019 Act requires this information to include how these steps have improved outcomes for service users.

Section 2(2) of the 2019 Act requires Health Boards, relevant Special Health Boards delivering direct patient care (i.e. NHS 24, the Scottish Ambulance Service Board, the State Hospitals Board for Scotland and the National Waiting Times Centre Board) and NHS National Services Scotland (referred to in the 2019 Act as the "Agency") (collectively referred to as "relevant organisations" in this template), when planning or securing the provision of health care from a third party under the 1978 Act to consider both the guiding principles for health and care staffing in section 1 of the Act and the need for the third party to have appropriate staffing arrangements in place. Section 2(3) of the Act requires relevant organisations to provide information to the Scottish Ministers on an annual basis on the steps they have taken to comply with this requirement. Section 2(4) of the 2019 Act requires this information to include how these steps have improved outcomes for service users.

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

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

Report approval

This tab should be completed by the person signing off the report. An electronic signature is acceptable. The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found.

Summary

This tab asks for an overall summary of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act (see https://www.gov.scot/publications/health-and-care-staffing-scotland-act-2019-overview/pages/roles-in-scope-of-the-act/ for more details of which staff groups are covered under the Act).

Following receipt of the reports from relevant organisations, the Scottish Ministers must collate these and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be considered in policies for staffing of the health service. To enable this process, the information provided by relevant organisations must be comprehensive and pertinent to the staffing of the health service. Please complete these questions in detail, setting out the key achievements, outcomes, learning and risks and how this information has been used to inform workforce planning at the local level.

The tab then asks for an overall level of assurance of the relevant organisation's compliance with the Act, using the assurance categories as detailed below.

Individual duties / requirements

The next tabs look at specific elements within each of the individual duties / requirements of the Act, asking relevant organisations to provide an assessment of compliance against each statement, using the RAG classification below. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act, with the exception of 12IJ and 12IL which only apply to certain types of health care, in certain locations using certain employees (more information is provided in these tabs). Next to the column for the RAG status is a column entitled 'Comment'. In this column, relevant organisations should provide detail to explain the RAG status, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus. For example, details of the organisational structures, systems and / or processes being used, such as SafeCare or SOPs in place. If the RAG status is not green then explanation should be provided advising of any gaps or areas of ongoing work, and of the NHS functions and / or professional groups that do not have systems and processes in place / are not using them.

Next, the relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future (for example, could learning in one area be applied to other areas). Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail.

The relevant organisation is then asked to provide details of any areas of risk where they have been unable to achieve or maintain compliance with the particular duty or requirement, or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this - to show the 'pathway to green'. Again, in order to provide meaningful information that can inform health care staffing policy, relevant organisations are asked to complete this in some detail.

Finally, relevant organisations are asked to provide a declaration of the level of assurance they have regarding compliance with the specific section of the 1978 / 2019 Act, using the classification as below. Two tabs, section 12IA and 'planning and securing services' ask additional questions to enable appropriate feedback to evidence compliance with these duties or requirements. Similar to above, these should be answered in sufficient detail and more guidance is given in these two tabs.

NHS Orkney additional information:

- A national reporting template was provided however for ease of reading and review it has been converted from excel into word and will subsequently be transcribed prior to submission.

- All boxes NHS Orkney requires to populate are bold outlined in red as demonstrated with this box

RAYG Status Definitions

When asked to provide a RAG status, please use this key.

Green		Systems and processes are in place for, and used by, all NHS functions and all professional groups
Yellow		Systems and processes are in place for, and used by, 50% or above of NHS functions and professional groups, but not all of them
Amber		Systems and processes are in place for, and used by, under 50% of all NHS functions and professional groups
Red		No systems are in place for any NHS functions or professional groups

Levels of Assurance Definitions

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

Level of Assurance		System Adequacy	Controls
Substantial assurance		A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable assurance		There is a generally sound system of governance, risk management and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.
Limited assurance		Significant gaps, weaknesses or non- compliance were identified. Improvement is required to the system of governance, risk management and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No assurance		Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

Name of organisation:	NHS Orkney
Report authorised by:	*Jay O'Brien* *Director of People and Culture* *Date: 11/04/2025*
Location where report is published:	https://www.ohb.scot.nhs.uk/

Summary Report

Please answer the questions below, to provide an overall assessment of how the organisation has carried out its duties under section 2 of the 2019 Act, and sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the 1978 Act (inserted by section 4 of the 2019 Act).

1. Please advise how the information provided in this report has been used or will be used to inform workforce plans.

Information within this report will inform local workforce plans by utilising the information and intelligence, as well as the structures in place to support the duties of the Act.

The local quarterly self-assessment and reports are available as part of internal operational and governance processes so there is a shared understanding of the information available, its purpose, and for all leaders to consider how this can effectively inform and influence workforce planning. The aggregated summary report is included and informs the quarterly local internal compliance report.

NHS Orkney aspires to undertake annual service reviews, which include budget setting (and agreement of budgeted establishments) using a process that consider demand, capacity, activity, and quality (DCAQ). The outputs from the different structures in place to support the Act provide important information and intelligence that is integral to this process. Capacity and engagement challenges has constrained our ability to generate and utilise the data in a meaningful way, e.g., daily real-time staffing assessment and completion of the Common Staffing Method.

To inform this process, individual services should consider the different elements of the Act and what that informs about healthcare staffing in that area, the impact it is having on quality safety and outcomes for patients, as well as the wellbeing of staff. An example of this would be the review of professional judgement in SafeCare as a metric to evidence real-time staffing assessment, and the review of any mitigated and unmitigated risks, to understand any themes, severe and recurrent risk, and to inform any action required through workforce planning to mitigate or remove these risks in the future. The Act doesn't sit in isolation and therefore it is important to consider the information related to the Act alongside other performance and governance measures and information.

Recognising this has been the first year working under the new legislation, there has been significant learning, as well as new and emerging questions and considerations about how NHS Orkney realise compliance in practice, and how the information and intelligence can be captured and used in a meaningful way. Whilst nursing and midwifery families should have had experience with running staffing level tools, the use of the Common Staffing method across all healthcare types in scope has been new this year, therefore considering how this information can best support workforce planning and align with the budget setting process has introduced new opportunities to be built on in the coming year. It is recognised that the afore mentioned capacity and engagement challenges has impacted on our ability to embed the Act into business as usual across all roles in scope of the legislation. This will be a priority area of focus for 2025-26.

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

Throughout 2024/25, in line with internal governance structures and to comply with duty 12IF, quarterly reports outlining current activities to support the implementation of the Act, and compliance with the Act have been submitted to the Staff Governance Committee as a standing committee of the NHS Orkney Board. This has provided a level of strategic oversight of the systems and processes required to be in place, any ongoing risks or challenges, and critical interdependencies.

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

Key learning: Adapting the Common Staffing Method principles for wider workforce establishment planning has been beneficial, particularly to services such as AHPs and wider nursing family.

Key learning: The ability to access and use a real-time staffing resource (SafeCare) across professional disciplines has provided services / teams a structure to help support workforce planning approaches and strengthen the professional voice. SafeCare allows a review of activity and staffing across the organisation in response to changing priorities and demands and capture the impact of these changes.

Key risk: 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.

Key risk: Clinical leadership capacity within the organisation remains a barrier to embedding the Act into business as usual and is a high risk on the corporate risk register. Significant work is required to ensure appropriate time and resource are made available to clinical leaders.

Key risk: There continues to be variation in engagement across professional disciplines, with a significant lack of participation in frontline services. This is in part due to incomplete leadership structures, and organisational construct in place requiring more bespoke consideration, but also the added benefit of introducing further process for limited benefit. This is especially true for medical staff who have clear escalation processes, however, cannot be audited through current processes, but introducing SafeCare will create additional work with limited perceived benefit. This staff group will be the last professional discipline to be onboarded to eRoster to allow these concerns to be worked through and to agree the right approach to ensure compliance with the Act, without creating unnecessary administrative burden. Due to the challenges faced with the limited compliance this is a risk held on the corporate risk register.

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

Limited assurance

Duty to ensure appropriate staffing (12IA)

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary are working in such numbers as are appropriate for the health, wellbeing and safety of patients; the provision of safe and high-quality health care; and in so far as it affects either of those matters, the wellbeing of staff.	Amber	There are unconfirmed structures and processes in place, which require to be supported by relevant SOPs which are still in development, across areas to ensure there is the ability to assess staffing requirements in real-time, escalation and seek support from leaders and managers (SafeCare, safety huddles). The systems available are inconsistently utilised to record staffing levels on a daily basis and we don't currently use other alternatives which are available, e.g., TURAS platform. Professional groups will be represented at the Operational Workforce Group as it embeds in; receive the locally produced quarterly self-assessment for completion (Q4 45.5% completed self-assessment returns). The Operational Workforce Group reports into the staff governance committee which helps to bring together other elements of staff governance and wellbeing, relevant to the legislation. There is variation in the processes used, and mechanisms for being assured of compliance across the broad range of service and professions within the organisation. eRostering/SafeCare should enable consistency of approach and an ability to demonstrate compliance through a range of reporting functions within this product when fully utilised by staff Usage is currently not widespread, and is an area for improvement for 2025-26 (24% completed a real time staffing assessment at least once a day, 50% or more of the time; 76% completing less than 50% of the time or not at all). Local resources have been developed, along with sign posting to national resources to support staff understanding of the Act, and how they can support the Board meet its legislative duties, and ensure there is appropriate staffing for the health, wellbeing and safety of patients, and wellbeing of staff.
These systems and processes include having regard to the nature of the particular kind of health care provision.	Amber	The systems and processes that should be in place across NHS Orkney require the leaders, managers, and decision makers to have regard to the kind of healthcare provision, several of which are delivered by a singleton

		practitioner. For nursing, and midwifery professions this is achieved through the use of staffing level tools and the use of the common staffing method to determine appropriate staffing levels to provide an establishment, and staff requirement for each shift which considers the kind of healthcare provided. Engagement with the Common Staffing Method is mixed (Q3 35% compliance). The staff on each 'shift' should apply professional judgement to determine whether the staffing is sufficient, or to consider a change in need where the kind of healthcare provision may have changed (for example, during winter pressures there may be a planned reduction in elective care to increase capacity for unscheduled care, which may require a different staffing compliment). This should be recorded in SafeCare. Whilst the Common Staffing Method currently is not legislated for all professional groups, they do have access to the multi-disciplinary professional judgement staffing level tool which is in development along with SafeCare and supports workforce planning processes, e.g., demand, capacity, activity and quality, the kind of healthcare provision, and on an ongoing basis the professional leads, clinical teams and managers should review and make any adjustments required to staffing requirements, skill mix, or service capacity. Although there are systems and processes in place to support future workforce planning these are not clear or well understood, as well as consider any immediate and medium terms changes that may create a risk or change, to ensure appropriate staffing provision is in place.
These systems and processes include having regard to the local context in which it is being provided.	Amber	Service planning is the responsibility of local managers, engaging with local teams and services to ensure local context is recognised, e.g., singleton practitioner, considered and had regard to when considering staffing requirements. For services using the Common Staffing Method, this is integral to this process, and the structure and approach is recommended for other services to support service planning, inclusive of broader range of considerations, which then feeds into wider system workforce planning approaches, and should

		ensure local context is reflected in staffing establishments and models (35% compliance).
These systems and processes include having regard to the number of patients being provided it.	Amber	The workforce requirements should reflect the activity, or number of patients being cared for by a person or a service but is not consistently recorded. These should be considered in real-time as part of real-time assessment to reflect variation in demand and activity, to ensure staffing meets any change in patient activity. This then should form part of any service or performance review, any risks or impact on patient quality and/or safety escalated and considered through clinical and staff governance committee(s) as appropriate, and should inform all levels of workforce planning, and establishment setting.
These systems and processes include having regard to the needs of patients being provided it.	Amber	The service and workforce planning processes should consider speciality specific information reflecting the specific needs of patients within individual services. On a day-to-day basis, real-time staffing assessment (SafeCare) should be embedded in practice and will therefore ensure that the needs of patient can be recorded, and any risk to providing appropriate staff(ing) to meet the needs of the real-time demands can be identified, mitigated or escalated for support. This data is not consistently recorded (35% compliance).
These systems and processes include having regard to appropriate clinical advice.	Amber	Clinical advice should be readily accessible within all functions. A Standard Operating Procedure is in draft to help support this aspect and includes arrangements for clinical advice 24/7. Managers and leaders should be aware and be supported to ensure they seek relevant clinical advice to support decision making.
These systems and processes include having regard to the guiding principles when carrying out the duty.	Amber	The guiding principles for health and care should underpin healthcare planning and delivery and should be reflected in the ways of working within NHS Orkney, e.g., the use of the Common Staffing Method, and used as a structure to support workforce planning processes to ensure all elements are considered and had regard to. These should be reflected in the Boards person centred practice, human rights approach, engagement and feedback from patients and staff, providing a holistic, whole systems approach when considering workforce requirements, to underpin high quality, safe and effective healthcare, with the best possible

		outcomes for patients/service users, and in relation to the principles of the Act, the wellbeing of staff.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met).	Amber	Compliance monitoring relies on several different processes / structures resulting in variation, resulting in an inconsistent assurance process. Locally produced quarterly self-assessment should be received from each operational or professional team, providing an assessment of compliance; those which are received lack data. This should provide a basic structure for feeding back any risks to compliance, to allow mitigation or actions to be taken to address any areas of non-compliance. eRostering and SafeCare should when fully embedded provide a more reliable and consistent mechanisms for monitoring compliance and addressing any areas of risk, concern or non-compliance. The feedback from the operational delivery leads is then incorporated into the quarterly internal compliance report. Staff 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. As the use of SafeCare expands, the reports available within this system will be used as the primary source of compliance monitoring.

Please provide information on the steps taken to comply with this Duty
These are steps taken to comply with 12IA in general. Examples could include information about workforce planning, national and international recruitment, retention, retire and return, service redesign, innovation, staff wellbeing, policies around supplementary staffing.

NHS Orkney is due to launch the 'Your Employee Journey' Programme as part of the Boards People and Culture workstream, which maps an employee journey from recruitment and onboarding through to exit and will be used to engage with teams to define excellence at the key touchpoints along the journey, and to prioritise improvements in staff experience and wellbeing to value support and develop staff and ensure the most efficient an defective use of staff to meet the needs of patients.

Examples include streamlined recruitment processes to ensure rigor with agreeing new posts, via the Vacancy Control Panel, with timeliness of progressing through recruitment to advert, targeted recruitment campaigns, successful overseas recruitment for difficult to recruit areas across a range of professions, e.g., nursing, speech and language. The has been positive feedback from staff joining NHS Orkney and we have seen retention of these new staff. This programme is at risk with the change to funding available, however this is being reviewed within NHS Orkney.

All leavers should have the opportunity for an exit interview to understand reasons for leaving, and opportunities to reduce staff leavers - this feedback should be captured and reviewed by the People and Culture team for themes and trends to inform any strategic action, as well as any local actions required in response to feedback. NHS Orkney supports and promotes retire to return, which is discussed with all staff considering retirement to help retain high levels of experience and expertise.

Wellbeing activities continue, such as providing access to the Employee Assistance Programme, which offers free counselling and support and includes access to the Wisdom app for wellbeing resources. A renewed focus on sickness absence (especially absence due to stress) to ensure that staff are supported to be well at work and have everything they need to return to work as soon as they are well enough. Launch of the NHS Orkney Wellbeing Hub, which is a central location for colleagues to access a range of health and wellbeing resources. This includes links to local support groups and national initiatives. The hub also provides an opportunity to share fun activities that are taking place, with our most recent additions being the Christmas 2024 activities.

Team Orkney Awards were launched last year with this year's awards launched last week, which included some new and refreshed categories in response to your feedback and that of our patients and community. Long Service Awards have been reinstated, with 400 colleagues recognised for their service to NHS Orkney and the NHS more broadly. Work continues to ensure every member of staff receives an annual appraisal. Good quality appraisals are a keyway to value and recognise you, to check in and to plan your personal development.

Workforce planning should be in place, with annual reviews of all services considering demand, capacity, activity and quality. The current practices of the Board are being reviewed and better embedded into the governance framework. These processes are being revised to consider the guiding principles and capture the key elements within the legislation, to ensure there is learning from information and intelligence as an outcome from the systems and processes in place for the legislation and directly linked to future workforce planning.

General principles and duties underpin NHS Orkney Corporate Strategy Year 2 Priorities and Key Performance Indicators, Annual Delivery Plan and external Cultural Development, Governance and Senior Leadership review Action Plan.

Career stories feature on social media, local press and internal Weekly Staff Bulletin to encourage consideration of NHS careers.

Please provide information on how these systems and processes, and their application, have improved outcomes for service users
This should include, but not be limited to, data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting; what this data has shown and any trends; and any actions taken as a result.

The bring together of patient quality and safety data, alongside staffing information is an area which is yet to be fully explored. Clinical governance structures should review patient quality and safety information, patient outcomes, feedback and patient experience data. The triangulation with workforce data, and intelligence from the duties of the Act is yet to be integrated at a local and service level into quality and performance review structures. At a Board level, this will be achieved through representation from clinical governance within the Operational Workforce Group, and the professional lead roles. Within nursing and midwifery this is underpinned by the Excellence in Care (EiC) programme, and the Care Assurance and Improvement Resource (CAIR) Dashboard quality of care measures, which bring together and help triangulate nationally agreed measures with workforce data at a ward level.

There are other processes whereby quality, and safety is reviewed to understand causes, for example, through the use of Care Opinion, the Integrated Incident and Risk Management Reporting System reviews, e.g., local and Significant Adverse Event Reviews. Monitoring of incidents and adverse events that have staffing identified as a contributing factor are included in the quarterly internal compliance report, which has elicited minimal data with which to develop themes or trends.

There have been no moderate, major, or severe harm reported through our adverse event reporting that is related to staffing. Patient feedback .... This will be a workstream for the coming year to better understand the clinical benefits and impact on patient outcomes as the duties of the Act, and digital systems in place to support these duties are more embedded and can assist with more robust data analysis.

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

Area of success / achievement / learning	Details	Further action
Optima Health Care roll out	NHS Orkney is transitioning to Optima Health Care, including phase implementation of SafeCare for all roles in scope of the legislation.	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 2025/26 with a view to implementing across all services and professions by 31 March 2026.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
Act Capacity	With no more funding from Scottish Government to support the awareness raising and compliance of the Act, there will be reduced capacity to continue to build on our successes and may even start failing to comply as well.	Ensure all duties are in built to induction and annual training programmes to ensure consistency and legacy for WFL work. Use existing structures e.g. extended senior leadership team meetings, morning huddle to keep staff aware of their responsibilities.
NHS Scotland: support and intervention framework - NHS Orkney escalated to Level 3	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.	NHS Scotland Action Plan in place.

Roles in Scope of the legislation	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, & the lack of affordable housing only adds to the issue. Staff retention is becoming increasingly more challenging, with staff choosing to move to other teams or into the independent sector, e.g., GP practices. HR, SAER, incidents, complaints & whistleblowing review recommendation(s) & 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.	New recruitment campaign to be rolled out. HR, SAER, incidents, complaints & whistleblowing review(s) - Triangulation of themes & tracking of learning recommendations & 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.
Incomplete clinical leadership structure	Capacity is an issue due to NHS Orkney has an incomplete clinical leadership structure, predominantly at senior level.	An up to date organisational and professional structures organogram publication date is anticipated by end of April 2025.
Inclusion of HCSA Implementation into Workforce and Planning Group(s)	Organisational structure, including identification of professional alinement not accessible. Benchmarking across the Board is yet to be completed to assess the communication forums for clinical leaders to discuss the duty laid out in 12IA. Confirm workforce steering group(s) are aware of the requirements from this duty across services, inclusive of the requirement to have real time staffing assessment in place.	The Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green.
Impact of reduced working week	The impact of the RWW has been significant in terms of reviewing rosters and working patterns, but additionally the impact on updating rosters has affected the roll out of eRostering and SafeCare as key enablers to the Act and Act compliance. Further changes to the rosters will further impact implementation and roll out of these systems to support the	Ensure lessons learned from the first reduction to be prepared and as effective as possible with any future changes.

	board demonstrate and monitor compliance, as well as have more qualitative data to consider impact and patient outcomes.	
Policies / SOPs not in place	Robust organisational policies are required be put in place for facilitating and monitoring of the requirement to have real time staffing assessment in place, including how to record staff who provide services via on-call.	The Operational Workforce Group to task subgroup to draft policy / SOP which includes an audit and compliance framework.

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

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

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, for the real-time assessment of compliance with the duty to ensure appropriate staffing, in all NHS functions and professional groups.	Amber	All services have access to SafeCare and therefore should have an agreed process in place that facilitates real-time staffing assessment to identify risk to patient safety, quality and outcomes underpinned by a SOP. SafeCare completion remains low (Q3 - 24% completed real-time staffing assessment at least once a day, 50% or more of the time; 76% completed less than 50% of the time or not at all). Safety Huddles, led by Acute Services, take place at 0900 and 1600 hrs Monday to Friday. All professional groups and clinical areas are not consistently included in the morning Safety Huddle, and the 1600 hrs handover report contains nursing and midwifery staffing only. Work is required to ensure all roles within scope of the Act are included in the Safety Huddle and handover report, are utilising SafeCare, which populates the starburst summary to inform the Safety Huddle and 1600hrs handover report, and for Safety Huddles and handovers report(s) to take place out of hours, at weekends, and on public holidays. Work is required to explore how escalation through the agreed professional structure, when required, including recording of, and explaining decisions made that conflict with clinical advice, along with identifying associated risks are to be achieved, including underpinned by a Standard Operating Policy (SOP). There were 6 incidents related to workforce or patient safety logged on the incident management system for FY 2024/25. The Board made the decision to implement SafeCare concurrently with the eRoster roll-out, following which no additional services have onboarded to the TURAS RTSR.
These systems and processes include the means for any member of staff to identify any		All staff are able to identify a risk caused by staffing levels however as noted above SafeCare completion remains low.

risk caused by staffing levels to the health, well-being and safety of patients; the provision of safe and high-quality health care; or, in so far it affects either of those matters, the wellbeing of staff.	Amber	The team leader should assess the staffing available against the planned workload and use their professional judgement to determine whether there is a risk or not. Action should be taken at a local level to address or mitigate any identified risk, where appropriate. SafeCare red flags should be utilised within SafeCare for review, mitigation or escalation of risks at Safety Huddles, but this is not used consistently. Safety Huddles are yet to utilise the SafeCare sunburst to inform safety huddle decision making.
These systems and processes include the means for the initial notification / reporting of that risk to the relevant individual with lead professional responsibility.	Amber	Systems and processes vary across services. At a team level, the team leader/SCN/SCM will manage risk raised to them and should then go into SafeCare or manual reporting into safety huddle(s) to record the staffing issues / risk, decision(s) made and who made the decision / clinical decision. A review of safety huddle documents these were found to be incomplete or not completed. The Board-wide risk management policy is under review. SOPs on risk escalation are in draft and support services / professional groups to detail lines of reporting. How widely this has been adopted is unclear. The Integrated Incident and Risk Management Reporting System reporting line is to the staff members line manager in the first instance. This provides the first level of escalation to the lead with professional responsibility (where this is the line manager), first opportunity to mitigate the risk and provide clinical input. All incidents reported via the Integrated Incident and Risk Management Reporting System escalate automatically to the executive level for action. In clinical teams where SafeCare is utilised, all red flags should be reviewed and mitigation agreed within the safety huddle. Any risk not safely mitigated should be escalated onto the Integrated Incident and Risk Management Reporting System. Generally, staff will raise a risk directly with their line manager, but this is not consistently recorded. Examples of appropriate mitigations include bringing in additional resource from another

		area, redeployment of available staff and/or a reprioritising of workload for the staff in the area. All staff have access to the Integrated Incident and Risk Management Reporting System and can raise a risk there. They are able to provide details of the exact risk or concern as it relates to staffing. Any risk raised that could not be mitigated would be recorded on the Integrated Incident and Risk Management Reporting System.
These systems and processes include the means for mitigation of risk, so far as possible, by the relevant individual with lead professional responsibility, and for that individual to seek, and have regard to, appropriate clinical advice as necessary.	Amber	The locally produced reporting template from operational reporting lines should provide assurance that appropriate clinical advice is sought (Q4 45% compliance). The draft SOP(s) on risk and risk escalation, local chart(s) templates are included for services / professional groups to set out who to seek appropriate clinical advice from for each service.
These systems and processes include means for raising awareness among all staff of the methods for identifying risk, reporting to the individual with lead professional responsibility, mitigation, and seeking and having regard to clinical advice.	Amber	The locally produced reporting template from operational reporting lines should provide assurance that appropriate clinical advice is sought (Q4 45% compliance). The draft SOP(s) on risk and risk escalation, local chart(s) templates are included for services / professional groups to set out who to seek appropriate clinical advice from for each service.
These systems and processes include means for encouraging and enabling all staff to use the systems and processes available for identifying and notifying risk to the individual with lead professional responsibility.	Amber	Awareness-raising has been a big focus for all staff ahead of commencement with the Act to ensure staff are aware of the Act, and the systems and processes in place within their work environment to support the Board meet its legislative duties. Staff are encouraged to access the available TURAS learning resources, as well as information developed locally, shared via the internal Weekly Staff Bulletin, NHS Orkney Blog, Teams communication. All new staff are made aware of the legislation at corporate induction. The structures and processes in place to identify, communicate and report any risks with staffing should be included in team / service orientation / induction. Training in SafeCare is provided at the point of registration and access permission being provided. The training includes how to meet the requirements of the duties. Data to corroborate this is in place is currently not available.

These systems and processes include the means to provide training to relevant individuals with lead professional responsibility on how to implement the arrangements in place to comply with this duty.	Amber	Internal engagement sessions have been delivered to Area Clinical Forum, NAMAC, TRADAC, Hospital Subgroup, Senior NMAHP Group, SCN meeting, Whole System Group, Staff Governance Committee and Joint Clinical Care and Governance Committee and included signposting to the HIS HSP knowledge and skills modules hosted on TURAS. There are ongoing opportunities for professional leads to access additional support via ongoing steering groups, workshops, training resources and the Board Act facilitator, to support individual and teams of leaders on how to implement the arrangements in place to comply with this duty.
These systems and processes include means for ensuring that individuals with lead professional responsibility receive adequate time and resources to implement those systems and processes.	Amber	The Operational Workforce Group to work with professional leads to identify clinical leaders, benchmark the duty to ensure adequate time is given to clinical leaders, collate preferred time to lead and produce SBAR for consideration / endorsement by senior leadership team / staff governance committee. The Director of People and Culture has led and collated ideas from a meeting to scope practical steps to release time to lead. Time to lead remains a recognised issue for clinical leaders across the organisation. 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. Clinical leader(s) job descriptions, work plans and TURAS appraisals to include / detail time to lead. 'Time to Lead' SOP in draft.
There is a clearly defined mechanism for monitoring compliance with this duty and	Green	NHS Orkney has mechanisms for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met). The

escalation of non-compliance (when this cannot be adequately met)		locally produced quarterly self-assessment returns from service leads for all professions and functions should be submitted to Operational Workforce Group with an assessment of compliance, and any action required / in place to address areas of non-compliance or where processes required to be strengthened (Q4 45.5% completed self-assessment returns). The feedback from the operational delivery leads is then incorporated into the quarterly internal compliance report. Staff 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. As the use of SafeCare expands, the reports available within this system will be used as the primary source of compliance monitoring.

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

Area of success / achievement / learning	Details	Further action
SafeCare roll out and monitoring	SafeCare implementation initially saw positive engagement from many teams / services initially.	Currently within Optima, time to lead is set up differently depending on the unit. We are seeking to adopt a uniform approach across all units to standardise reporting.
Path to green	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.	Operational Workforce Group to secure commitment and support to enable clinical leaders to engage with SafeCare.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action

Path to green	Clinical leaders need to be encouraged to utilise the system to capture challenges with staffing in real-time.	Continue to work with clinical leaders to utilise SafeCare. Develop and monitor systems and processes. Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green
Double-keying	Double-keying 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.	This risk is being managed by the local eRostering programme Board, with escalation to agree governance routes.
Incomplete clinical leadership structure	Capacity is an issue due to NHS Orkney has an incomplete clinical leadership structure, predominantly at senior level.	An up to date organisational and professional structures organogram publication date is anticipated by the end of April 2025.
Current SafeCare configuration does not support all elements of duty	Engage with SafeCare national configuration work and engage with relevant working group(s).	Engage with relevant working group(s).
Inclusion of HCSA Implementation into Workforce and Planning Group(s)	Organisational structure, including identification of professional alinement not accessible. Benchmarking across the Board is yet to be completed to assess the communication forums for clinical leaders to discuss the duty laid out in 12IC. Confirm workforce steering group(s) are aware of the requirements from this duty across services, inclusive of the requirement to have real time staffing assessment in place.	The Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green.
Policies / SOPs not in place	Robust organisational policies are required be put in place for facilitating and monitoring of the requirement to have real time staffing assessment in place, including how to record staff who provide services via on-call.	The Operational Workforce Group to task subgroup to draft policy / SOP which includes an audit and compliance framework.

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

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

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the escalation of any risk identified through the real-time staffing assessment processes which has not been possible to mitigate.	Amber	All of the areas should operate dynamic risk assessment either through use of Safety Huddles or in response to unplanned absence/vacancy which impact staffing levels. Staff can voice concern regarding appropriate staffing in real time directly to their line manager / OOHs manager, who can take action to mitigate any risk identified, e.g., bringing in additional resource from another area(s), redeployment of available staff and/or a reprioritising of workload for the staff in the area. This should be underpinned by agreed SOPs, which are in draft. Safety Huddles, led by Acute Services, take place at 0900 and 1600 hrs Monday to Friday. All professional groups and clinical areas are not consistently included in the morning Safety Huddle, and the 1600 hrs handover report contains elements of nursing and midwifery staffing information only. All roles within scope of the Act require to complete real time staffing assessment at least once a day. SafeCare is the platform that NHS Orkney is utilising, populates a sunburst summary which should inform Safety Huddle(s) and 1600hrs handover report. Safety Huddle(s) and handover report(s) should take place out of hours, at weekends, and on public holidays with decisions made recorded, including by whom. This should be documented within SafeCare. What is not clear are the decision(s) made or who made the decision / clinical decision. Of note there were only 6 incidents related to workforce or patient safety logged on the Integrated Incident and Risk Management Reporting System during FY 2024/25. 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.

		In addition to safety huddles, staff and mangers can also raise a concern regarding appropriate staffing in real time directly to their line manager to provide dynamic risk assessment by the manager of the staffing provision in the area and take action to mitigate any risk identified. Near miss, or incidents of omissions of case can be captured within the Integrated Incident and Risk Management Reporting System, which also hosts operational risk registers, where services can capture relevant risks to staffing. Use of these systems is inconsistent, hindering NHS Orkney's ability to robustly capture and evidence all risk escalations, and associated action / mitigations within our current structures.
These systems and processes include the means for the lead with professional responsibility to report the risk to a more senior decision-maker.	Amber	Safety Huddles should have clear processes for reporting of outcomes to senior professional leads (who are often in attendance at Safety Huddles). Unmitigated Real Time Staffing risks are escalated through line management and operational reporting lines and captured within SafeCare (senior review function is not yet in use) and reported on Integrated Incident and Risk Management Reporting System as appropriate. All incidents reported via the Integrated Incident and Risk Management Reporting System escalate automatically to the executive level for action. The draft risk escalation SOP clearly sets out the process that needs to be followed and individuals with lead professional responsibility should be trained in their responsibilities under the Act. Risk module(s) for staff with management and leadership responsibilities are in development.
These systems and processes include the means for that senior decision-maker to seek, and have regard to, appropriate clinical advice, as necessary, when reaching a decision on a risk, including on how to mitigate it.	Amber	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. The draft SOP(s) on risk and risk escalation, local chart(s) templates are included for services / professional groups to set out who to seek appropriate clinical advice from for each service.

		The draft SOP(s) on risk and risk escalation details the need to seek appropriate clinical advice, local chart(s) templates are included for services / professional groups to set out who to seek appropriate clinical advice from for each service. 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 that. It is possible to record within SafeCare that clinical advice has been sought. Where risk or adverse event has been captured within the Integrated Incident and Risk Management Reporting System, this can be recorded here. There is the ability to report and / or record where this has not occurred, and there is concern about whether appropriate clinical advice has been sought with decision making through operational and professional structures, and SafeCare or the Integrated Incident and Risk Management Reporting System reporting, to provide a balancing measure to capture potential non-adherence with this duty.
These systems and processes include the means for the onward reporting of a risk to a more senior decision-maker in turn, and for that decision-maker to seek, and have regard to, appropriate clinical advice as necessary, when reaching a decision on a risk, including on how to mitigate it.	Amber	The structures for onward escalation 24/7 until this reaches a Board level executive isn't clearly articulated for all roles in scope, should this be required, including the requirement to seek appropriate clinical advice. The draft SOP(s) on risk and risk escalation details the need to seek appropriate clinical advice, local chart(s) templates are included for services / professional groups to set out who to seek appropriate clinical advice from for each service.
These systems and processes include means for this onward reporting in (c) to escalate further, as necessary, in order to reach a final decision on a risk, including, as appropriate, reporting to members of the board of the relevant organisation.	Amber	The structures for onward escalation until this reaches a member of the Board isn't clearly articulated for all roles in scope, should this be required. The reporting of workforce risk on SafeCare and Integrated Incident and Risk Management Reporting System have 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. All incidents reported via the Integrated Incident and Risk Management Reporting System escalate automatically to the executive level for action. All services have a Business Continuity plan, 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. Mechanisms should be 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 for all roles in scope, underpinned by a SOP.
These systems and processes include means for notification of every decision made following the initial report, and the reasons for that decision, to anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice.		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 capacity & capability, issue escalation, mitigation & management of severe & 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.
These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to record any disagreement with any decision made following the initial identification of a risk.	Amber	All staff should have the ability to escalate concerns with a staffing decision following the processes outlined in 12ID(1). For all services this should be using the red fleg functionality on SafeCare. Audit of compliance is via SafeCare (24% completed a real time staffing assessment at least once a day, 50% or more of the time; 76% completing less than 50% of the time or not at all), quarterly self-assessment feedback

		(Q4 45% compliance), or by exception reporting by staff where this hasn't been achieved. The upgrade to SafeCare to include identification, mitigation and escalation of risk will support the identification of severe and recurring risks as these will be report generating functions for review at the Risk Management Group in the future.
These systems and processes include means for anyone involved in identifying the risk, attempting to mitigate the risk, escalation of the risk and providing clinical advice to request a review of the final decision made on an identified risk (except where that decision is made by members of board of the relevant organisation).	Amber	As above, all staff should have the ability to escalate concerns with a staffing decision following the processes outlined in 12ID(1). All services should be on SafeCare and have access to the red flag functionality, as previously mentioned the level of engagement has been low. Audit of compliance is via SafeCare where available, self-assessment feedback, or by exception reporting by staff where this hasn't been achieved. Disagreement or Reviews can be included in the Integrated Incident and Risk Management Reporting system (this needs to be developed in partnership with the governance team). The upgrade to SafeCare to include identification, mitigation and escalation of risk should support the identification of severe and recurring risks as these will be report generating functions for review at the Risk Management Group in the future.
These systems and processes include means for raising awareness amongst all staff of the arrangements stated in (a) to (g) above.	Amber	As above, all staff should have the ability to escalate concerns with a staffing decision following the processes outlined in 12ID(1). All services should be on SafeCare and have access to the red flag functionality, as previously mentioned the level of engagement has been low. Audit of compliance is via SafeCare where available, self-assessment feedback, or by exception reporting by staff where this hasn't been achieved. Disagreement or Reviews can be included in the Integrated Incident and Risk Management Reporting system (this needs to be developed in partnership with the governance team).

		The upgrade to SafeCare to include identification, mitigation and escalation of risk should support the identification of severe and recurring risks as these will be report generating functions for review at the Risk Management Group in the future.
These systems and processes include the means to provide training to relevant individuals with lead professional responsibility and other senior decision-makers on how to implement the arrangements in place to comply with this duty.	Amber	eRostering training was delivered as part of the implementation plan. Transition to BAU with SafeCare, includes delivery of training to unit leads / manager. Risk module(s) for staff with management and leadership responsibilities are in development, including use of the Integrated Incident and Risk Management Reporting System. The HCSA implementation facilitator has delivered internal engagement sessions with accountable managers and professional leads, including Staff Governance Committee, Area Clinical Forum, Senior NMAHP Group, NAMAC, TRADAC, Hospital Sub and Whole System Group. Training and awareness session requirements will be reviewed on completion of any future updates to risk management processes and the Integrated Incident and Risk Management Reporting System and rolled out as appropriate for compliance with the duty, underpinned by SOP(s). TURAS learning and development modules are available (informed, skilled and enhanced level) to support general awareness of the legislation.
These systems and processes include means for ensuring that individuals with lead professional responsibility and other senior decision-makers receive adequate time and resources to implement the arrangements.	Amber	This duty is linked to the work associated with Duty 12IH. Current provision to ensure adequate time is given to clinical leaders is not consistently in place across the organisation and currently not audited. PLDPs, appraisal reviews job planning, time built into job descriptions, activity manager on Optima Health Care etc is available to underpin and support data capture. This work strand will be explored through the work of the Operational Workforce Group. Risk management and risk escalation are processes utilised to underpin 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).
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	NHS Orkney has mechanisms for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met). The locally produced quarterly self-assessment returns from service leads for all professions and functions should be submitted to Operational Workforce Group with an assessment of compliance, and any action required / in place to address areas of non-compliance or where processes required to be strengthened (Q4 45.5% completed self-assessment returns). The feedback from the operational delivery leads is then incorporated into the quarterly internal compliance report. Staff 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.

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

Area of success / achievement / learning	Details	Further action
SafeCare roll out and monitoring	Safe Care implementation initially saw positive engagement from many teams / services initially.	Currently within Optima, time to lead is set up differently depending on the unit. We are seeking to adopt a uniform approach across all units to standardise reporting.
Path to green	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.	Operational Workforce Group to secure commitment and support to enable clinical leaders to engage with SafeCare, specifically risk escalation.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
Resource pressures	Time and resources to continue to embed these resources and support practice, as new learning emerges, increased activity with compliance monitoring and reporting.	Continue to monitor highlight risk with reduced resource next financial year when SG funding no longer available.
Lack of standardised approach	Variable processes. A clearer process is required to facilitate monitoring and reporting.	Explore development of Integrated Incident and Risk Management Reporting System and SafeCare to provide reporting, escalation and monitoring of staffing risks.
Policies / SOPs not in place	Robust organisational policies are required be put in place for facilitating and monitoring of the requirement to have risk escalation process in place related to staffing.	The Operational Workforce Group, in conjunction with the Risk Management Group, to draft policy / SOP for risk escalation of staffing issues, which includes an audit and compliance framework.
Inclusion of HCSA Implementation into Workforce and Planning Group(s)	Organisational structure, including identification of professional alinement not accessible. Benchmarking across the Board is yet to be completed to assess the communication forums for clinical leaders to discuss the duty laid out in 12ID. Confirm workforce steering group(s) are aware of the requirements from this duty across services, inclusive of the requirement to have risk escalation process in place related to staffing.	The Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green.

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

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

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, for the collation of information relating to every risk escalated to such a level as the relevant organisation considers appropriate.	Amber	Publication of ratified organisational and professional structures is awaited. Incomplete senior clinical leadership structure. 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. A staff training programme is under development 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 Workforce 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 (24% completed a real time staffing assessment at least once a day, 50% or more of the time; 76% completing less than 50% of the time or not at all).
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to identify and address risks that are considered severe and / or liable to materialise frequently.	Amber	All identified severe and recurring risks should be reported through the governance lines as detailed above. Thematic reports are available from Integrated Incident and Risk Management Reporting System. It is for each areas / service 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 service delivery within these frameworks. This is currently not clearly identified for all areas. Ratification and publication of the draft risk escalation SOP will mitigate this. All severe risks should be recorded within the Integrated Incident and Risk Management Reporting System as a high-level trend. Clinical Governance group(s) should review all Integrated Incident and Risk Management Reporting System submissions for trends. Clarification will be sought from the local eRostering team (Optima Health Care and SafeCare) via the Operational Workforce Group on red flag review (identified risks), how this will be undertaken and by whom, for trends. SafeCare, once fully operational, will provide more reliable information to support the identification of recurrent risk within the system.
These systems and processes include the means for recording risks that are considered severe and / or liable to materialise frequently.	Amber	Thematic reports are available from the Integrated Incident and Risk Management Reporting System from which risk specific dashboards can be created. Each service has the ability to pull risks specific to their area providing localised and operational picture of risk. All risks raised on the Integrated Incident and Risk Management Reporting System are allocated a rating for impact (severity) and likelihood (anticipated likelihood of recurrence).

		Integrated Incident and Risk Management Reporting System submissions can be reviewed across functional groups for trends and occurrences. Once fully operational reports can be generated from SafeCare which will underpin the existing system, which is currently unable to capture the spectrum of mitigated risks that occur. A review of risk management (corporate & operational) has taken place with the way forward presented to and agreed by the Risk Management Group.
These systems and processes include the means for reporting of a risk considered severe and / or liable to materialise frequently, as necessary, to a more senior decision-maker, including to members of the board of the relevant organisation as appropriate	Amber	All risks raised and recorded on the Integrated Incident and Risk Management Reporting System are submitted through line management lines to a more senior decision maker for action or onward escalation. All risks (severe) risks are escalated to executive level decision makers. SafeCare use can capture the spectrum of mitigated risks that occur frequently strengthen the Board's awareness and response to recurrent risk.
These systems and processes include means for mitigation of any risk considered severe and / or liable to materialise frequently, so far as possible, along with a requirement to seek and have regard to appropriate clinical advice in carrying out such mitigation.	Amber	The Integrated Incident and Risk Management Reporting System allows for application of mitigating actions to be applied with involvement of clinical advisors being recorded through the inclusion of the clinical advisor (when the risk is not being mitigated by a clinical professional) in the systems communication channel(s). However, this is not currently identified as a requirement within the Integrated Incident and Risk Management Reporting System or in written processes. This requirement needs to be included in the escalation risk management SOP and the Integrated Incident and Risk Management Reporting System for all professional lines and functions. SafeCare, once fully functional and embedded, will be able to record and report on mitigations in place for risks, along with assurance that clinical advice has been sought strengthen the current process described above. Through the work of the Operational Workforce Group, in conjunction with the Risk Management Group, assurance will be sought that SafeCare escalation structures for all roles in scope have an escalation route which includes clinical advice.

These systems and processes include means for identification of actions to prevent the future materialisation of such risks, so far as possible.	Amber	Our governance processes include Adverse Event Reviews relevant to the reported severity, including Significant Adverse Event Reviews (SAER) for specific severe events to mitigate the risk recurrence. These processes are contained within the Risk Management policy, which details the process to manage risk from service level to Executive strategic level risks. The governance processes are currently under review, including how lessons identified are communicated across the organisation, e.g., to the Operational Workforce Group, to take forward. Completion of any incident and near misses and/or any SAERs linked to staffing, in a timely manner, and in-line with national guidance has been impacted by a lack of staff capacity.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	NHS Orkney has mechanisms for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met). The locally produced quarterly self-assessment returns from service leads for all professions and functions should be submitted to Operational Workforce Group with an assessment of compliance, and any action required / in place to address areas of non-compliance or where processes required to be strengthened (Q4 45.5% completed self-assessment returns). The feedback from the operational delivery leads is then incorporated into the quarterly internal compliance report. Staff 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.

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

Area of success / achievement / learning	Details	Further action

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
Risk dashboard	Creation of a staffing related risks dashboard, updated monthly prior to the Operational Workforce Group should 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.	Operational Workforce Group to consider implementation / the use of a staffing related risk dashboard
Risk oversight / Management	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).	Embed discussing risks at the groups listed.
Path to green	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.	The Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green.

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

Duty to seek clinical advice on staffing (12IF)

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to seek and have regard to appropriate clinical advice in making decisions and putting in place arrangements relating to staffing under sections 12IA to 12IE and 12IH to 12IL and to record and explain decisions which conflict with that advice.	Amber	Professional Leads should be in place for the majority of services to support or provide professional advice with real-time staffing decisions and address any risk escalation and provide representation on workforce planning groups (oversee workforce monitoring and planning at operational level and corporate level) within their areas of responsibility. There are currently some gaps resulting in an incomplete clinical leadership structure, predominantly at senior level. An up to date organisational and professional structures organogram publication date is TBC. Systems and processes are not consistently in place for all the roles in scope across the organisation. Draft flowcharts and SOP templates have been written and disseminated to clinical leads. Utilisation is low. Escalation, decisions made and by whom are not consistently being recorded by all roles in scope across the organisation. The draft SOP - Real-time Staffing and Risk Escalation for Clinical Leaders / Managers includes this duty and 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, emails, SafeCare or other local system in place, in addition to verbal feedback and communications.
These systems and processes include the means whereby if a relevant organisation decides which conflicts with clinical advice received, any risks caused by that decision are identified and mitigated so far as possible.	Amber	The Operational Workforce Group is required to agree what risk management system is to be utilised to incorporate recording of clinical advice, including risk identified and how this is mitigated (day-today, workforce planning and vacancy control panel), underpinned by SOP(s) which clearly sets out the steps required to record any conflict with clinical advice given, including the escalation process. Draft SOP include an assessment of risk in the event 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.

		Dialogue and discussion between the decision maker and individual providing clinical advice is expected, 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 should be identified and mitigated so far as possible. The assumption is that this practice is followed, it requires SOP(s) to be in place, and awareness / training of decision makers, there is no single mechanism or process of evidencing this practice at present. SafeCare can capture any conflict with clinical advice and any ensuing risks and mitigation as a result of this one level up only at present (NB: new 'senior review' functionality is available in v 11.4.2), and the Integrated Incident and Risk Management Reporting System (IIRMPS) is also available to report and record any resulting adverse event (near miss and actual harm) if considered necessary.
These systems and processes include the means whereby if a relevant organisation makes a decision which conflicts with clinical advice received, any person who provided clinical advice on the matter is notified of the decision and the reasons for it and this person is able to record any disagreement with the decision made.	Red	There is not currently a system in place to ensure we are complaint whereby if a decision which conflicts with clinical advice received, any person who provided clinical advice on the matter is notified of the decision and the reasons for it and this person is able to record any disagreement with the decision made. The draft SOPs details the requirement 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 reason 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. 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, by using SafeCare or Integrated Incident and Risk Management Reporting System, by email communication or other local processes. There is variation across the organisation about how and where this is recorded which make audit and assurance of compliance difficult to evidence. 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.

		As above, the use of SafeCare, the development of the Integrated Incident and Risk Management Reporting System to incorporate recording of clinical advice and/or the development of SOPs to clearly lay out the steps required to record any conflict with clinical advice given will meet this requirement.
These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the board of the relevant organisation on at least a quarterly basis about the extent to which they consider the relevant organisation is complying with the duties in 12IA to 12IF and 12IH to 12IL.	Amber	Within the organisation the individuals with lead clinical professional responsibility are the Medical Director and Director of Nursing, Midwifery and AHPs / Chief Officer Acute Services (DoNMAHP). The Operational Workforce Group is working with operational and professional structures to coordinate implementation of the transition to BAU plan. The monitoring of compliance is through quarterly self-assessment returns received from the relevant leaders/ managers (Q4 45.5% completed self-assessment returns). The Operational Workforce Group prepares a report on behalf of the Medical and Nurse Director outlining the extent to which the organisations is complying with the duties, and this is reported through the Staff Governance Committee and into the Board. This occurs on a quarterly basis as routine, however there are mechanisms for escalation out with these times as required.
These systems and processes include the means for individuals with lead clinical professional responsibility for a particular type of health care to enable and encourage other employees to give views on the operation of this section and to record those views in the reports to the members of the board of the relevant organisation.	Amber	The systems and processes being developed by the organisation will 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, e.g., NAMAC, TRADAC, GP Sub, Hospital Sub etc. 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 NHS Orkney board members. 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 / flash reports / self-assessment returns / feedback from operational services into the

		Operational Workforce Group, iMatter feedback or direct engagement sessions with professional leads.
These systems and processes include the means to raise awareness among individuals with lead clinical professional responsibility for a particular type of health care in how to implement the arrangements in this duty.	Red	NHS Orkney systems and processes are evolving in relation to raising awareness among individuals with lead clinical professional responsibility for a particular type of health care in how to implement the arrangements in this duty. A communication strategy should be in place that identifies clear communication lines and to raise awareness. There should be information sessions and training for individuals with lead clinical professional responsibility at an executive level but also throughout professional structures. Any SOP should be reviewed to include the requirement and arrangements for seeking clinical advice, making it applicable to all professional groups and it could cross references the routes identified within the communication strategy. An education programme should be available specific to the requirements and processes in place to comply with this duty. There should be internal engagement sessions with accountable managers and professional leads.
These systems and processes include means for ensuring that individuals with lead clinical professional responsibility for a particular type of health care receive adequate time and resources to implement the arrangements.	Amber	Capacity is an issue due to NHS Orkney has an incomplete clinical leadership structure, predominantly at senior level. An up to date organisational and professional structures organogram publication date is TBC. 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 is unclear. This duty is linked to implementation of Duty 12IH. Optima Health Roster and SafeCare include information on clinical leaders working clinically. These systems require to be monitored through operational processes to identify any reduced provision of supervision time. 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.

These systems and processes include means for the relevant organisation to have regard to the reports received.	Amber	Systems and processes include means for NHS Orkney to have regard to the reports received (quarterly and annually), with reporting via Staff Governance committee to the Board. The governance structure of the organisation ensures that the organisation has regard to reports created.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	NHS Orkney has mechanisms for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met). The locally produced quarterly self-assessment returns from service leads for all professions and functions should be submitted to Operational Workforce Group with an assessment of compliance, and any action required / in place to address areas of non-compliance or where processes required to be strengthened (Q4 45.5% completed self-assessment returns). The feedback from the operational delivery leads is then incorporated into the quarterly internal compliance report. Staff 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.

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

Area of success / achievement / learning	Details	Further action
Path to green	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.	Operational Workforce Group to secure commitment and support to enable clinical leaders to engage with SafeCare.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
Engagement with SafeCare	Challenges with services and professions to utilise SafeCare on a consistent basis, including recording of clinical advice given and by whom.	Operational Workforce Group to secure commitment and support to enable clinical leaders to engage with SafeCare.
Incomplete clinical leadership structure	Capacity is an issue due to NHS Orkney has an incomplete clinical leadership structure, predominantly at senior level.	An up to date organisational and professional structures organogram publication date is TBC

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

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

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all employees receive such training as considered appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b) and such time and resources as considered adequate to undertake this training.	Yellow	Statutory and mandatory training requirements for all staff hosted on TURAS Learn NHS Orkney Learning Zone, with compliance monitored via Staff Governance Committee and Performance Review meetings. Training on the CSM and staffing level tools, incorporates preparatory education sessions, via 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. TURAS resources available to all staff involved in Staffing Level tool runs. Annual appraisal on TURAS monitored for completion of PDPs (38.33% completed) All employees undergo induction and orientation. Compliance levels with mandatory and induction completion are monitored and are there are currently system wide issues with compliance. Role specific training for all NHS functions and professional groups is being collated by in-house education team(s) for professions and provide educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) to deliver new knowledge and skills requirements. PDP completion monitored through TURAS platform along with completion of mandatory and essential training at one-to-one meetings between managers and staff within all professions. Education Strategy in development, as is a leadership development framework for Executives and clinical leaders.

		Working with Further/Higher Education Institutions to improve the way the education needs of the workforce are planned, and what collaboration takes place to ensure education curriculums offered can respond to the changing population health needs both locally and nationally.
These systems and processes include means to determine the level of training required, and time and resource to support this, for all relevant employees.	Amber	Statutory / Mandatory Training Steering Group considers, agrees and publishes NHS Orkney statutory / mandatory training, plus the time to complete has been calculated and included. Ensuring staff are rostered to attended / complete the training during worktime is not consistently applied across the organisation. Training within the organisation is determined along the lines of Mandatory, Essential and Development requirements for each profession and role, e.g., Aspiring Heads of Midwifery, and Queen's Nurse programmes. Mandatory and essential training for all NHS functions and professional groups is being collated by in-house education team(s) for professions and provide educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) to deliver new knowledge and skills requirements. The funded establishment is currently under review. There are areas where predicted absence allowance has not been included (study leave 2%). Protected learning time has not yet been fully embedded across the organisation. Low compliance with statutory / mandatory training is a live risk on the corporate risk register. All training should be supported with protected time to facilitate completion of all training requirements, resources and protected time should be agreed within PLDPs. Different professions have different set national training curriculums. These are to be supported through professional lines, training needs analysis, funding and expert support e.g. practice Development Facilitators, and clinical educators. Assurance of compliance with this duty is monitored through: Staff Governance Committee, performance review meetings, annual appraisals and

		TURAS systems for compliance levels with mandatory and induction training for all staff within scope.
These systems and processes include the means to deliver the agreed level of training to all relevant employees.	Amber	Statutory / Mandatory Training Steering Group considers, agrees and publishes NHS Orkney statutory / mandatory training, plus the time to complete has been calculated and included. Training within the organisation should be determined along the lines of Mandatory, Essential and Development requirements for each profession and role, e.g., Aspiring Heads of Midwifery, and Queen's Nurse programmes. Mandatory and essential training for all NHS functions and professional groups is being collated by in-house education team(s) for professions and provide educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) to deliver new knowledge and skills requirements.
These systems and processes include the means to ensure all relevant employees receive both time and resources to undertake the training.	Amber	As an island Board maintenance / currency of the suite of skills required to deliver high quality, safe and effective care is challenging, requiring regular updates via mainland Boards. This comes at a cost and as the Board is attempting to rebalance financially, this will impact on what, if any education, training and development available. Optima Health Roster can build in roster allocation time to release staff for training, e.g., time allocated for training is protected time (Staff competency and capacity is part of Six Step methodology in workforce planning; as is review of completion rates of training to identify future workforce need to training resource and time). Statutory and mandatory compliance remains a challenge for the FY 2024/25 with <85% target across multiple teams but improvements are now being made
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	Assurance of compliance with this duty is monitored through: Staff Governance Committee, performance review meetings, annual appraisals and TURAS systems for compliance levels with mandatory and induction training for all staff within scope. This is incorporated into the quarterly internal

		compliance report that goes to Staff Governance Committee, and the Board Meeting. 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. All reporting lines are required to complete a self-assessment return quarterly (Q4 45% compliance).

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

Area of success / achievement / learning	Details	Further action
Improved induction and training of medical locums	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.	Ongoing monitoring of utilisation and feedback on opportunity for improvement.
Path to green	Education Strategy in development, plus review of statutory / mandatory, and essential training underway.	Complete and publish Education Strategy, review of Statutory and Mandatory, and essential training. Monitor compliance via performance review meetings, Operational Workforce Group and Staff Governance Committee. Assurance of compliance with duty 12II via quarterly internal compliance report to the Staff Governance Committee.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
Path to green	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.	Confirm the process and procedures to be completed, including timing, e.g., annually or 2 yearly etc, and who responsible & accountable for completing underpinned by a policy / SOP
Inclusion of HCSA Implementation into Workforce and Planning Group(s)	Benchmarking across NHS Orkney is yet to be completed to assess the communication forums for clinical leaders to discuss the duty laid out in 12II. Confirm workforce steering group(s) are aware of the requirements from this duty across services, inclusive of the requirement to ensure appropriate training of staff (induction, statutory/mandatory, essential etc	The Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green
Consistency of application across all professions in all clinical settings	Whilst there are some systems and process in place, there is further work required 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.
Embedding protected learning time	Currently work required to ensure staff received protected learning time in order to complete statutory / mandatory and role specific training / development.	The Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green
Level of Assurance - Please indicate level of assurance provided		**Limited Assurance**

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

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups, to ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties.	Amber	The Operational Workforce Group to work with professional leads to identify clinical leaders, benchmark the duty to ensure adequate time is given to clinical leaders, collate preferred time to lead and produce SBAR for consideration / endorsement by senior leadership team / staff governance committee. The Director of People and Culture has led and collated ideas from a meeting to scope practical steps to release time to lead. 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. Clinical leader(s) job descriptions, work plans and TURAS appraisals to include / detail time to lead. 'Time to Lead' SOP in draft. The job planning and/or activity manager modules (once fully rolled out) will provide assurance through Health roster for monitoring of non-patient facing activities in other professions such as AHP, HCS etc. Indicative measures for leadership activities available on TURAS via appraisal process with the ability to monitor PDPs.
These systems and processes include time and resources for these individuals to supervise the meeting of the clinical needs of patients in their care; to manage, and support	Red	NHS Orkney is developing its systems and processes to ensure adequate time and resources are given to clinical leaders to supervise the meeting of the clinical needs of patients in their care, to manage, and support the

the development of, the staff for whom they are responsible; and to lead the delivery of safe, high-quality and person-centred health care.		development of, the staff for whom they are responsible, and to lead the delivery of safe, high-quality and person-centred health care.
These systems and processes include the means to identify all roles, and therefore individuals, with lead clinical professional responsibility for a team of staff.	Yellow	NHS Orkney has a number of systems to identify all roles and individuals with lead clinical professional responsibility for a team. This includes SSTS payroll systems via SSTS structures, Optima Health Roster, all roles are identified within eESS (Electronic Employee Staff System) and TURAS. All are arranged through job role and titles. Staff job descriptions reflect the specific leadership responsibilities, requirements and expectations within each role. Publication of ratified organisational and professional structures is in development.
These systems and processes include the means to determine what constitutes sufficient time and resources for any particular individual.	Amber	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 included in clinical rota; being moved in to clinical rota to mitigate / as per job description, e.g., 60% time to lead: 40% clinical etc. Clinical leader(s) job descriptions, job plans and TURAS appraisals to include / detail time to lead
These systems and processes include the means for ensuring this duty has been reviewed and considered within the context of job descriptions, job planning and work plans, as appropriate.	Amber	Work is yet to commence on monitoring job plan sign off for all staff in role of the legislation, how this will be monitored; how workforce group(s) when developing workforce plans review staffing levels, levels of redeployment, non-case holding time of clinical leaders and quality indicators to inform workforce plans. TURAS appraisal, job planning sign-off completion rates can be monitored through respective systems.
These systems and processes include the means to consider outputs from activities carried out to meet this duty in order to inform future workforce planning and protect the leadership time required for clinical leaders.	Red	All professional leads have access to annual appraisal, PDPs and will have access to job planning and activity manager, where appropriate, through the roll out of the RLDatix National contract. Access for all these systems will be dependent on the programme(s) roll out.

		Discussion time with line managers to agree level of time and resource to discharge their responsibilities and clinical workload to be a core component of annual appraisal meetings. Appraisal completion rates are monitored by People and Culture (38.33% completed).
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Amber	Assurance of compliance with this duty is monitored through TURAS and SafeCare reports, and the Integrated Incident and Risk Management Reporting System (IIRMPS). The data is incorporated into the quarterly internal compliance report that goes to Staff Governance Committee, and the Board Meeting. The Executive 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. All reporting lines are required to complete a self-assessment return quarterly (Q4 45% compliance).

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

Area of success / achievement / learning	Details	Further action
The Operational Workforce Group is aware of this duty and requirements of the Act	The Operational Workforce Group is aware of the requirements from this duty across services, inclusive of the requirement of adequate time for clinical leaders.	

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
Policies, systems and processes in place	Robust Organisational policies, systems and processes are required to be in place for facilitating and monitoring of Clinical leaders' time.	Develop an audit and compliance framework
Path to green	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.	Continue to work with clinical leaders to utilise SafeCare. Develop and monitor systems and processes. Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green

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

Duty to follow the common staffing method (12IJ)

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, to follow the common staffing method no less often than the frequency prescribed in Regulations (see https://www.legislation.gov.uk/ssi/2024/43)	Amber	Clinical Manager and practice education capacity / engagement necessitating SG funded board support for HCSA implementation (18.5 hrs) to assist services / teams with preparation, education, running, reviewing, quality assuring, reporting on each staffing level tool run (to ensure all aspects of the Common Staffing Method are met). NB: for adult inpatient specialist staffing level tool none of the sub-specialties a line to inpatients 1 (acute admissions, multiple specialties, single rooms) requiring data to be entered multiple times under different sub-specialties, e.g., medical and surgical. Completion of the CSM is limited for a number of reasons, including leadership capacity and incomplete structures. A SOP specific to the Common Staffing Method (CSM) is in draft, which will include the requirement for staff consultation/engagement in local staffing level tool runs (before, during and after), training utilising the HIS HSP learning resource(s), and is mandatory for all staff in scope. Staff are required to access HIS HSP learning resources and completion of TURAS resources is monitored. Registered Nurse Development Days commenced in March 2025 and will be held every 3rd Tuesday each month thereafter. The HCSA, including the Common Staffing Method is being incorporated into the programme. 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.

These systems and processes include use of the relevant speciality specific staffing level tool and professional judgement tool as prescribed in Regulations (see https://www.legislation.gov.uk/ssi/2024/43), and considering results from those tools.	Amber	All speciality specific staffing level tools are identified and allocated as appropriate across the types of health care listed. This includes professional judgement and quality tools. NHS Orkney works closely with HIS to ensure all relevant updates and developments are incorporated into the staffing level tool(s) run schedule in a timely manner. There is limited engagement with the usage of the CSM. A SOP specific to the Common Staffing Method (CSM) is in draft, which includes the relevant speciality specific staffing level tool, professional judgment tool and, where applicable the quality tool legislative requirements for types of health care listed in legislation. The internal governance pathway to feed outcomes into workforce plans and local management meetings is under discussion and once confirmed will be specified in the local CSM SOP.
These systems and processes include considering relevant measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H (1) of the 1978 Act by the Scottish Ministers (including any measures developed as part of a national care assurance framework).	Amber	A range of quality measures such as Clinical Quality Indicators, patient safety data, waiting times etc should be utilised for completion of triangulation under the CSM and input into workforce plans. Section 3 incorporates quality measure and includes any care assurance indicators, such as EIC dashboard, clinical incidents, complaints, comments by staff and patients. There is limited engagement with the usage of the CSM.
These systems and processes include considering current staffing levels and any vacancies	Amber	This is included in the local produced CSM reporting template and is also included in training on Common Staffing Method. Sections 1 (Appendix 1) & 4 - Funded establishment, actual staffing (including current vacancies), substantive staff usage, PAA v Actual absence. Optima / SafeCare and SSTS (Boxi) have extensive reporting capabilities to allow this section of CSM to be included in reports. There is limited engagement with the usage of the CSM.
These systems and processes include considering the different skills and levels of experience of employees	Amber	This is included in the local produced CSM reporting template and included in local training. Section 4 - Local context: consider skill mix, experience of employees and age profile of employees. There is limited engagement with the usage of the CSM.

These systems and processes include considering the role and professional duties of individuals with lead clinical professional responsibility for the particular type of health care.	Amber	Lead professionals with responsibility and accountability for delivery of staffing level tool runs, Common Staffing Method triangulation and report are offered pre and post tool training, including in relation to their role and responsibilities plus provided with national resources. Uptake to date has been poor. All training is recorded locally to provide assurance for this duty. A local produced CSM reporting template ensures this is included in CSM report. There has been limited uptake.
These systems and processes include considering the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care (particularly those to which the common staffing method does not apply).	Red	All reports should be submitted for review to the Interim Deputy Director of Nursing / Lead Midwife. The internal governance pathway to feed outcomes into workforce plans and local management meetings is under discussion and once confirmed will be specified in the local CSM SOP.
These systems and processes include considering the local context in which health care is provided.	Amber	This is included in the locally produced CSM reporting template and included in local training. Section 4 - Local Context: Staff are encouraged to use this section to describe local context within their service. Examples given include skill mix, missed care results, psychological safety results, iMatter scores, staff experiences, age profile of employees, capacity and demand, supplementary staffing usage, PAA v actual, etc. There is limited engagement with the usage of the CSM.
These systems and processes include considering patient needs.	Amber	Included in the locally produced CSM reporting template - review of complaints, feedback forms, changing acuity and demand levels etc. Patient need taken into consideration for both current and unmet need. There is limited engagement with the usage of the CSM.
These systems and processes include considering appropriate clinical advice.	Amber	Included in the locally produced CSM reporting template and included in local training - Section 6 - Risk assessment & prioritisation: Is clinical professional advice/ guidance sought where required? Section 7 - Decision making, recommendations and next steps: has professional advice/ guidance been sought from clinicians and workforce planning colleagues? All accountable managers are asked to provide assurance by responding to the prompts provided in the reporting template. There is limited engagement with the usage of the CSM.

These systems and processes include considering any assessment by HIS, and any relevant assessment by any other person, of the quality of health care provided.	Amber	Included in the locally produced CSM reporting template and included in local training. All inspection, audits and surveys are included for review within the CSM process. This duty is cross covered within Section 3 - quality measures, and context elements of triangulation. There is limited engagement with the usage of the CSM.
These systems and processes include considering experience gained from using the real-time staffing and risk escalation arrangements under 12IC, 12ID and 12IE.	Amber	Included in the locally produced CSM reporting template and included in local training. Section 6 - risk assessment and prioritisation include the need to report on Realtime staffing risks, mitigations, escalation of risks and guidance sought regarding risk. This includes data on severe and recurring risks from the Integrated Incident and Risk Management Reporting System (IIRMPS), and SafeCare. There is limited engagement with the usage of the CSM.
These systems and processes include considering comments by patients and individuals who have a personal interest in their health care, which relate to the duty imposed by section 12IA.	Amber	Included in the locally produced CSM reporting template and included in local training. Section 3 - Quality Measures "patient complaints, patient comments". NHS Orkney uses care opinion, local feedback, patient forums and social media to record views of service users and these are utilised in the triangulation of the CSM. There is limited engagement with the usage of the CSM.
These systems and processes include considering comments by employees relating to the duty imposed by section 12IA.	Amber	Included in the locally produced CSM reporting template and included in local pre and post staffing level tool run training and discussion. Opportunity to feedback / comment during service / team discussion pre and post staffing level tool run. Section 5 - Staff engagement and feedback. There is limited engagement with the usage of the CSM.
These systems and processes include means to identify and take all reasonable steps to mitigate any risks.	Amber	Included in the locally produced CSM reporting template and included in local training. Section 6 - risk assessment and prioritisation: staff are asked to explain internal reporting, escalation and prioritisation process considering the key factors listed: is real-time staffing assessment on place, have risks been identified, have identified risks been mitigated, how are risks escalated and to whom, is clinical advice sought. This duty will also link into the work underway for Duty 12IC, 12ID and 12IE. There is limited engagement with the usage of the CSM.
These systems and processes include means to decide what changes (if any) are needed to the staffing establishment and the way in which health care is provided as a	Amber	Included in the locally produced CSM reporting template and included in local training. Section 7 - decision making, recommendations and next steps: staff are supported to make their recommendations and next steps considering the factors listed and any others which may be relevant, e.g., is redesign or

result of following the common staffing method.		service/roster/skill mix required? is a workforce plan required? Has professional advice been sought? How are staff consulted and informed during this process? Section 8 - is staffing appropriate to provide safe, high-quality care: does this report identify that an SBAR is required for this location? There is limited engagement with the usage of the CSM.
There is a clearly defined mechanism for monitoring compliance with this duty and escalation of non-compliance (when this cannot be adequately met)	Yellow	All reporting lines use the self-assessment returns to report quarterly to the Staff Governance Committee via the Operational Workforce Group. This is incorporated into the quarterly internal compliance report that goes to the Board. All reporting lines of the health care types are required to complete a self-assessment return quarterly (Q4 0% compliance). 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.

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

Area of success / achievement / learning	Details	Further action
CSM and Staffing Level Tool Framework	Through 1:1 engagement and training 35% completion of the locally produced CSM reporting template	Operational Workforce Group to secure commitment and support to enable clinical leaders to engage with CSM, including completion of report.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
CSM and Staffing Level Tool Framework	The completion of staffing level tool runs for those areas listed in the HCSA during 2024/25 has been minimal despite dates identified and endorsed by the HCSA Programme Board (Duty 12IK).	Need to understand the barriers to staff engaging with the CSM and staffing level tool(s) run(s) in order to progress and embed into business as usual.
Policies / SOPs not in place	Robust organisational policies are required be put in place for facilitating and monitoring of the Common Staffing Method.	Ratify CSM and staffing level tool framework SOP; agree staffing level tool run dates for 2025/26 via the Operational Workforce Group.
Inclusion of HCSA Implementation / transition to BAU into Workforce and Planning Group(s)	Benchmarking across the Board is yet to be completed to assess the communication forums for all clinical leaders to discuss the duty laid out in 12IJ. Confirm workforce steering group(s) are aware of the requirements from this duty across services, inclusive of the requirement to follow the Common Staffing Process.	Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green
Act Capacity	With no more funding from Scottish Government to support the awareness raising and compliance of the Act, there will be reduced capacity to progress on our journey to, as a minimum, reasonable assurance.	Ensure all duties are built into induction and annual training programmes to ensure consistency and legacy for HCSA facilitator work. Use existing structures e.g. morning huddle to keep staff aware of their responsibilities etc.

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

Training and consultation of staff (12IL)

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff.	Amber	There is currently no clearly defined system and process in place and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff. Work is underway to ensure the clinical advisory structure is agile, robust and effective. A SOP specific to the Common Staffing Method (CSM) is in development, which will include the requirement for staff consultation/engagement in local staffing level tool runs (before, during and after), training utilising the HIS HSP learning resource(s), and is mandatory for all staff in scope. Staff are required to access HIS HSP learning resources and completion of TURAS resources is monitored. Registered Nurse Development Days commenced in March 2025 and will be held every 3rd Tuesday each month thereafter. The HCSA, including the Common Staffing Method is being incorporated into the programme. 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 and CSM training provided.
These systems and processes include means to encourage and support employees to give views on staffing arrangements for the types of health care described in section 12IK.	Amber	There is currently no clearly defined system and process in place and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff. Work is underway to ensure the clinical advisory structure is agile, robust and effective. 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 (35% completed; 65% outstanding).

		In addition, a 'Rostering' workshop, Oct 24, reference the CSM.
These systems and processes include means for considering and using views received to identify best practice and areas for improvement in relation to staffing arrangements.	Amber	There is currently no clearly defined system and process in place and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff. Work is underway to ensure the clinical advisory structure is agile, robust and effective. Staff involvement should be encouraged and evidenced via the locally produced CSM reporting template and included in local training. - Section 3: Quality Measures - 'comments by staff' - Section 4: Local Context - 'iMatter, employee experience' - Section 5: Staff Engagement and Feedback - Section 7: Decision making, Recommendations and Next Steps - How are staff consulted during this process, and how are staff informed during this process? Included in standardised reporting template and included in local training. 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. The internal governance pathway to feed outcomes into workforce plans and local management meetings is under discussion and once confirmed will be specified in the local CSM SOP.
These systems and processes include training employees (in particular those employees of a type mentioned in section 12IK) who use the common staffing method on how to use it.	Amber	There is currently no clearly defined system and process in place and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff. Work is underway to ensure the clinical advisory structure is agile, robust and effective. 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) for all staff in scope of the legislation.

		Registered Nurse Development Days commenced in March 2025 and will be held every 3rd Tuesday each month thereafter. The HCSA, including the Common Staffing Method is being incorporated into the programme. Staff are required to complete TURAS learning resources and this is monitored.
These systems and processes include ensuring that employees who use the common staffing method receive adequate time to use it.	Amber	There is currently no clearly defined system and process in place and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff. Work is underway to ensure the clinical advisory structure is agile, robust and effective. This should be assessed using the same methods as set out in 12IH - through using Optima Health Roster and SafeCare. Utilisation to date has been limited due to time to lead has not yet having been fully implemented.
These systems and processes include providing information to employees engaged in the types of health care mentioned in section 12IK about its use of the common staffing method, including the results from the staffing level tool and professional judgement tool; the steps taken under 12IJ(2)(b), (c) and (d) and the results of the decisions taken under 12IJ(2)(e).	Amber	There is currently no clearly defined system and process in place and utilised, in all the types of health care, locations and employees listed in section 12IK, for the training and consultation of staff. Work is underway to ensure the clinical advisory structure is agile, robust and effective. 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' (35% completed; 65% outstanding). This includes the Emergency Department staff running the Emergency Care Provision tool (nursing and medical staff).
There is a clearly defined mechanism for monitoring compliance with this duty and	Yellow	A quarterly update is provided to the Director of Nursing, Midwifery and AHPs / Chief Officer Acute and the Interim Deputy Director of Nursing / Lead Midwife

escalation of non-compliance (when this cannot be adequately met)		on a quarterly basis highlighting areas of good practice and concern. This has increased to monthly during Q4. This is incorporated into the quarterly internal compliance report that goes to Staff Governance Committee, and the Board Meeting. The Executive 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. All reporting lines are required to complete a self-assessment return quarterly (Q4 0% compliance).

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

Area of success / achievement / learning	Details	Further action
Path to green	Staff induction includes 'Introduction video: Knowledge and Skills Framework for Health and Care Staffing in Scotland'. Resources and training opportunities are available to all staff groups via HCSA facilitator (18.75 hrs). Registered Nurse Development Days commenced in March 2025 and will be held every 3rd Tuesday each month thereafter. Health and Care Staffing in Scotland is being incorporated into the programme.	Embed informed, skilled, enhanced and expert level into role specific training.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
Inclusion of HCSA Implementation into	Benchmarking across the Board is yet to be completed to assess the communication forums for clinical leaders to discuss	The Operational Workforce Group to review amber grading and implement an

Workforce and Planning Group(s)	the duty laid out in 12IL. Confirm workforce steering group(s) are aware of the requirements from this duty across services.	action plan to transition from amber > yellow > green underpinned by policy / SOP
Engagement / ownership by clinical leaders	Issues with capacity were identified across all staff groups, plus lack of engagement by clinical leaders.	Understand the barriers preventing senior clinical leaders for taking responsibility for embedding duty 12IL into BAU.
Inclusion of HCSA Implementation / transition to BAU into Workforce and Planning Group(s)	Benchmarking across the Board is yet to be completed to assess the communication forums for all clinical leaders to discuss the duty laid out in 12IL. Confirm workforce steering group(s) are aware of the requirements from this duty across services, inclusive of the requirement to follow the Common Staffing Process.	Operational Workforce Group to review amber grading and implement an action plan to transition from amber > yellow > green
Act Capacity	With no more funding from Scottish Government to support the awareness raising and compliance of the Act, there will be reduced capacity to progress on our journey to, as a minimum, reasonable assurance.	Ensure all duties are built into induction and annual training programmes to ensure consistency and legacy for HCSA facilitator work. Use existing structures e.g. morning huddle to keep staff aware of their responsibilities etc.
Advisory Committee (governance) Structure	Work is currently required to sure the clinical advisory structure is cognisant and actively engaged with embedding all aspects of the Act into business as usual.	Work is underway to ensure the clinical advisory structure is agile, robust and effective.

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

Planning and securing services.

Item	RAYG Status	Comment
Clearly defined systems and processes are in place, and utilised, in all NHS functions and professional groups to ensure that when the relevant organisation is planning or securing the provision of health care from a third party, it has regard to the guiding principles for health and care staffing and the need for that third party from whom the provision is being secured to have appropriate staffing arrangements in place.	Yellow	The guiding principles and appropriate staffing arrangements are considered when planning and securing services. The Procurement department will ensure that any new or refreshed service level agreements (SLA), contracts and Memorandum of Understanding (MoU) will include the relevant clause. The SLA cover sheet contains a prompt/checklist to ensure that the owner has considered the legislative requirements. In addition, the requirements of the Act, procurement of health care services from another provider within the Board looks at costs and other considerations such as service providers personnel clauses, scope of service, data protection, compliance with legal obligations etc whenever an SLA or other agreements are signed. Next steps are to convene a working group to focus on the requirements under the Act for contracted staff group(s).

Please provide information on the steps taken to comply with this Duty *These are steps taken to comply with this duty in general. Examples could include information about procurement and commissioning processes, how the guiding principles are considering and what procedures are in place for obtaining information about staffing arrangements.*
Commencing end of January 2025 a short life working group met to oversee the governance of SLA, contract and MoU.

Please provide information on how these systems and processes, and their application, have improved outcomes for service users *This should include but not be limited to data in relation to patient safety and quality of care measures and outcomes, patient feedback and adverse event reporting; what this data has shown and any trends; and any actions taken as a result.*

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

Area of success / achievement / learning	Details	Further action
Procurement engagement	Procurement colleagues engaged in the implementation of HCSA	Continue to develop and monitor
Awareness of this requirement within the Act	As part of general awareness raising, communication and training to support application of the Act, we are ensuring staff are aware of this duty, and how it applies to all contracts, agreements and arrangements. Meeting(s) held between HCSA facilitator and Procurement Manager; clinical professional leads.	To work with colleagues from Finance and Procurement 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.

Please provide details of areas of escalation where the relevant organisation has been unable to achieve or maintain compliance, or any challenges or risks associated with carrying out the requirements, and the actions in place to address these.

Area of escalation / challenge	Details	Further action
All professions	The need for formalised processes in order to demonstrate full compliance with this duty is acknowledged.	The Operational Workforce Group now has representation from all professional leads.
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.	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.	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.

Inclusion of HCSA Implementation / transition to BAU into Planning Group(s)	Benchmarking across the Board is yet to be completed to assess the communication forums for all clinical leaders to discuss this duty. Confirm workforce steering group(s) are aware of the requirements from this duty across services, inclusive of the requirement to follow the Common Staffing Process.	Operational Workforce Group to review yellow grading and implement an action plan to transition from yellow > green

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