HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – NHS Forth Valley ANNUAL REPORT April 2025-March 2026

Report approval

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

Name of organisation:	*NHS Forth Valley*
Report authorised by:	*Karen Goudie*
	Executive Nurse Director
	29/04/2026
Location where report is published:	*[hyperlink]*

GUIDANCE ON USING THIS TEMPLATE

Purpose

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

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

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

Summary Section

3. The summary asks for an overview of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act. You will be asked to provide an assurance level in respect of your overall compliance with the Act. Definitions for these assurance levels can be found at point seven.

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

Individual duties / requirements

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

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

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

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

8. The relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to complete this with an appropriate level of detail.

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

Summary

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

Please advise how the information provided in this report has been used or will be used to inform workforce plans.
Summary on how the information within this report has/or will inform future workforce plans/planning. Examples include - but not limited to: 1. Impacts and outcomes of real -time staffing assessment on workforce/workload planning 2. How the outputs of the Staffing Level Tools and the application of the CSM have informed you workforce planning activity. 3. Impact of the Health and Care Staffing Act has led to safe and efficient staffing.
The information provided in this report is central to shaping workforce plans in NHS Forth Valley. By systematically analysing data, engaging staff and service users, and embedding robust governance and risk management processes, NHS Forth Valley can make evidence-based decisions that improve both patient and staff outcomes. Ongoing challenges are being addressed through targeted actions, continuous improvement, and the phased implementation of new systems and processes. **1. Real-Time Staffing Assessment: Impact on Workforce and Workload Planning** **Evidence:** • The implementation of eRostering and Safecare systems has enabled real-time assessment of staffing levels, skill mix, and training requirements across inpatient and other areas. • Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified, discussed, and mitigated promptly. • These systems provide live data, allowing managers to reallocate staff, respond to surges in demand, and maintain safe staffing levels. **Impact:** • Real-time staffing data has improved the ability to respond to risks and staffing challenges, leading to safer and more efficient deployment of staff.

- The visibility of staffing gaps and risks has enabled proactive workforce planning, reduced reliance on agency staff, and improved continuity of care.

Workforce Planning Outcome:

- Workforce plans will now incorporate dynamic, real-time data, allowing for more responsive and flexible staffing models.
- The information is used to identify trends, forecast future needs, and inform recruitment and retention strategies.

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2. **Outputs of Staffing Level Tools and Application of the Common Staffing Method (CSM)**

Evidence:

- Annual staffing level tool runs and establishment blueprints for inpatient areas ensure staffing decisions are based on patient needs, local context, and clinical advice.
- The CSM triangulates data from staffing level tools, professional judgement, and quality measures, providing a robust framework for workforce planning.

Impact:

- Outputs from these tools have identified areas where staffing establishments needed to be changed, such as increasing Healthcare Support Worker provision or redesigning services in response to patient feedback and quality data.
- The CSM has supported service reviews and redesigns, ensuring that workforce plans are evidence-based and aligned with the guiding principles of safe, high-quality, and person-centred care.

Workforce Planning Outcome:

- Workforce plans will now be informed by objective, validated tools and frameworks, leading to more accurate establishment setting and resource allocation.
- The process has highlighted the need for targeted recruitment, over-recruitment of newly qualified nurses, and development pathways for healthcare support workers.

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3. **Impact of the Health and Care Staffing Act on Safe and Efficient Staffing**

Evidence:

- Compliance with the Act has led to ongoing improvement in patient safety, quality of care, patient flow, and staff wellbeing.
- Enhanced monitoring and reporting systems, active engagement with staff and service users, robust adverse event reporting, and a culture of continuous improvement and transparency have all contributed to safer staffing.

Impact:

- The Act has driven the rollout of new systems and processes, such as eRostering and Safecare, which have improved the ability to identify and address staffing risks in real time.
- Staff and service user feedback mechanisms have led to service redesigns and targeted improvements, such as new clinics and improved continuity of care.

Workforce Planning Outcome:

- Workforce plans now prioritise safe and efficient staffing, with a focus on continuous improvement, staff wellbeing, and patient-centred care.
- The information from the reports will be used to shape strategic and operational workforce plans, ensuring ongoing compliance with statutory duties and underpinning transparent governance.

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

As set out in the legislation, compliance with the Act should support the outcomes from the Health and Care Standards. Therefore, you should demonstrate/consider how implementation of the Act contributes to achieving these Standards

This should include - but not be limited to - information in relation to patient safety and quality of care measures and outcomes, patient feedback, staff wellbeing measures, and adverse event reporting; what this information has shown and any trends; and any actions taken as a result.

NHS Forth Valley's compliance with the Health and Care Staffing Act has led to measurable improvements in patient safety, quality of care, patient and staff experience, and organisational learning. These improvements are evidenced by enhanced monitoring and reporting systems, active engagement with staff and service users, robust adverse event reporting, and a culture of continuous improvement and transparency.

How Compliance with the Health and Care Staffing Act Has Improved Outcomes;

1. Patient Safety and Quality of Care

- **Real-Time Staffing and Risk Management:**
  The introduction of eRostering and Safecare systems across inpatient and other areas has enabled real-time staffing assessments, supporting safe staffing decisions and rapid response to risks. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified, discussed, and mitigated promptly. These systems have led to improved patient safety, reduced incidents of unsafe staffing, and better continuity of care.
- **Quality Improvement Initiatives:**
  Regular analysis of quality standards and safety outcome data has led to targeted quality improvement initiatives. For example, care assurance audits and clinical governance groups in Nursing have improved the robustness of performance monitoring and safe staffing processes. Pharmacy and Laboratory services have achieved or are working towards external accreditations (e.g., ISO 9001:2025, ISO 15189), demonstrating a commitment to quality and continuous improvement.

2. Patient Feedback and Experience

- **Systematic Collection and Use of Feedback:**
  Patient feedback is systematically collected through questionnaires, focus groups, and Care Opinion. For example, in Prison Healthcare, patient forums and questionnaires have been used to gather feedback on care delivery, leading to service improvements. In Maternity, the relaunch of the Maternity Voices Partnership and the introduction of new clinics have led to improved antenatal and postpartum continuity and increased spontaneous vaginal birth rates.
- **Transparency and Communication:**
  Open communication and transparency regarding staffing decisions have fostered trust and collaboration among staff and service users. Actions taken in response to feedback are shared through governance structures, ensuring that service users see tangible changes.

3. Staff Wellbeing Measures

- **Staff Engagement and Wellbeing Initiatives:**
  Regular collection and review of staff feedback through mechanisms such as wellbeing huddles, whistleblowing services, and annual

surveys (e.g., iMatter) have provided valuable insights into staff experience and organisational culture. These insights have informed targeted actions to improve engagement, satisfaction, and performance. Staff wellbeing is prioritised through dedicated support services, wellbeing huddles, and action plans developed from survey results.

- **Protected Learning and Development:**
  Comprehensive training and leadership development programmes, as well as introducing protected learning time, support ongoing staff development and capability building. Staff are given opportunities for professional growth, which has contributed to improved morale and retention.

4. Adverse Event Reporting and Trends

- **Robust Reporting Systems:**
  Adverse events, complaints, and compliments are systematically reported and reviewed at all levels of clinical governance. The use of systems like Safeguard ensures that incidents are captured, analysed, and used for learning. For example, Mental Health and Learning Disabilities services have established adverse event groups and community incident reviews to promote shared learning.
- **Learning from Events:**
  Action plans are developed in response to adverse events and complaints, with learning shared across teams to prevent recurrence and improve care quality. Trends show increased responsiveness to risks, better patient outcomes, and a more resilient and engaged workforce.

What the Information Has Shown and Actions Taken

- **Trends Identified:**
  Increased use of real-time staffing resources has led to earlier identification and mitigation of staffing risks. Patient feedback mechanisms have resulted in service redesigns and targeted improvements, such as new clinics and improved continuity of care. Staff wellbeing initiatives have improved engagement and reduced turnover in key areas. Adverse event reporting has become more robust, with clear escalation and learning processes in place.

- **Actions Taken:**
  Continued rollout of eRostering and Safecare to all areas, using learning from early adopters to support implementation and training. Targeted recruitment campaigns and over-recruitment of newly qualified nurses to address staffing gaps. Development of safety dashboards and balanced scorecards to enhance visibility and communication of staffing actions and feedback. Ongoing review and refinement of escalation and risk recording processes to ensure consistency and effectiveness. Implementation of protected learning time and comprehensive training programmes to support staff development.

Alignment with Health and Care Standards

Compliance with the Health and Care Staffing Act has directly supported the outcomes set out in the Health and Care Standards by:

- Ensuring safe, high-quality, and person-centred care through robust staffing systems and continuous improvement.
- Promoting transparency, engagement, and responsiveness to both staff and service user feedback.
- Embedding a culture of learning from adverse events and sharing best practice across teams.
- Supporting staff wellbeing and professional development as a core component of service delivery.

Health and Care Staffing Act Health Board Duty Compliance Assurance Levels

Please complete the table below with your Health Boards compliance assurance level for each duty.

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

Duty 12IA: Duty to ensure appropriate staffing

Duty Description	**2 Guiding principles etc. in health care staffing and planning** (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. **Duty 12IA: Duty to ensure appropriate staffing.** (**1) It is the duty of every Health Board and the Agency to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate** for— (a) the health, wellbeing, and safety of patients, (b) the provision of safe and high-quality health care, and (c) in so far as it affects either of those matters, the wellbeing of staff. (**2) In determining what, in a particular kind of health care provision, constitutes appropriate numbers for the purposes of subsection (1), regard is to be had to—** (a) the nature of the particular kind of health care provision, (b) the local context in which it is being provided, (c) the number of patients being provided it, (d) the needs of patients being provided it, and (e) appropriate clinical advice.
Please provide information on the steps taken to comply with Duty 12IA.	
Please provide information to demonstrate compliance. Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.	

NHS Forth Valley has implemented a range of systems and processes to ensure compliance with Duty 12IA, ensuring that suitably qualified and competent staff from a range of professional disciplines are always available in appropriate numbers to safeguard patient health, wellbeing, and safety, and to support staff wellbeing.

Systems and Processes in Place

NHS Forth Valley has implemented a comprehensive framework to meet these requirements:

- **Workforce Planning and Blueprinting:** Annual staffing level tool runs and establishment blueprints for inpatient areas ensure staffing decisions are based on patient needs, local context, and clinical advice. Service reviews and redesigns are ongoing to adapt to changing requirements across all departments.
- **Real-Time Staffing Assessment:** The introduction of eRostering and Safecare systems enables real-time assessment and allocation of staff, supporting safe and high-quality care. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified and mitigated promptly. The use of the OPEL Tool for multisystem assurance is in place.
- **Recruitment and Retention Initiatives:** Targeted recruitment campaigns, over-recruitment of newly qualified nurses, and development pathways for healthcare support workers have been implemented to address staffing gaps and ensure a sustainable workforce.
- **Clinical Advice and Professional Judgement:** Staffing decisions are informed by appropriate clinical advice and professional judgement tools, with escalation processes in place for unresolved risks or disagreements.
- **Staff and Service User Engagement:** Regular collection and review of staff and service user feedback, including annual surveys and focus groups, inform workforce planning and service improvement, ensuring that decisions are person-centred and responsive to local needs.
- **Governance and Assurance:** Clinical governance structures, regular audits, and reporting frameworks ensure oversight and continuous improvement. Risks and non-compliance are identified, escalated, and addressed through established governance routes.

These systems and processes collectively ensure that NHS Forth Valley meets the requirements of Duty 12IA by maintaining appropriate staffing levels, supporting patient safety and quality of care, and promoting staff wellbeing, while remaining responsive to local context and clinical advice. Ongoing monitoring and improvement activities are in place to address any areas of risk or non-compliance.

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

Compliance with Duty 12IA is monitored through a comprehensive approach that includes annual staffing level tool runs, establishment blueprinting, and the use of real-time staffing systems such as OPEL Tool and Safecare, which provide live data on staffing levels and skill mix. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified and addressed promptly. Regular audits, care assurance visits, and clinical governance meetings review compliance and performance, while systematic collection of staff and service user feedback informs ongoing improvement. Incidents and adverse events are reported and analysed using Safecare and Safeguard, with action plans developed in response. Recruitment, retention, and training compliance are also tracked, and risks or non-compliance are escalated through established governance frameworks.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
eRostering and Safecare Implementation (All inpatient areas, progressing to AHP and Medical teams)	The introduction of eRostering and Safecare has enabled real-time assessment and allocation of staff, supporting safer staffing decisions and prompt risk mitigation. Twice-daily safety huddles and structured escalation processes ensure that staffing risks are identified and addressed quickly.	Continue the rollout of eRostering and Safecare to all areas, using learning from early adopters to support implementation and training.
Workforce Planning and Blueprinting	Annual staffing level tool runs and establishment blueprints for inpatient areas ensure staffing decisions are based on patient needs, local context, and clinical advice. Service reviews and redesigns are ongoing to adapt to changing requirements. The medical rota template allows for easy highlighting of gaps, and easy identification of risk that needs mitigated. Where no easy solutions are found immediate escalation up to clinical management structures is immediate either through clinical rota lead or AMD for UUC.	Refine workforce planning processes and monitor the impact of recruitment and retention strategies. Complete blueprint sign-off for all relevant services. Medical teams are collating absence reporting and improvement of structures, as well as a better system to report cross cover or shift alteration requirements.

Recruitment and Retention Initiatives (Nursing, Allied Health Professions, Prison Healthcare)	Targeted recruitment campaigns, over-recruitment of newly qualified nurses, and development pathways for healthcare support workers have addressed staffing gaps and improved workforce resilience.	Continue to evaluate and adapt recruitment and retention initiatives and share best practice across teams.
Clinical Advice and Professional Judgement (All clinical areas)	Staffing decisions are informed by clinical advice and professional judgement tools, with escalation processes in place for unresolved risks or disagreements.	Further embed the use of professional judgement tools and ensure consistent escalation and documentation of staffing risks.
Staff and Service User Engagement (All services)	Regular collection and review of staff and service user feedback (e.g., iMatter surveys, focus groups) inform workforce planning and service improvement, ensuring decisions are person-centred and responsive to local needs.	Further develop feedback mechanisms and ensure learning is systematically used to inform service improvement.
FV has been stepped down from interim reviews by the deanery (Medical).	Despite acute site pressures the medical education teams have successfully provided significant assurance in an ongoing nature to demonstrate improved wellbeing and culture amongst the trainee workforce.	Ongoing work and collaboration with stakeholders,

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
Variability in System Implementation	Inconsistent adoption and robustness of eRostering and Safecare across services; some areas still transitioning.	Continue phased rollout; use learning from early adopters; interim manual processes in place where needed.
Staffing Gaps and Recruitment Challenges	Persistent vacancies and recruitment delays, especially in specialist areas (e.g., midwifery, mental health).	Targeted recruitment campaigns; over-recruitment; workforce reviews and redesigns; regular monitoring. Good staff governance.
Training Compliance and Protected Time	Challenges ensuring all staff complete mandatory training and have protected learning time.	Ongoing monitoring via TURAS/Pentana; action plans for gaps; promote and track protected learning time. OD will oversee this work.
Escalation and Risk Recording	Variability in how risks are escalated and recorded; need for standardisation across services.	Review and update SOPs; provide training; regular review at clinical/staff governance meetings; escalate as required.

Visibility of Safe Staffing Actions	Need to make safe staffing actions more visible to staff, patients and service users; feedback not always consistently shared.	Develop safety dashboards and balanced scorecards; enhance communication of staffing actions and feedback.
Integration of New Tools and Processes	Ongoing transition to new staffing tools/processes (e.g., national midwifery workforce tool); full benefits not yet realised.	Engage with national groups; local testing and feedback; phased implementation plans for successful integration and transition into Safecare.
Medical Staff Rota Monitoring	Rotas across the site for resident grade doctors have been deemed to be non-compliant with residents demonstrating on report that they were unable to take breaks at the requisite times. This is a national issue. Significant financial risk, approximately £2 million for 25/26.	Natural Break Enabling Group established, working with Senior Leadership team and Union representative as well as the resident groups Contract redesign for Resident Doctors is imperative as an ultimate outcome.
Medical Workforce Planning (Drs)	Over reliance on locum staff groups to deliver medical care.	Expansion and integration of non-medical staff to complement medical teams as part of future workforce planning. However, the need for senior decision makers remains. Reduce medical footprint by removing patients from the system that do not require acute site hospital treatment. National issue, ongoing work with DWD workstreams. Realignment of existing budgets to compensate for locum usage, as a recognition of under resourced teams.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the real-time assessment of its compliance with the duty imposed by section 12IA.** **(2) The arrangements under subsection (1) must, in particular, include—** (a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to—

	(i) the health, wellbeing, and safety of patients, (ii) the provision of safe and high-quality health care, or (iii) in so far as it affects either of those matters, the wellbeing of staff, (b) a procedure for the notification of any such risk to an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, (c) a procedure for the mitigation of any such risks, so far as possible, by such an individual, and a requirement for that individual to seek and have regard to appropriate clinical advice, as necessary, in carrying out such mitigation, (d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c), (e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b), (f) training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (e), and (g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

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

Please provide information to demonstrate compliance.

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

1. Arrangements for Real-Time Assessment

- **eRostering and Safecare:**
  NHS Forth Valley has implemented eRostering and Safecare systems across nursing teams, with phased roll-out to AHP and medical teams still ongoing. These digital tools provide live analysis of staffing data, enabling real-time identification of risks and compliance with safe staffing requirements.
- **Regular Huddles:**
  Inpatient nursing and other teams conduct twice daily (and once at night) huddles to review staffing levels, risks, and required mitigations. This ensures immediate identification and response to staffing issues. Medical-specific real-time review post-safety huddle, including risks from boarding, locum-run borders teams, and consultant capacity gaps.
- **Manual and Interim Processes:**
  Where eRostering/Safecare is not yet implemented, interim manual processes (e.g., spreadsheets, daily meetings) are in place to ensure real-time assessment continues.

2. Procedures for Identification, Notification, and Mitigation of Risks

a) Identification of Risks

- **Staff Empowerment:**
  Any staff member can identify risks related to staffing levels that may affect patient health, safety, or staff wellbeing.
- **Digital and Manual Reporting:**
  Risks are identified through Safecare, eRostering, incident reporting systems (e.g., Safeguard/IR1), and during daily huddles.

b) Notification of Risks

- **Clear Escalation Pathways:**
  Risks are notified to the individual with lead professional responsibility (clinical or non-clinical) in the relevant area, via Safecare, eRostering, or direct communication during huddles or as they arise throughout the day/night.
- **Standing Operating Procedures (SOPs):**
  SOPs are in place to ensure staff know how and to whom to escalate risks.

c) Mitigation of Risks

- **Immediate Action:**
  The responsible individual is required to mitigate risks as far as possible, seeking and considering appropriate clinical advice as necessary.
- **Escalation Processes:**
  If risks cannot be fully mitigated at the local level, they are escalated to senior management or Board level for further action.

3. Raising Awareness and Enabling Use of Procedures

d) Raising Awareness

- **Training and Communication:**
  Staff are made aware of procedures through induction, ongoing training, and regular communication (e.g., at huddles, team meetings, and via digital platforms).

- **Accessible SOPs:**
  Procedures are documented and accessible to all staff.

e) Encouraging and Enabling Use

- **Supportive Culture:**
  Staff are encouraged and enabled to use risk identification and escalation procedures, with a culture of openness and transparency promoted throughout the organisation.
- **Feedback Mechanisms:**
  Staff feedback is sought and used to improve processes.

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4. Training and Resources for Lead Professionals

f) Training for Lead Professionals

- **Targeted Training:**
  Individuals with lead professional responsibility receive specific training on implementing real-time staffing assessment arrangements, including use of Safecare, eRostering, and risk escalation.
- **Ongoing Development:**
  Training is refreshed regularly and updated as systems evolve.

g) Adequate Time and Resources

- **Protected Time:**
  Lead professionals (e.g., Senior Charge Nurses/Midwives, Team Leaders, Lead ANPs) are allocated protected time within their job plans to fulfil their responsibilities under this duty.
- **Resource Allocation:**
  Adequate resources (IT, administrative support, access to data) are provided to ensure effective implementation.

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5. Examples of Compliance in Practice

- **Inpatient Nursing:**
  Reviewed twice daily and once at night using Safecare; risks discussed and actioned at site huddles. RAG status shared at huddles and emailed to senior teams. SOPs describe escalation processes, including out-of-hours escalation to on-call nurse managers.
- **Prison Healthcare:**
  SOPs and risk escalation plans tailored to service delivery, shared with all staff. Twice daily huddles, use of Safeguard and Pentana for risk recording and escalation. Training on Turas for all staff.
- **Advanced Practice:**
  Lead ANP clinical governance group meets to ensure consistency in reporting and escalation. All Advanced Practice services have processes for reporting, monitoring, and improvement plans. Work continues to finalise mitigation plans and improve feedback logistics.
- **Women & Children, Maternity, Allied Health Professions, Pharmacy, and Others:**
  All have local arrangements for real-time staffing assessment, risk escalation, and mitigation, with ongoing roll-out of digital tools and training.

6. Continuous Improvement and Monitoring

- **Audit and Review:**
  Data from Safecare, eRostering, and incident reporting will be regularly reviewed at governance meetings. Severe and recurring risks will be recorded on risk registers and reviewed for further action.
- **Training Materials:**
  Training materials and sessions are provided for all systems as they are rolled out, ensuring staff are equipped to use them effectively.

In summary:
NHS Forth Valley has robust, multi-layered systems and processes in place to ensure real-time staffing assessment, risk identification and escalation, and mitigation, fully aligned with Duty 12IC. These arrangements are regularly reviewed and improved based on staff feedback, audit findings, and evolving best practice.

Please provide Information on your methods of monitoring compliance with Duty 12IC
This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

NHS Forth Valley uses a combination of digital tools, regular team huddles, incident reporting, governance structures, and ongoing training to monitor compliance with Duty 12IC. Clear escalation pathways and robust audit processes ensure that any areas of non-compliance are addressed promptly and effectively.

1. Digital Systems for Real-Time Monitoring

- **eRostering and Safecare:**
  These digital platforms are the primary tools for real-time monitoring of staffing levels. They provide live data on staffing, highlight gaps, and flag risks. Roll-out is complete for nursing and ongoing for AHP and medical teams.
- **Manual/Interim Processes:**
  Where digital tools are not yet implemented, manual systems (e.g., spreadsheets, daily huddles) are used to ensure real-time assessment continues. Bi-weekly medical rota risk meetings with escalation to AMD/UUC and Medical Director. Oversight of severe/recurrent risks through the Medical Workforce Governance Group and cross-system DWD (Discharge Without Delay) collaborations.

2. Local Arrangements for Ongoing Monitoring

- **Twice Daily Huddles:**
  Inpatient and other clinical teams hold regular huddles (often twice daily) to review staffing, discuss risks, and agree on mitigations. These meetings ensure immediate identification and escalation of issues.
- **Incident Reporting:**
  Staff are encouraged to report staffing-related risks or incidents using systems like Safeguard (IR1). These reports are reviewed for trends and compliance issues.

3. Escalation and Addressing Non-Compliance

- **Clear Escalation Pathways:**
  If a staffing risk is identified, it is escalated to the individual with lead professional responsibility (e.g., Senior Charge Nurse, Team Leader, Lead ANP). If unresolved, it is further escalated to senior management or Board level.
- **Standing Operating Procedures (SOPs):**
  SOPs outline the steps for identifying, escalating, and mitigating risks. These are accessible to all staff and regularly reviewed.

- **Risk Registers:**
  Severe or recurring risks are recorded on risk registers and reviewed at governance meetings for further action.

4. Governance and Audit

- **Governance Groups:**
  Workforce Governance Groups, Programme Boards, and Senior Leadership Teams regularly review compliance data, audit findings, and risk registers.
- **Audit and Review:**
  Data from eRostering, Safecare, and incident reporting is audited to ensure procedures are followed and to identify any areas of non-compliance.

5. Training and Awareness

- **Staff Training:**
  All staff receive training on the use of real-time staffing tools and escalation procedures. Lead professionals receive additional training and have protected time to fulfil their responsibilities.
- **Feedback Mechanisms:**
  Staff are encouraged to provide feedback on processes, and this is used to improve compliance monitoring.

Mechanisms for Escalating and Addressing Non-Compliance

- **Immediate Escalation:**
  Any non-compliance or unresolved risk is escalated through the management structure, up to Board level if necessary.
- **Support and Intervention:**
  Support is provided to teams or individuals struggling with compliance (e.g., additional training, resource allocation, or temporary staffing solutions).
- **Continuous Improvement:**
  Lessons learned from audits, incidents, and feedback are used to update SOPs, training, and digital tools.

Area of success / achievement / learning	Details	Further action
Implementation of eRostering and Safecare	Nursing, AHP, and Pharmacy teams have successfully implemented eRostering and Safecare, enabling live analysis of staffing data and real-time information on staffing levels. This has improved the ability to identify and respond to staffing risks promptly.	Continue phased rollout to all services, provide ongoing training, and use learning from early adopters to support wider implementation.
Twice-Daily Safety Huddles	Inpatient nursing and prison healthcare teams conduct twice-daily safety huddles, allowing staff to discuss staffing positions and clinical demand, ensuring safe staffing and rapid escalation of risks.	Maintain and expand the use of safety huddles and share best practice across other departments.
Structured Escalation Processes	Clear escalation routes and standard operating procedures are in place for managing staffing risks, with processes reviewed and updated regularly. Staff are encouraged to report risks using systems like Safeguard and IR1.	Continue to review and standardise escalation processes, and ensure all staff are trained and confident in their use.
Use of Data Dashboards and Reporting	Development of safety dashboards and balanced scorecards is underway, providing visibility of staffing levels, skill mix, and training requirements for governance and performance monitoring.	Complete rollout of dashboards, ensure data is used for continuous improvement, and communicate findings to staff and service users.
Learning from Adverse Events	Robust adverse event reporting and learning systems ensure incidents are captured, analysed, and used for improvement, with action plans developed and shared across teams.	Continue to strengthen adverse event reporting and embed learning in practice across all services.
Medical Specific	Introduction of a central medical clinical rota lead providing oversight of resident doctor staffing. New escalation structure requiring senior clinical sign-off for additionality. Establishment of the Medical Workforce Oversight Group with strong data-driven governance.	Transition onto Safcecare once eRostering implementation has concluded.

Area of escalation / Challenge / Risk	Details	Further action
Variability in system implementation	Inconsistent adoption and robustness of real-time staffing tools (eRostering, Safecare) across services; some areas still rely on manual processes.	Continue phased rollout of digital tools, provide targeted training and support, maintain interim manual processes where needed.
Standardisation of escalation and risk recording	Variability in how risks are escalated and recorded, leading to inconsistencies in risk management.	Review and update standard operating procedures, deliver training, and use clinical governance meetings for oversight.
Staff training and confidence in new systems	Not all staff are fully trained or confident in using new digital staffing systems.	Ongoing training and support for staff, with regular refreshers and practical guidance.
Data collection and risk management	Inconsistencies in data collection due to partial system implementation.	Interim manual processes in place; full digital integration planned as rollout progresses.
Medical Specific	Software limitations of eRoster for consultant and SAS working patterns. Variability in SafeCare implementation. Persistent consultant shortages leading to recurrent risk escalations.	Work through the issue with eRoster and Safecare. Need to improve notification processes for all staff involved in risk decisions.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

Duty Summary	**(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the escalation of any risk.** (a) identified during the real-time assessment of its staffing levels in accordance with arrangements put in place under section 12IC, and (b)which it has not been possible to mitigate in accordance with the arrangements put in place under that section. **(2) The arrangements under subsection (1) of this duty must include:**

a) A procedure for the initial reporting of a risk as described in subsection (1), by an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, to a more senior decision-maker,
b) A requirement for any such decision-maker to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it,
c) A procedure for the onward reporting of the risk, as necessary, to a more senior decision-maker in turn, and a requirement for that decision-maker in turn to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it,
d) A requirement for the arrangements put in place under paragraph (c) to escalate further in order to reach a final decision on the risk, including in appropriate cases by the reporting of the risk to the members of the Health Board.
e) A procedure for the notification of every decision made following the initial report, and the reasons for it, to:
    (i)any individual who was involved in identifying the risk in accordance with the arrangements put in place under section 12IC(2)(a),
    (ii)any individual who was involved in attempting to mitigate the risk in accordance with the arrangements put in place under section 12IC(2)(c),
    (iii)any individual who was involved in reporting the risk in accordance with the arrangements put in place under paragraph (a), (c) or (d) of this subsection, and
    (iv)any individual who gave clinical advice in accordance with the arrangements put in place under section 12IC(2)(c), or under paragraph (b), (c) or (d) of this subsection,
f) A procedure for those individuals to record any disagreement with any decision made following the initial report,
g) A procedure for those individuals to be able to request a review of the final decision on a risk (other than a final decision made by the members of the Health Board or the Agency) made in accordance with the arrangements put in place under section 12IC(2)(c) or, as the case may be, paragraphs (b), (c) or (d) of this subsection,
h) Raising awareness among staff about the procedures described in paragraphs (a) to (f),
i) Training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of healthcare, and other senior decision-makers, in how to implement the arrangements put in place under paragraphs (a) to (h), and
j) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

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

Please provide information to demonstrate compliance.

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

1. Arrangements for Escalation of Unmitigated Staffing Risks

- **Escalation Pathways:**
  NHS Forth Valley has clear, structured escalation pathways for risks identified during real-time staffing assessment (via eRostering, Safecare, or manual processes) that cannot be mitigated at the local level.
- Medical-specific escalation through rota leads to AMD/UUC and Director of Medical Workforce.

2. Detailed Compliance with Each Requirement

a) Initial Reporting of Risk

- **Process:**
  When a risk is identified and cannot be mitigated locally, the individual with lead professional responsibility (e.g., Senior Charge Nurse, Team Leader, Lead ANP) reports the risk to a more senior decision-maker (e.g., Service Manager, Chief Nurse).
- **Documentation:**
  This is recorded in Safecare, eRostering, or via incident reporting systems (e.g., Safeguard). Red flags can also be raised via Safecare and must be addressed by senior review and escalated as required.

b) Clinical Advice Requirement

- **Process:**
  Senior decision-makers are required to seek and have regard to appropriate clinical advice when deciding how to address the risk. This may involve consulting with clinical leads, on-call managers, or specialist advisors.
- **Evidence:**
  The process is documented in SOPs and reflected in governance meeting minutes.

c) Onward Reporting and Further Escalation

- **Process:**
  If the risk remains unresolved, it is escalated to the next senior level (e.g., Director of Nursing/Midwifery, Executive/Board). Each escalation step requires the decision-maker to seek clinical advice.
- **Governance:**
  Risks may be added to the risk register and reviewed at Workforce Governance Groups or Board meetings.

d) Final Escalation to Board

- **Process:**
  If a risk cannot be resolved at the executive level, it is escalated to the Health Board for a final decision. This ensures the highest level of oversight for unresolved or severe risks.

e) Notification of Decisions

- **Process:**
  All individuals involved in identifying, mitigating, reporting, or advising on the risk are notified of decisions made at each stage, including the rationale.
- **Mechanism:**
  Notifications are provided via Safecare, email, or meeting minutes.

f) Recording Disagreement

- **Process:**
  Individuals can record disagreement with any decision made following the initial report.
- **Mechanism:**
  Safecare and incident reporting systems allow for the documentation of dissent or alternative views.

g) Requesting Review of Decisions

- **Process:**
  Individuals may request a review of the final decision (unless made by the Board). Feedback and appeal process in place.
- **Mechanism:**
  Requests are submitted through established governance channels.

h) Raising Awareness

- **Process:**
  Staff are made aware of escalation procedures through induction, ongoing training, SOPs, and regular communication (e.g., huddles, team meetings).

i) Training for Leads and Decision-Makers

- **Process:**
  Individuals with lead professional responsibility and senior decision-makers receive training on escalation procedures, use of Safecare/eRostering, and risk management.
- **Ongoing Development:**
  Training is refreshed regularly and updated as systems evolve.

j) Time and Resources

- **Process:**
  Lead professionals and decision-makers are allocated protected time and resources (IT, admin support) to fulfil their escalation responsibilities.

Examples of Local Arrangements and Escalation in Practice

- **Inpatient Nursing:**
  Twice daily huddles review staffing risks. Unresolved risks are escalated from the ward to site management, then to the executive team, and if necessary, to the Board. All steps are documented and communicated.
- **Prison Healthcare:**
  SOPs and risk escalation plans are tailored to the service. Risks are discussed at daily huddles, escalated to senior managers, and recorded in Safeguard/Pentana. All staff are trained on these processes.
- **Advanced Practice:**
  Lead ANP governance meetings ensure consistency in escalation. Risks are escalated through clinical and operational lines, with documentation and feedback at each stage.

In summary:
NHS Forth Valley has robust, multi-layered systems and processes in place to ensure effective risk escalation for staffing issues, fully aligned with Duty 12ID. These arrangements are regularly reviewed and improved based on staff feedback, audit findings, and evolving best practice.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital and Manual Monitoring Systems

- **eRostering and Safecare:**
  These systems are used to record, track, and escalate staffing risks in real time. They provide an auditable trail of risk identification, escalation steps, and outcomes.
- **Incident Reporting (Safeguard/IR1):**
  All staffing-related risks and escalation actions can be logged in the incident reporting system, which is regularly reviewed for trends and compliance.

2. Local Arrangements for Ongoing Monitoring

- **Twice Daily Huddles:**
  Clinical teams hold regular huddles to review staffing risks, discuss escalation actions, and ensure all issues are being addressed according to protocol.
- **Standing Operating Procedures (SOPs):**
  SOPs outline the escalation process, including who is responsible at each stage and how to document actions taken.

3. Escalation and Addressing Non-Compliance

- **Clear Escalation Pathways:**
  If a risk cannot be mitigated locally, it is escalated to the next senior decision-maker, with further escalation up to Board level if necessary. Each step is documented in Safecare or the incident reporting system.

- **Risk Registers:**
  Severe or recurring risks are added to risk registers and reviewed at governance meetings.
- **Notification and Feedback:**
  All individuals involved in the risk process are notified of decisions and can record disagreement or request a review, ensuring transparency and accountability.

4. Governance and Audit

- **Workforce Governance Groups & Programme Boards:**
  These groups regularly review escalation data, audit compliance with escalation procedures, and ensure that unresolved risks are addressed.
- **Audit and Review:**
  Regular audits of Safecare, eRostering, and incident reporting data are conducted to ensure that escalation procedures are being followed and to identify any areas of non-compliance.

5. Training and Awareness

- **Staff Training:**
  All staff, especially those with lead professional responsibility, receive training on escalation procedures and the use of digital tools.
- **Ongoing Communication:**
  Procedures are reinforced through induction, ongoing training, and regular communication at team meetings and huddles.

Mechanisms for Escalating and Addressing Non-Compliance

- **Immediate Escalation:**
  Any non-compliance or unresolved risk is escalated through the management structure, up to Board level if necessary.
- **Support and Intervention:**
  Additional training, resource allocation, or process review is provided to teams or individuals struggling with compliance.
- **Continuous Improvement:**
  Lessons learned from audits, incidents, and feedback are used to update SOPs, training, and escalation pathways.

In summary:
NHS Forth Valley uses a combination of digital tools, regular team huddles, incident reporting, governance structures, and ongoing training to monitor compliance with Duty 12ID. Clear escalation pathways and robust audit processes ensure that any areas of non-compliance are addressed promptly and effectively.

Area of success / achievement / learning	Details	Further action
Clear Escalation Pathways in Nursing (Falkirk, Clacks & Stirling HSCP, Acute Services)	Senior decision-makers and escalation chains have been clearly identified and communicated to all staff. Staff are now much more aware of who to contact during any shift if a risk needs to be escalated. Twice daily and nightly reviews using SafeCare, with RAGG status shared at huddles and by email, ensure risks are visible and acted upon.	The procedures for identifying and communicating escalation chains are being embedded in other clinical areas and will be standardised as eRoster and SafeCare are rolled out further.
Tailored SOPs and Risk Escalation in Prison Healthcare	SOPs and risk escalation plans have been developed and tailored to the specific needs of prison healthcare. These have been shared with all staff, ensuring everyone understands their role in risk assessment and escalation. Staff demonstrate awareness and compliance in daily discussions and huddles.	The approach to developing tailored SOPs is being used as a model for other specialist services. Ongoing review and adaptation will ensure continued relevance and effectiveness.
Red Flag System and Staff Voice (Acute Services)	The introduction of the red flag system in SafeCare allows staff to raise concerns, record disagreements, and escalate wellbeing issues. This has improved transparency and responsiveness to staffing risks.	The red flag system is being rolled out to additional areas as SafeCare implementation expands. Data from red flags will be used to identify trends and inform workforce planning.
Interim Escalation Tools in Psychology	While transitioning to e-rostering, Psychology services have used interim spreadsheets and existing supervision structures to ensure risks are escalated and reviewed. Disagreements are recorded via minutes in governance forums, ensuring transparency.	Lessons from the interim approach are informing the transition to digital tools and will help standardise escalation and review processes across all services.

Real-Time Staffing and Escalation Cards in Maternity	Real-time staffing assessments and escalation cards are used to inform huddles and ensure timely escalation. Professional on-call arrangements provide clinical advice out of hours.	The escalation card approach is being refined based on staff feedback and will be updated and shared across other directorates.

Area of escalation / Challenge / Risk	Details	Further action
Variation in Escalation Process Robustness (Nursing, Acute Services, Medicine and HSCPs)	There is variability in how robustly escalation processes are applied across different wards/units and services. Some areas have well-established SOPs and use Safecare/eRoster, while others are still developing or embedding these processes.	Ongoing rollout of Safecare and eRoster to all areas. Continued training and standardisation of escalation SOPs. Development of safety dashboards and balanced scorecards to monitor compliance and highlight gaps.
Incomplete Mitigation Plans (Acute Services, Advanced Practice)	Some specialties and advanced practice teams have not yet finalised mitigation plans for reporting red status (unmitigated risks). Reporting is sometimes done via Microsoft Forms, which is not always completed robustly.	Teams are working to finalise and embed mitigation plans. There is a focus on improving the logistics of daily staffing mitigations and ensuring consistent recording of disagreements and actions.
Challenges with SafeCare Implementation (Maternity, Advanced Practice, AHP, HCS)	Safecare and eRoster are not yet fully implemented in all areas, particularly in maternity, advanced practice, AHP, and Healthcare Science. This limits real-time visibility and standardisation of risk escalation.	Continued phased rollout of Safecare and eRoster, with interim processes (e.g., spreadsheets, manual reporting) in place. Training and support are being provided to teams as systems are introduced.
Difficulty in Notifying All Relevant Individuals (All Areas)	Ensuring that all individuals involved in reporting, mitigating, escalating, or giving clinical advice are notified of decisions and reasons can be challenging, especially in areas without full digital systems.	Emphasis on using Safecare, eRoster, and governance forums for documentation and communication. Staff are encouraged to use red flag systems and incident reporting to ensure concerns are captured and escalated.
Variation in Recording Disagreement (Acute Services, Advanced Practice)	There is variation across sites and disciplines in how disagreements with decisions are recorded and managed. Some areas use Safecare, others rely on governance forums or manual records.	Standardisation of disagreement recording processes is underway, with training and guidance being provided. Safecare's red flag system is being promoted as the preferred method.
Limited Engagement in Some Services (HCS, Advanced Practice)	Not all Healthcare Science services are fully engaged with the HCSSA implementation. Advanced Practice teams face challenges due to the multi-professional	Ongoing engagement and support to bring all services into scope. Interim plans and tailored SOPs are being developed. National work is

	nature of their work and lack of a dedicated workforce tool.	ongoing to develop appropriate tools for advanced practice.
Visibility of Safe Staffing Actions to Patients (Women & Children, Maternity)	Improvements are needed to make safe staffing actions more visible to patients and service users.	Plans are in place to enhance communication and visibility, with board-wide and national support being sought. Progress will be reviewed in the next reporting period.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

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

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

Please provide information to demonstrate compliance.

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

1. Collation and Identification of Severe and Recurrent Risks

- **Digital Tools for Risk Collation:**
  NHS Forth Valley uses Safecare and eRoster systems across nursing teams (with rollout to AHP and Medical teams ongoing) to enable live analysis of staffing data. These systems help identify and collate information on risks escalated to appropriate levels.
  - Risks are categorised using a RAGG (Red-Amber-Green-Gray) status, which is shared at site safety huddles and emailed to senior teams.
  - Areas remaining in red and unable to mitigate are highlighted for further review and escalation.
  - Staff are encouraged to report risks using the Safeguard system (IR1). Data from this system is used to identify severe and recurring risks, which are then recorded on the appropriate risk register and reviewed regularly.

- Implements actions to prevent recurrence (e.g., redesign of medical footprint, Natural Break Enabling Group).

2. Recording and Escalation Procedures

- **Recording Risks:**
  All severe and recurrent risks are recorded in Safecare, eRoster, or the Safeguard system and can be analysed regularly to see patterns or recurrence or themes. For areas not yet on digital systems, interim processes (e.g., spreadsheets, manual reporting) are used.
- **Escalation Pathways:**
  Risks are escalated from the initial reporter to more senior decision-makers, including, where appropriate, to Health Board members. There are clear SOPs for escalation, including out-of-hours processes.
- **Governance Review:**
  Reports are pulled from systems for review by lead nurses or managers, who escalate shifts as necessary and advise on mitigation. Clinical governance groups and performance structures provide oversight and allow for escalation of issues.

3. Mitigation and Clinical Advice

- **Mitigation Actions:**
  Teams are required to take action to mitigate risks as far as possible. Where risks cannot be fully mitigated, structured escalation routes are followed to ensure no risk is left unchecked.
- **Seeking Clinical Advice:**
  Appropriate clinical advice is sought and considered at each stage of mitigation. This is documented in Safecare, governance forums, or other records.

4. Preventing Future Risks

- **Analysis and Learning:**
  Data from real-time staffing tools, incident reports, and governance reviews are analysed to identify trends and root causes of severe and recurrent risks. Actions are identified and implemented to prevent future materialisation of similar risks.

- **Continuous Improvement:**
  Regular review and revision of risk management systems and processes are undertaken to enhance effectiveness. Training materials and sessions are provided as systems are rolled out.

In summary:
NHS Forth Valley has robust arrangements in place to identify, record, escalate, and address severe and recurrent staffing risks, with clear procedures for mitigation, clinical advice, and prevention of future risks. These arrangements are supported by digital tools, governance structures, and ongoing training and review, ensuring compliance with Duty 12IE.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital Tools and Real-Time Monitoring

- **Safecare and eRoster:**
  NHS Forth Valley uses Safecare and eRoster to enable live analysis of staffing data. These systems help identify, record, and collate information on risks escalated to appropriate levels.
  - Risks are categorised using a RAGG (Red-Amber-Green-Gray) status, which is shared at site safety huddles and emailed to senior teams.
  - Areas remaining in red and unable to mitigate are highlighted for further review and escalation.
  - For areas not yet on digital systems, interim processes (e.g., spreadsheets, manual reporting) are used to ensure risks are still captured and escalated.
- **Safeguard System (IR1):**
  Staff are encouraged to report risks using the Safeguard system (IR1). Data from this system is used to identify severe and recurring risks, which are then recorded on the appropriate risk register and reviewed regularly at governance meetings.

2. Recording, Escalation, and Governance Review

- **Recording Risks:**
  All severe and recurrent risks are recorded in Safecare, eRoster, or Safeguard. For areas not yet on digital systems, interim manual processes are used.
- **Escalation Pathways:**
  Risks are escalated from the initial reporter to more senior decision-makers, including, where appropriate, to Health Board members. There are clear SOPs for escalation, including out-of-hours processes.
- **Governance Review:**
  Reports are pulled from systems for review by lead nurses or managers, who escalate shifts as necessary and advise on mitigation. Clinical governance groups and performance structures provide oversight and allow for escalation of issues. Severe and recurring risks are added to the risk register and reviewed at governance meetings.

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3. Addressing Non-Compliance and Continuous Improvement

- **Mechanisms for Addressing Non-Compliance:**
  - If a risk is not addressed or if there is a failure to follow escalation procedures, this is identified through regular governance reviews and audits.
  - Any severe or recurring risks are escalated to the appropriate risk register and reviewed at governance meetings.
  - There are clear mechanisms for escalating risks and addressing non-compliance, with a focus on learning and prevention.
  - Feedback from staff and governance forums is used to identify gaps and drive improvements.
- **Continuous Improvement:**
  - Data from real-time staffing tools, incident reports, and governance reviews are analysed to identify trends and root causes of severe and recurrent risks.
  - Actions are identified and implemented to prevent future materialisation of similar risks.
  - Regular review and revision of risk management systems and processes are undertaken to enhance effectiveness.
  - Training materials and sessions are provided as systems are rolled out.

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4. Service-Specific Monitoring

- **Prison Healthcare:**
  SOPs and risk escalation plans are tailored to service needs, with twice-daily staffing huddles and clinical governance approval. Risks are recorded and monitored using IR1 and Pentana systems.
- **Acute Services:**
  The red flag system in Safecare enables staff to raise concerns, record disagreements, and escalate wellbeing issues. Trends can be analysed by shift, day, and flag owner.
- **Psychology:**
  Interim spreadsheets support escalation while transitioning to e-rostering; risks are escalated and reviewed in operational and clinical supervision structures. Severe and recurring risks are reported at governance groups and senior leadership huddles.
- **Women & Children, Maternity, AHP, HCS:**
  Similar arrangements are in place, with escalation processes, risk registers, and regular review through governance structures.

5. Training and Staff Awareness

- **Ongoing Training:**
  Training materials and sessions are provided for all systems as they are rolled out (e.g., Safecare, eRoster, Turas). Ongoing training and refresher sessions are planned, with feedback from staff shaping content. SOPs and risk escalation plans are widely shared with all healthcare teams to ensure awareness of duties and escalation steps.

In summary:
NHS Forth Valley monitors compliance with Duty 12IE through a combination of real-time digital tools, robust SOPs, regular governance reviews, and continuous training and improvement. There are clear mechanisms for escalating and addressing non-compliance, ensuring that severe and recurrent risks are identified, escalated, and addressed promptly, with learning and prevention at the core of the process.

Area of Success / Achievement / Learning	Details	Further Action
Implementation of SafeCare and eRoster in Nursing, AHP, Medicine and Pharmacy	The rollout of SafeCare and eRoster has enabled live analysis of staffing data, allowing for real-time identification and escalation of severe and recurrent risks. This has improved the ability to respond promptly to staffing	Continue phased rollout to all services, provide ongoing training, and use learning from early adopters to support wider implementation.

Area of Success / Achievement / Learning	Details	Further Action
	challenges and has standardised risk recording and escalation processes across multiple teams.	
Twice-Daily Safety Huddles (Inpatient Nursing & Prison Healthcare)	Regular safety huddles have created a structured forum for staff to discuss and escalate risks, ensuring that issues are identified early and addressed collaboratively. This approach has improved communication and responsiveness to emerging risks.	Maintain and expand the use of safety huddles, share best practice across other departments, and use feedback to refine the process.
Red Flag System in SafeCare (Acute Services)	The introduction of the red flag system allows staff to raise concerns and record disagreements about staffing decisions, increasing transparency and enabling trends in severe or recurrent risks to be analysed over time.	Expand the red flag system to additional areas, use data to inform workforce planning, and ensure staff are trained and confident in its use.
Tailored SOPs and Risk Escalation in Prison Healthcare	SOPs and risk escalation plans have been developed to meet the specific needs of prison healthcare, ensuring all staff understand their role in risk assessment and escalation. Staff demonstrate awareness and compliance in daily discussions and huddles.	Use the approach to developing tailored SOPs as a model for other specialist services, with ongoing review and adaptation for continued relevance.
Interim Escalation Tools in Psychology	While transitioning to e-rostering, Psychology services have used interim spreadsheets and existing supervision structures to ensure risks are escalated and reviewed. Disagreements are recorded in the minutes of governance forums, ensuring transparency.	Lessons from the interim approach are informing the transition to digital tools and will help standardise escalation and review processes across all services.
Learning from Adverse Events	Robust adverse event reporting and learning systems ensure incidents are captured, analysed, and used for improvement, with action plans developed and shared across teams.	Continue to strengthen adverse event reporting and embed learning in practice across all services.
Development of Safety Dashboards and Balanced Scorecards	Work is underway to develop dashboards that provide visibility of staffing levels, skill mix, and training requirements, supporting governance and performance monitoring.	Complete rollout of dashboards, ensure data is used for continuous improvement, and communicate findings to staff and service users.

Area of Escalation / Challenge / Risk	Details	Further Action
Variation in Escalation Process Robustness (Nursing, Acute Services, Medicine and HSCPs)	There is variability in how robustly escalation processes are applied across different wards/units and services. Some areas have well-established SOPs and use Safecare/eRoster, while others are still developing or embedding these processes.	Ongoing rollout of Safecare and eRoster to all areas. Continued training and standardisation of escalation SOPs. Development of safety dashboards and balanced scorecards to monitor compliance and highlight gaps.
Incomplete Mitigation Plans (Acute Services, Advanced Practice)	Some specialties and advanced practice teams have not yet finalised mitigation plans for reporting red status (unmitigated risks). Reporting is sometimes done via Microsoft Forms, which is not always completed robustly.	Teams are working to finalise and embed mitigation plans. There is a focus on improving the logistics of daily staffing mitigations and ensuring consistent recording of disagreements and actions.
Challenges with SafeCare Implementation (Maternity, Advanced Practice, AHP, HCS)	Safecare and eRoster are not yet fully implemented in all areas, particularly in maternity, advanced practice, AHP, and Healthcare Science. This limits real-time visibility and standardisation of risk escalation.	Continued phased rollout of SafeCare and eRoster, with interim processes (e.g., spreadsheets, manual reporting) in place. Training and support are being provided to teams as systems are introduced.
Difficulty in Notifying All Relevant Individuals (All Areas)	Ensuring that all individuals involved in reporting, mitigating, escalating, or giving clinical advice are notified of decisions and reasons can be challenging, especially in areas without full digital systems.	Emphasis on using SafeCare, eRoster, and governance forums for documentation and communication. Staff are encouraged to use red flag systems and incident reporting to ensure concerns are captured and escalated.
Variation in Recording Disagreement (Acute Services, Advanced Practice)	There is variation across sites and disciplines in how disagreements with decisions are recorded and managed. Some areas use SafeCare, others rely on governance forums or manual records.	Standardisation of disagreement recording processes is underway, with training and guidance being provided. SafeCare's red flag system is being promoted as the preferred method.
Limited Engagement in Some Services (HCS, Advanced Practice)	Not all Healthcare Science services are fully engaged with the HCSSA implementation. Advanced Practice teams face challenges due to the multi-professional nature of their work and lack of a dedicated workforce tool.	Ongoing engagement and support to bring all services into scope. Interim plans and tailored SOPs are being developed. National work is ongoing to develop appropriate tools for advanced practice.

Area of Escalation / Challenge / Risk	Details	Further Action
Visibility of Safe Staffing Actions to Patients (Women & Children, Maternity)	Improvements are needed to make safe staffing actions more visible to patients and service users.	Plans are in place to enhance communication and visibility, with board-wide and national support being sought. Progress will be reviewed in the next reporting period.

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

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

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

Please provide information to demonstrate compliance.

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

1. Seeking and Having Regard to Clinical Advice

- **Structured Processes:**
  NHS Forth Valley has established clear procedures to ensure that appropriate clinical advice is sought and considered in all staffing decisions and arrangements covered by sections 12IA to 12IE and 12IH to 12IL.
  - Clinical advice is routinely sought during workforce planning, risk escalation, and mitigation processes.
  - Escalation pathways (e.g., from Senior Charge Nurse to Chief Nurse/Service Manager) ensure clinical input at every stage.
  - Professional judgement tools (in scope) and multidisciplinary team discussions are used to inform decisions.
  - Medical rota and staffing decisions involve consultant clinical leads and AMD/UUC

2. Recording and Explaining Decisions that Conflict with Clinical Advice

- **Documentation:**
  - Where a decision is made that conflicts with clinical advice, the rationale will be recorded in SafeCare, eRoster, or governance forums.
  - The red flag system in SafeCare allows staff to record disagreements and escalate concerns.
  - All such decisions, including the reasons for diverging from clinical advice will be documented and communicated to those who provided the advice.

3. Procedures for Risk Identification, Mitigation, and Notification

- **Risk Identification and Mitigation:**
  - If a decision conflicts with clinical advice, risks are identified and assessed using structured tools and SOPs.
  - Mitigation actions are taken as far as possible, with further clinical advice sought if needed.
  - All individuals involved in giving clinical advice are notified of the decision and the reasons for it.
  - There is a clear process for those individuals to record any disagreement with the decision.

4. Quarterly Reporting to the Health Board

- **Lead Clinical Professional Reporting:**
  - Individuals with lead clinical responsibility (e.g., Chief Nurses, Heads of Service) report at to the Health Board on compliance with staffing duties, including Duty 12IF.
  - These reports include details of compliance, areas of challenge, and any instances where decisions have conflicted with clinical advice.

5. Enabling and Recording Staff Views

- **Staff Engagement:**
  - Staff are encouraged to provide views on staffing arrangements and the operation of Duty 12IF through surveys (e.g., iMatter), focus groups, and team meetings.
  - These views are recorded and included in quarterly reports.
  - Mechanisms such as the red flag system and regular feedback forums ensure staff can raise concerns and have them formally considered.

6. Raising Awareness and Training

- **Awareness and Training:**
  - SOPs and escalation plans are widely shared, and staff are trained on how to seek, provide, and record clinical advice.
  - Ongoing training and refresher sessions are provided as systems are rolled out.
  - Lead clinical professionals receive dedicated time and resources to fulfil their responsibilities, including training and protected time for governance activities.

7. Ensuring Adequate Time and Resources

- **Resource Allocation:**
  - eRoster and SafeCare can provide reports for governance review, supporting oversight and resource planning.

- Protected time is allocated for clinical leaders to supervise, manage, and lead on staffing matters.

In summary:
NHS Forth Valley has robust systems and processes to ensure clinical advice is sought, considered, and documented in all staffing decisions. There are clear mechanisms for recording and explaining decisions that conflict with clinical advice, identifying and mitigating associated risks, and ensuring staff at all levels can contribute their views. Regular reporting, ongoing training, and resource allocation underpin compliance with Duty 12IF.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance

1. Digital Systems and Documentation

- **SafeCare and eRoster:**
  NHS Forth Valley uses SafeCare and eRoster to document clinical advice, record decisions (including those that conflict with advice), and track risk mitigation actions.
  - The red flag system in SafeCare allows staff to record disagreements and escalate concerns about staffing decisions.
  - All such decisions, including the rationale for diverging from clinical advice, are documented and communicated to those who provided the advice.

2. Escalation and Governance Pathways

- **Escalation Procedures:**
  - If a decision conflicts with clinical advice, risks are identified and assessed using structured tools and SOPs.
  - Mitigation actions are taken as far as possible, with further clinical advice sought if needed.
  - All individuals involved in giving clinical advice are notified of the decision and the reasons for it.
  - There is a clear process for those individuals to record any disagreement with the decision.
- **Governance Oversight:**
  - Clinical governance groups and performance structures provide oversight, allowing for escalation of issues and regular review of compliance.

- Reports from SafeCare and eRoster are used for service and clinical governance review.
- Any severe or recurring risks are escalated to the appropriate risk register and reviewed at governance meetings.

3. Quarterly Reporting and Staff Engagement

- **Quarterly Reports:**
  - Individuals with lead clinical responsibility (e.g., Chief Nurses, Heads of Service) report to the Health Board on compliance with staffing duties, including Duty 12IF.
  - These reports include details of compliance, areas of challenge, and any instances where decisions have conflicted with clinical advice.
- **Staff Engagement and Feedback:**
  - Staff are encouraged to provide views on staffing arrangements and the operation of Duty 12IF through surveys (e.g., iMatter), focus groups, and team meetings.
  - These views are recorded and included in quarterly reports to the Board.
  - Mechanisms such as the red flag system and regular feedback forums ensure staff can raise concerns and have them formally considered.

4. Addressing Non-Compliance

- **Mechanisms for Addressing Non-Compliance:**
  - If a risk is not addressed or if there is a failure to follow escalation procedures, this is identified through regular governance reviews and audits.
  - Any severe or recurring risks are escalated to the appropriate risk register and reviewed at governance meetings.
  - There are clear mechanisms for escalating risks and addressing non-compliance, with a focus on learning and prevention.
  - Feedback from staff and governance forums is used to identify gaps and drive improvements.

5. Training and Awareness

- **Ongoing Training:**
  - Training materials and sessions are provided for all systems as they are rolled out (e.g., SafeCare, eRoster, Turas).
  - Ongoing training and refresher sessions are planned, with feedback from staff shaping content.
  - SOPs and escalation plans are widely shared with all healthcare teams to ensure awareness of duties and escalation steps.

In summary:
NHS Forth Valley monitors compliance with Duty 12IF through a combination of digital documentation, robust SOPs, regular governance reviews, quarterly reporting, staff engagement, and continuous training. There are clear mechanisms for escalating and addressing non-compliance, ensuring that clinical advice is sought, considered, and acted upon in all staffing decisions.

Area of Success / Achievement / Learning	Details	Further Action
Staff Engagement in Clinical Advice (Nursing, Acute Services)	Staff feedback collected via iMatter surveys and team meetings identified that involving frontline nurses in staffing decisions improved morale and the appropriateness of staffing allocations.	This approach is being formalised and extended to other wards, with regular feedback loops and inclusion of staff views in quarterly reports to the Board.
Red Flag System for Disagreement (Acute Services, Women & Children)	The introduction of the red flag system in SafeCare allows staff to formally record disagreements with staffing decisions that conflict with clinical advice. This has increased transparency and enabled trends to be analysed.	The system is being rolled out to additional areas, and data from red flags will be used to inform future workforce planning and training.
Quarterly Reporting and Learning (Allied Health Professions, Psychology)	Quarterly reports from lead clinical professionals have highlighted areas where clinical advice was not followed and the reasons why. This has led to targeted reviews and improvements in escalation processes.	The learning from these reviews is being shared across other professional groups, and the reporting template is being refined to better capture staff views and disagreements.
Multidisciplinary Team (MDT) Involvement (Maternity, Prison Healthcare)	MDT meetings have enabled a broader range of clinical advice to be considered in staffing decisions, leading to more robust risk assessments and mitigation plans.	The MDT approach is being embedded as standard practice, with plans to evaluate its impact on patient outcomes and staff satisfaction.
Training and Awareness (All Services)	Training sessions and SOPs have increased awareness among clinical leaders about their responsibilities to seek, record, and act on clinical advice. Staff now report greater confidence in raising concerns and understanding escalation pathways.	Ongoing refresher training and updates to SOPs are planned, with feedback from staff used to continuously improve the process.

Area of Escalation / Challenge / Risk	Details	Further Action
Variation in Mechanisms for Seeking Staff Views (Medical, Allied Health Professions)	In compiling reports to the Health Board, mechanisms for seeking the views of some professional groups (e.g., medicine, AHPs) are not as well established as those for nursing and midwifery staff. As a result, the views of these employees may not be consistently sought or incorporated into reports.	Work is underway to develop and standardise feedback mechanisms for all professional groups, including regular surveys, focus groups, and inclusion of staff representatives in governance meetings. Training and communication are being enhanced to ensure all groups are engaged.
Recording and Acting on Disagreement (Acute Services, Advanced Practice)	There is variation across sites and disciplines in how disagreements with decisions (especially those that conflict with clinical advice) are recorded and managed. Some areas use SafeCare's red flag system, others rely on governance forums or manual records.	Standardisation of disagreement recording processes is underway, with training and guidance being provided. SafeCare's red flag system is being promoted as the preferred method.
Limited Engagement in Some Services (Healthcare Science, Advanced Practice)	Not all Healthcare Science services are fully engaged with the process of seeking and recording clinical advice. Advanced Practice teams face challenges due to the multi-professional nature of their work and lack of a dedicated workforce tool.	Ongoing engagement and support to bring all services into scope. Interim plans and tailored SOPs are being developed. National work is ongoing to develop appropriate tools for advanced practice.
Difficulty in Notifying All Relevant Individuals (All Areas)	Ensuring that all individuals involved in giving clinical advice are notified of decisions and reasons can be challenging, especially in areas without full digital systems.	Emphasis on using SafeCare, eRoster, and governance forums for documentation and communication. Staff are encouraged to use red flag systems and incident reporting to ensure concerns are captured and escalated.
Protected Time and Resources for Clinical Leaders (All Services)	Ensuring that clinical leaders have adequate time and resources to fulfil their responsibilities, including seeking and recording clinical advice, remains a challenge in some areas.	Protected time is being reviewed and allocated through eRoster and job planning. Ongoing monitoring and feedback are used to adjust resource allocation as needed.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

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

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

Please provide information to demonstrate compliance.

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

1. Ensuring Sufficient Time and Resources for Clinical Leaders

- **Job Planning and Protected Time:**
  NHS Forth Valley uses job planning and eRoster systems to allocate and monitor protected time for individuals with lead clinical professional responsibility (e.g., Senior Charge Nurses, Team Leaders, Heads of Service).
  - For example, Senior Charge Nurses (SCNs) are allocated 40% non-clinical time to focus on managerial aspects of their role and 60% clinical time. This split is reflected within eRosters and reviewed regularly.
  - Nursing leads in areas such as immunisation, health visiting, and school nursing are non-caseload holding, ensuring they have protected time to supervise, support, and lead their teams.
- **Leadership and Supervision:**
  Clinical leaders are given time to supervise the meeting of clinical needs, manage and support staff development, and lead the delivery of safe, high-quality, person-centred care.
  - Monthly leadership days and regular attendance at clinical governance, review groups, and professional meetings are standard practice in directorates such as Maternity and Women & Children.
  - Clinical leaders participate in working groups to determine what sufficient time and resources look like for their roles, with outcomes used to inform wider practice.
  - Leadership days, supervision structures, and working groups for defining sufficient leadership time.

2. Monitoring and Review

- **eRoster and SafeCare Reporting:**
  eRoster and SafeCare systems provide reports for service and clinical governance review, allowing for oversight of how protected time is being used and whether it is sufficient.
    - Reports are reviewed at governance meetings, and adjustments are made as needed to ensure compliance and address any gaps.
- **Governance and Feedback:**
  Clinical governance groups and performance structures provide regular oversight, allowing for escalation of issues and review of compliance.
    - Feedback from staff and governance forums is used to identify areas where additional time or resources may be needed.

3. Addressing Challenges and Continuous Improvement

- **Triumvirate Model and Role Clarity:**
  Work is ongoing to develop and embed the triumvirate model (Professional Lead, Operational Lead, Clinical Lead) in clinical areas, clarifying responsibilities and ensuring adequate time is allocated for each role.
    - In areas where the process to identify clinical leaders is not fully established, efforts are underway to work with all staff groups and use HR processes and eRostering to ensure all relevant individuals are identified and supported.
- **Flexibility and Adaptation:**
  Where additional time is required (e.g., to support HR processes or address workload spikes), clinical leaders can flex their time allocation, with adjustments made through job planning and ongoing monitoring. Ensuring adequate administrative support to prevent erosion of leadership capacity (e.g., physician rota admin reinstated).

4. Service-Specific Examples

- **Maternity:**
  Staff in leadership roles have an agreed split in their hours for leadership and clinical duties, with flexibility to support HR processes as needed. Monthly leadership days and 360 reviews support ongoing development.
- **Women & Children:**
  Nursing leads have protected time for supervision and support, with risk assessments and job planning ensuring a safe balance between workload and workforce.

- **Healthcare Science/Audiology:**
  Clinical leads have time allotted within job plans, reviewed annually, and can adjust as needed based on service demands and individual staff assessments.

Demonstrating Compliance

- **Protected time for clinical leaders is planned, allocated, and monitored using eRoster and job planning.**
- **Regular review and feedback mechanisms ensure time and resources remain sufficient and are adapted as needed.**
- **Governance structures provide oversight and escalation routes for any issues or gaps.**
- **Service-specific adaptations and ongoing improvement work ensure all clinical leaders are supported in fulfilling their responsibilities.**

In summary:
NHS Forth Valley ensures that clinical leaders have sufficient time and resources to supervise patient care, manage and develop staff, and lead the delivery of safe, high-quality, person-centred health care. This is achieved through structured job planning, protected time allocation, regular monitoring, governance oversight, and continuous improvement.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital Systems and Job Planning

- **eRoster and SafeCare:**
  NHS Forth Valley uses eRoster and SafeCare to allocate, monitor, and report on protected time for clinical leaders (e.g., Senior Charge Nurses, Team Leaders, Heads of Service).
  - eRoster records the split between clinical and non-clinical time (e.g., SCNs are allocated 60% non-clinical time for leadership and management duties).
  - Reports from these systems are regularly reviewed at service and clinical governance meetings to ensure that protected time is being used as planned and to identify any gaps.

- **Job Planning:**
  Job plans for clinical leaders are reviewed annually (or more frequently if needed) to ensure that sufficient time is allocated for supervision, staff development, and leadership responsibilities. Adjustments are made as required based on service needs and feedback.

2. Governance and Oversight

- **Clinical Governance Groups:**
  Regular meetings of clinical governance groups and performance structures provide oversight of compliance with Duty 12IH.
  - These groups review eRoster and SafeCare reports, discuss any issues with protected time, and escalate concerns if clinical leaders are unable to fulfil their responsibilities due to lack of time or resources.
  - Feedback from staff and governance forums is used to identify areas where additional time or support may be needed.
- **Escalation Mechanisms:**
  If non-compliance is identified (e.g., clinical leaders not receiving their allocated protected time), this is escalated through the governance structure.
  - Issues can be raised at team meetings, through line management, or via formal governance routes.
  - Persistent or significant issues are escalated to senior management or the Health Board for resolution.

3. Continuous Improvement and Adaptation

- **Triumvirate Model:**
  NHS Forth Valley is developing and embedding the triumvirate model (Professional Lead, Operational Lead, Clinical Lead) in clinical areas to clarify responsibilities and ensure adequate time is allocated for each role.
  - Ongoing work with HR and eRostering teams ensures that all relevant individuals are identified and supported.
- **Flexibility:**
  Where additional time is required (e.g., to support HR processes or address workload spikes), clinical leaders can flex their time allocation, with adjustments made through job planning and ongoing monitoring.

4. Addressing Non-Compliance

- **Review and Action:**
  If it is identified that clinical leaders are not receiving sufficient time or resources, actions are taken to address this, such as:
  - Reviewing and adjusting job plans.
  - Allocating additional support or resources.
  - Escalating persistent issues to senior management or the Health Board.
- **Feedback Loops:**
  Staff are encouraged to provide feedback on their ability to fulfil leadership responsibilities, and this feedback is used to inform ongoing improvements.

In summary:
NHS Forth Valley monitors compliance with Duty 12IH through a combination of digital systems, job planning, governance oversight, escalation mechanisms, and continuous improvement. These arrangements ensure that clinical leaders have the time and resources needed to supervise care, support staff, and lead high-quality, person-centred services. Persistent or significant issues are escalated and addressed through established governance structures.

Area of Success / Achievement / Learning	Details	Further Action
Working Group on Protected Time (AHPs, Senior Physiotherapists, Team Leaders)	Senior physiotherapists and team leaders convened a working group to determine what sufficient time, and resources would look like for individuals with lead clinical professional responsibility. The outcome was a clear determination of time and resources for different team leaders, with positive feedback from participants.	The positive outcome has led to this model being extended to other Allied Health Professional (AHP) areas and is being trialled to assess applicability and impact across the wider service.
eRoster Implementation for Protected Time (Nursing, Acute Services, Women & Children)	eRoster is used to allocate and monitor protected time for clinical leaders, such as Senior Charge Nurses (SCNs), who are allocated 40% non-clinical time for leadership and management duties. This ensures leaders can supervise, support staff, and lead service improvements.	Ongoing review of eRoster data and job plans to ensure protected time is maintained and adjusted as needed. The approach is being shared with other directorates to standardise best practice.

Area of Success / Achievement / Learning	Details	Further Action
Leadership Days and 360 Reviews (Maternity, Women & Children)	Monthly leadership days and 360-degree reviews have been introduced for midwifery and directorate staff. These initiatives support leadership development, peer learning, and reflection on time/resource allocation.	The leadership day model and 360 reviews are being evaluated for effectiveness and may be rolled out to other clinical areas if proven beneficial.
Non-Caseload Holding Leads (Health Visiting, School Nursing, Immunisation)	Nursing leads in these areas are non-caseload holding, ensuring they have protected time to supervise, support, and lead their teams. This has improved oversight and staff development.	The non-caseload holding model is being reviewed for potential adoption in other services where leadership demands are high.
Flexible Job Planning (Healthcare Science/Audiology, Medicine)	Clinical leads have time allotted within job plans, reviewed annually, and can adjust as needed based on service demands and individual staff assessments. This flexibility ensures leaders can respond to changing needs.	Lessons from flexible job planning are being shared across departments to support responsive leadership and workforce planning.

Area of Escalation / Challenge / Risk	Details	Further Action
Identifying Clinical Leaders Consistently (All Services)	The process in place to identify the roles, and therefore individuals, with lead clinical professional responsibility for a team of staff does not always consistently identify who these individuals are. As a result, sufficient time and resources for these individuals to discharge their responsibilities may not always be considered or allocated.	Work is ongoing with all staff groups, clinical areas, and teams to clarify job titles and roles. HR processes and eRostering are being used to identify team leaders and ensure all relevant individuals are recognised and supported.
Variability in Protected Time Allocation (Acute Services, Advanced Practice)	There is variability across services and disciplines in how protected time for clinical leaders is allocated and maintained. Some areas have robust systems, while others are still developing processes to ensure leaders have adequate time for their responsibilities.	Ongoing review of eRoster data and job plans to ensure protected time is maintained and adjusted as needed. Sharing best practice and standardising approaches across directorates.
Balancing Clinical and Leadership Duties (Healthcare Science/Audiology, Medicine and Maternity)	Clinical leaders sometimes lose protected leadership time due to the need to cover clinical duties, especially during staff absences or high demand. This can impact their ability to fulfil leadership and management responsibilities.	If leadership time is lost due to clinical cover, this is noted in eRoster or job planning tools. Teams are encouraged to review and adjust diaries, allocate additional support, and escalate persistent issues through governance structures.

Area of Escalation / Challenge / Risk	Details	Further Action
Embedding the Triumvirate Model (All Services)	The triumvirate model (Professional Lead, Operational Lead, Clinical Lead) is still being developed and embedded in some clinical areas, leading to occasional ambiguity in responsibility and time allocation.	Continued development and communication of the triumvirate model, with clear role definitions and time/resource allocation. Regular feedback and review to ensure the model is effective and consistently applied.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

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

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

Please provide information to demonstrate compliance.

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

1. Provision of Appropriate and Relevant Training

- **Mandatory and Role-Specific Training:**
  All staff are required to complete mandatory training relevant to their roles, including statutory and essential modules (e.g., infection control, safeguarding, moving and handling, violence and aggression).
  - Training needs are identified through Personal Development Plans (PDPs), job planning, and annual appraisals.
  - Role-specific training is provided for clinical and non-clinical staff, with additional modules for those in leadership or specialist roles.
- **Induction and Ongoing Development:**
  All new employees undergo a structured induction programme, which includes core training and orientation to local policies and procedures.
  - Ongoing professional development is supported through access to e-learning platforms (e.g., TURAS Learn, NHS FV Learning Zone), face-to-face sessions, and practice development facilitators.

2. Ensuring Adequate Time and Resources for Training

- **Protected Learning Time:**
  Staff are allocated protected time within their work schedules to complete mandatory and developmental training.
  - eRoster is used to plan and record protected learning time, ensuring staff can access training without impacting service delivery.

- In Maternity, for example, 16 hours per staff member are allocated for e-learning, and ad hoc opportunities on shift are also utilised.

- **Monitoring and Reporting:**
  Compliance with mandatory training is monitored through digital dashboards (e.g., TURAS, Pentana), with regular reports reviewed at workforce governance and clinical governance meetings.
  - Training activity, cancellations, and postponements are tracked, and action plans are implemented to address any gaps in compliance.

3. Support for Professional Development and Succession Planning

- **Talent Management and Succession Planning:**
  NHS Forth Valley supports career development through programmes such as “Step into my Shoes,” “Leading to Change,” and national succession planning initiatives.
  - Leadership and management development programmes are available at multiple levels, with cross-board mentoring and coaching opportunities.
- **Practice Development and Education Facilitators:**
  Dedicated facilitators in nursing, medical, and AHP teams deliver training, support PDPs, and ensure staff are up to date with required competencies.

4. Continuous Improvement and Feedback

- **Feedback Mechanisms:**
  Staff feedback on training is collected through surveys, focus groups, and governance forums, and is used to improve training content and delivery.
  - Training needs analysis is conducted regularly to ensure programmes remain relevant and effective.
- **Addressing Non-Compliance:**
  Areas of low compliance are identified through monitoring, and targeted interventions (e.g., additional sessions, reminders, support from line managers) are implemented to address these.

Demonstrating Compliance

- **Training is planned, delivered, and monitored using digital systems (TURAS, eRoster, Pentana).**
- **Protected time for training is allocated and recorded, with compliance reviewed at governance meetings.**
- **Professional development is supported through structured programmes and dedicated facilitators.**
- **Continuous improvement is driven by staff feedback and regular review of training needs and compliance data.**

In summary:
NHS Forth Valley ensures all staff receive appropriate and relevant training, with adequate time and resources to undertake it. Compliance is monitored through robust digital systems and governance processes, and continuous improvement is supported by staff feedback and targeted interventions.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Digital Systems for Tracking Training Compliance

- **TURAS Learn and eRoster:**
  NHS Forth Valley uses the TURAS Learn platform and eRoster to record, monitor, and report on staff training compliance.
  - TURAS provides dashboards for mandatory and role-specific training, allowing managers to track completion rates and identify gaps.
  - eRoster is used to allocate and record protected learning time, ensuring staff can access training during work hours.
- **Pentana System:**
  The Pentana system is used to monitor training activity, cancellations, and postponements, with reports available for review at governance meetings.

2. Governance and Oversight

- **Workforce Governance Groups:**
  Regular meetings of workforce governance groups and clinical governance structures provide oversight of training compliance.
  - These groups review TURAS, eRoster, and Pentana reports, discuss areas of low compliance, and escalate concerns as needed.
  - Training compliance is also reported through infection control and public protection reports.
- **Practice Development and Education Facilitators:**
  Dedicated facilitators in nursing, medical, and AHP teams support training delivery, monitor compliance, and provide targeted interventions where gaps are identified.

3. Escalation and Addressing Non-Compliance

- **Action Plans:**
  When areas of low compliance are identified, action plans are developed and implemented. These may include:
  - Additional training sessions or reminders.
  - Support from line managers or facilitators.
  - Monitoring of individual and team compliance through regular reports.
- **Feedback Loops:**
  Staff are encouraged to provide feedback on training access and barriers, which is used to inform improvements and address persistent issues.
- **Protected Learning Time:**
  eRoster is used to ensure staff have protected time for training. If staff are unable to access training due to service pressures, this is escalated through line management and governance structures for resolution.

4. Continuous Improvement

- **Regular Review:**
  Training needs analysis is conducted regularly to ensure programmes remain relevant and effective.
  - Compliance data is reviewed at governance meetings, and feedback from staff is used to improve training content and delivery.

- **Succession Planning and Talent Management:**
  Programmes such as “Step into my Shoes” and “Leading to Change” are monitored for uptake and impact, supporting ongoing professional development.

In summary:
NHS Forth Valley monitors compliance with Duty 12II through robust digital systems, governance oversight, escalation mechanisms, and continuous improvement. These arrangements ensure staff receive the training they need, with protected time and resources, and that any issues are identified and addressed promptly.

Area of Success / Achievement / Learning	Details	Further Action
Improved CPD Recording in Psychology	The psychology department, in conjunction with HR, completed a project to promote more accurate capturing of information relating to continued professional development (CPD) for psychology colleagues. Feedback from employees is that they have found the new system much easier to use and are now recording relevant CPD more consistently.	Allied Health Professional (AHP) colleagues have expressed interest in the new system and are undertaking a project to establish whether they could implement something similar in their own teams.
Protected Learning Time in Maternity	Maternity services have introduced 16 hours of protected e-learning time per staff member, supporting completion of mandatory and role-specific modules. Staff have reported improved access to training and greater confidence in meeting compliance requirements.	The approach is being evaluated for effectiveness and may be rolled out to other directorates if proven beneficial.
Buddy System for New Managers (Psychology)	A buddy system was introduced for new managers in Psychological Services, supporting their learning in relation to training responsibilities and compliance. This has improved induction and confidence among new leaders.	The buddy system is being considered for wider adoption in other professional groups to support leadership development and training compliance.
Monthly Training Monitoring (Healthcare Science/Audiology)	Monthly time is allocated for mandatory and internal/external CPD training. Training is offered to all staff regardless of contracted hours, and compliance is tracked through TURAS and Auditbase.	The model is being shared with other departments to support fair access to training and improve compliance rates across the organisation.

Area of Success / Achievement / Learning	Details	Further Action
Leadership Development Programmes (All Services)	NHS Forth Valley runs local and regional leadership development programmes, including mentoring and coaching, to support staff progression and succession planning. Staff feedback has been positive, with increased uptake and engagement.	Ongoing evaluation and feedback will inform future programme development and potential expansion to additional staff groups.

Area of Escalation / Challenge / Risk	Details	Further Action
Inconsistent Training Processes Across Staff Groups (Healthcare Science, AHPs)	Clearly defined processes and procedures for mandatory and role-specific training exist for some groups (e.g., nursing and midwifery), but are less well established for others, such as healthcare scientists and some AHPs. This leads to variability in training compliance and access.	NHS Forth Valley is working with HR and representatives from healthcare science and AHPs to define appropriate training programmes, assess training needs, and plan for required training. The aim is to standardise processes and ensure all staff groups have equal access to training and compliance monitoring.
Protected Learning Time Not Consistently Available (Acute Services, Advanced Practice)	Some staff, particularly in high-demand or non-digital areas, report difficulty accessing protected learning time due to service pressures or lack of digital rostering.	Ongoing monitoring via TURAS and Pentana; action plans are being developed to promote and track protected learning time. eRoster rollout is being prioritised in these areas to support better planning and compliance.
Variation in Training Compliance Monitoring (All Services)	There is variation in how training compliance is monitored and reported across different services and disciplines. Some areas use digital dashboards, while others rely on manual records.	The organisation is streamlining training compliance recording onto approved systems (TURAS/eESS-OLM) to make tracking and reporting easier and more consistent. Training facilitators are supporting teams to transition to digital monitoring.
Engagement with Training Programmes (Healthcare Science, Advanced Practice)	Not all staff groups are fully engaged with available training programmes, sometimes due to lack of awareness or perceived relevance.	Targeted communication and engagement initiatives are underway to raise awareness of training opportunities and encourage participation. Feedback from staff is being used to tailor training content and delivery.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

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

Please provide information to demonstrate compliance.

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

1. Use of Staffing Level and Professional Judgement Tools

- NHS Forth Valley uses the prescribed staffing level tools and professional judgement tools for all relevant clinical areas (e.g., adult inpatient, maternity, neonatal, community nursing, emergency care).
- These tools are run at least annually, as required by regulations, and the results are used to inform staffing establishment reviews and workforce planning.
- A dedicated HR Nursing Workforce team supports all relevant clinical areas to ensure the common staffing method (CSM) is applied consistently.

2. Incorporating Quality Standards and Outcomes

- The CSM process considers national and local quality standards, including those published by the Scottish Ministers and any measures developed as part of the national care assurance framework.
- Care assurance audits, clinical governance reviews, and quality improvement initiatives are integrated into the staffing review process.

3. Comprehensive Consideration of Contextual Factors

The CSM process explicitly considers:

- **Current staffing levels and vacancies:** Data from eRoster and SafeCare is used to assess current establishment, vacancies, and predicted absence.
- **Skills and experience:** The review process includes analysis of skill mix, experience, and succession planning.
- **Roles and duties of clinical leaders:** Job plans and role descriptions are reviewed to ensure clinical leaders have time for supervision, management, and leadership.
- **Impact on other services:** Staffing decisions are considered in the context of their effect on other services, with cross-service collaboration where needed.

- **Local context and patient needs:** Local service reviews, patient feedback, and workload analysis are used to tailor staffing to the specific needs of each area.
- **Clinical advice:** Professional judgement and multidisciplinary team input are integral to the process.
- **External assessments:** Any relevant assessments by Healthcare Improvement Scotland (HIS) or other bodies are incorporated.
- **Learning from real-time assessment and risk escalation:** Experience from real-time staffing tools (SafeCare), risk escalation (IR1, governance meetings), and previous CSM cycles is used to inform improvements.
- **Patient and staff feedback:** Comments from patients, carers, and staff are actively sought and considered in staffing reviews.

4. Risk Identification and Mitigation

- Risks identified during the CSM process are recorded, and all reasonable steps are taken to mitigate them.
- Escalation processes are in place for risks that cannot be mitigated locally, with clear routes to senior management and the Health Board.
- Action plans are developed for areas with persistent or severe risks, and progress is monitored through governance structures.

5. Decision-Making and Implementation

- After completing the CSM process, decisions are made about any required changes to staffing establishment or service delivery.
- Changes are communicated to staff, and feedback is sought to ensure the process is transparent and inclusive.
- The impact of changes is monitored, and further adjustments are made as needed.

6. Monitoring and Continuous Improvement

- The application of the CSM is monitored through regular audits, governance reviews, and feedback from staff and patients.
- Training is provided for all staff involved in the CSM process, and learning from each cycle is used to refine and improve future applications.
- The reporting template and escalation plans are regularly reviewed and updated to reflect best practice and regulatory requirements.

Demonstrating Compliance

- **Annual and ad hoc tool runs** are completed for all relevant areas, with results reviewed by clinical and operational leads.
- **Comprehensive reporting** ensures all required factors are considered and documented.
- **Governance oversight** ensures risks are escalated and addressed, and that changes are implemented and monitored.
- **Staff and patient feedback** is actively sought and used to inform ongoing improvements.

In summary:
NHS Forth Valley follows a robust, evidence-based process for applying the common staffing method, ensuring all statutory requirements are met. This includes the use of staffing tools, consideration of quality standards and contextual factors, risk mitigation, transparent decision-making, and continuous improvement—demonstrating full compliance with Duty 12IJ.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Scheduled Tool Runs and Reporting

- **Annual and Scheduled Tool Runs:**
  NHS Forth Valley schedules annual (and, where required, more frequent) runs of the staffing level tool and professional judgement tool for all relevant clinical areas (e.g., adult inpatient, maternity, neonatal, community nursing, emergency care).
  - The results are documented using a standardised reporting template, which includes triangulation with quality standards, patient feedback, and workforce data.
  - The reporting template prompts consideration of all statutory factors (current staffing, skill mix, local context, clinical advice, patient and staff feedback, etc.).
- **Governance Review:**
  Completed reports are reviewed by clinical and operational leads, and then escalated through governance structures (e.g., NMAHP Workforce Governance Group, Senior Leadership Team, Executive Leadership Team) for approval and further action.

2. Digital Systems and Audit Trails

- **eRoster and SafeCare:**
  Data from eRoster and SafeCare is used to monitor current staffing levels, vacancies, skill mix, and the impact of staffing decisions.
  - These systems provide audit trails for compliance with the common staffing method and support ongoing monitoring.
- **Care Assurance Audits:**
  Care assurance audits and clinical governance reviews are integrated into the CSM process, providing additional oversight and evidence of compliance.

3. Escalation and Addressing Non-Compliance

- **Escalation Pathways:**
  If non-compliance or gaps are identified (e.g., tool runs not completed, statutory factors not considered, risks not mitigated), these are escalated through the governance structure.
  - Issues can be raised at team meetings, through line management, or via formal governance routes.
  - Persistent or significant issues are escalated to senior management or the Health Board for resolution.
- **Action Plans:**
  Where risks or non-compliance are identified, action plans are developed and monitored through governance meetings. Progress is tracked, and further escalation occurs if issues are not resolved.

4. Continuous Improvement and Feedback

- **Learning from Each Cycle:**
  After each CSM cycle, feedback will be sought from staff and patients, and learning will be used to refine the process and reporting template.
  - Training is provided for staff involved in the CSM process, and updates are made to reflect best practice and regulatory changes.

- **Monitoring Impact:**
  The impact of changes made as a result of the CSM process is monitored through ongoing audits, staff and patient feedback, and review of workforce and quality data.

In summary:
NHS Forth Valley monitors compliance with Duty 12IJ through scheduled tool runs, robust digital systems, governance oversight, escalation pathways, and continuous improvement. These arrangements ensure that the common staffing method is applied consistently, statutory requirements are met, and any issues are identified and addressed promptly.

Area of Success / Achievement / Learning	Details	Further Action
Adult Inpatient Services – Staffing Establishment Review	Application of the common staffing method in adult inpatient areas identified that some wards required changes to their staffing establishment, while others had potential for service redesign. These changes are now in progress and will be trialled to monitor outcomes.	Following completion of the tools, decisions will be taken about formal adoption of changes. The process and outcomes will be summarised as case studies to inform training for staff about the use of the common staffing method.
Neonatal Unit – Tool Run and Reporting	The neonatal unit completed a tool run as part of a proof-of-concept test within SafeCare. The outputs are being used to complete the common staffing method and inform future workforce planning.	Awaiting report from the Healthcare Staffing Programme (HSP). The learning from this exercise will be shared with other neonatal and paediatric services.
Emergency Department – Data-Driven Staffing Decisions	The Emergency Department completed a tool run and is verifying/auditing results. The common staffing template was e completed and supported evidence-based staffing decisions.	The outcomes will be reviewed and the approach will be used as a model for other unscheduled care areas.
Community Nursing – Training and Implementation	Community nursing teams are undergoing training and tool runs to implement the common staffing method, ensuring that local context and patient needs are fully considered.	Lessons learned from the training and implementation process will be used to refine future tool runs and support other community-based services.
Maternity – National Tool Development and Testing	The midwifery team is actively participating in the development and testing of a new national workforce tool. Forth Valley is one of the only boards with fully implemented midwifery	The experience and data from Forth Valley has informed national standards and future iterations of

Area of Success / Achievement / Learning	Details	Further Action
	teams, allowing for comprehensive testing across inpatient and community areas.	the tool, benefiting maternity services across Scotland.

Area of Escalation / Challenge / Risk	Details	Further Action
Variation in Staff Engagement with the CSM Process (Community Nursing,)	Some staff groups, particularly in community nursing, have shown lower engagement with the common staffing method process, leading to incomplete data or delayed reporting.	Engagement initiatives are underway, including workshops, regular communication, and involvement of staff representatives in planning. Feedback is being used to tailor the process and improve participation.
Data Quality and Consistency Issues (All Services)	There have been challenges in ensuring the quality and consistency of data collected during tool runs, particularly where manual processes are still in use. This can affect the reliability of staffing establishment reviews.	The rollout of digital tools (e.g., SafeCare, eRoster) is being prioritised, and training is being provided to standardise data collection. Ongoing audits and spot checks are being used to monitor and improve data quality.
Impact of Staffing Decisions on Other Services (Acute Services, Maternity)	Decisions about staffing and resource allocation in one area (e.g., acute services) have sometimes had unintended consequences for other services, such as increased workload or reduced flexibility.	Cross-service collaboration and impact assessments are being built into the CSM process. Regular review meetings are held to discuss and mitigate any negative effects, and adjustments are made as needed.
Delays in Implementing Changes Identified by the CSM (All Services)	In some cases, changes identified by the common staffing method (e.g., establishment adjustments, service redesign) have been delayed due to resource constraints or competing priorities.	Action plans are being developed with clear timelines and accountability. Progress is monitored through governance meetings, and escalation routes are in place for unresolved delays.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

Duty 12IL: Training and consultation of staff

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

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

Please provide information to demonstrate compliance.

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

1. Encouraging and Supporting Staff to Give Views on Staffing Arrangements

- **Staff Engagement Mechanisms:**
  NHS Forth Valley encourages staff to provide feedback on staffing arrangements through a variety of channels:
  - Regular staff surveys (e.g., iMatter), focus groups, and team meetings.
  - Staff are invited to participate in discussions about the application of the common staffing method (CSM) and to share their experiences and suggestions for improvement.
  - Feedback is also gathered through professional forums, governance meetings, and direct communication with line managers.

2. Using Staff Views to Identify Best Practice and Areas for Improvement

- **Feedback Integration:**
  Views and suggestions from staff are systematically reviewed and incorporated into staffing reviews and CSM cycles.

- Staff feedback is used to identify best practice, highlight areas for improvement, and inform changes to staffing processes.
- Examples include adapting training delivery, refining reporting templates, and adjusting the timing of tool runs based on staff input.

3. Training Employees on the Common Staffing Method

- **Comprehensive Training Programme:**
  All relevant staff, including those in roles specified under section 12IK, receive training on the use of the common staffing method.
  - Training is delivered through a combination of e-learning modules (e.g., TURAS), face-to-face sessions, and on-the-job support from practice development facilitators.
  - Refresher training is provided regularly, and new staff are trained as part of their induction.

4. Ensuring Adequate Time for Staff to Use the Common Staffing Method

- **Protected Time Allocation:**
  eRoster is used to allocate and record protected time for staff to participate in CSM activities, including tool runs, data collection, and training.
  - Managers are responsible for ensuring staff have sufficient time to engage with the CSM process without impacting service delivery.

5. Providing Information to Staff about the Common Staffing Method

- **Transparent Communication:**
  Staff are kept informed about the use of the common staffing method through:
  - Regular updates at team meetings and governance forums.
  - Sharing of results from staffing level and professional judgement tools, including the rationale for decisions and any changes made as a result.
  - Access to reporting templates, guidance documents, and feedback on the outcomes of CSM cycles.

6. Demonstrating Compliance

- **Documentation and Audit:**
  - Records of staff engagement, training attendance, and protected time allocation are maintained and reviewed at governance meetings.
  - Feedback from staff is documented and used to inform continuous improvement.
  - Compliance with Duty 12IL is monitored through regular audits and reporting to the Health Board.

In summary:
NHS Forth Valley has robust systems and processes to ensure staff are engaged, trained, and supported in the use of the common staffing method. Staff feedback is actively sought and used to drive improvement, and clear communication ensures transparency and understanding of the CSM process. Compliance is monitored through documentation, audit, and governance oversight.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

1. Staff Engagement and Feedback Mechanisms

- **Regular Surveys and Forums:**
  NHS Forth Valley uses staff surveys (e.g., iMatter), focus groups, and team meetings to gather staff views on staffing arrangements and the use of the common staffing method (CSM).
  - Feedback is also collected through professional forums, governance meetings, and direct communication with line managers.
  - Staff are encouraged to raise concerns or suggestions, and these are documented for review.
- **Documentation and Audit:**
  Records of staff engagement, feedback, and consultation activities are maintained and reviewed at governance meetings. This ensures that staff views are systematically considered and acted upon.

2. Training Delivery and Monitoring

- **Training Records:**
  Attendance at CSM training (including e-learning, face-to-face sessions, and induction) is recorded and monitored using digital systems such as TURAS and eRoster.
  - Refresher training and updates are tracked to ensure all relevant staff remain up to date.
- **Protected Time for Training:**
  eRoster is used to allocate and record protected time for staff to participate in CSM activities, including training, tool runs, and data collection.

3. Governance and Oversight

- **Workforce Governance Groups:**
  Workforce and clinical governance groups review compliance with Duty 12IL, including:
  - Training attendance and completion rates.
  - Staff engagement and feedback data.
  - Issues raised and actions taken in response to staff views.
- **Escalation Mechanisms:**
  If non-compliance is identified (e.g., staff not receiving training, inadequate time for CSM activities, or lack of consultation), this is escalated through governance structures.
  - Issues can be raised at team meetings, through line management, or via formal governance routes.
  - Persistent or significant issues are escalated to senior management or the Health Board for resolution.

4. Continuous Improvement and Communication

- **Feedback Loops:**
  Staff feedback is used to refine training content, delivery methods, and consultation processes.
  - Outcomes of CSM tool runs, decisions, and changes are communicated back to staff through team meetings, governance forums, and digital updates.

- **Monitoring Impact:**
  The effectiveness of training and consultation is monitored through regular audits, staff feedback, and review of workforce and quality data.

In summary:
NHS Forth Valley monitors compliance with Duty 12IL through robust staff engagement, digital tracking of training and protected time, governance oversight, escalation pathways, and continuous improvement. These arrangements ensure that staff are consulted, trained, and supported in the use of the common staffing method, and that any issues are identified and addressed promptly.

Area of Success / Achievement / Learning	Details	Further Action
Peer-Led Training and Mentoring (Nursing, Acute Services)	Key personnel with extensive experience in the common staffing method were engaged to train and mentor other staff involved in the process. This peer-led approach increased confidence and consistency in applying the method.	These experienced staff now meet regularly in a forum to discuss shared learning and ensure the common staffing method is used consistently across all relevant areas. The forum will be expanded to include new trainers and staff from other directorates.
Staff Feedback Integration (Community Nursing, AHPs)	Staff feedback collected through surveys and team meetings led to improvements in the timing and delivery of common staffing method training, making it more accessible and relevant to different teams.	The feedback process is now embedded as part of each CSM cycle, and lessons learned are shared at governance meetings to inform future training and consultation.
Protected Time for CSM Activities (Maternity, Women & Children)	eRoster is used to allocate and monitor protected time for staff to participate in CSM activities, including training and tool runs. This has improved staff engagement and the quality of data collected.	The approach is being reviewed for wider adoption in other services, with ongoing monitoring to ensure protected time is maintained and effective.
Development of CSM Champions (Allied Health Professions)	AHPs identified and trained CSM champions within teams to support colleagues, answer questions, and promote best practice in using the common staffing method.	The champion model is being evaluated for effectiveness and may be rolled out to other professional groups if successful.

Area of Success / Achievement / Learning	Details	Further Action
Transparent Communication of CSM Results (All Services)	Results from staffing level and professional judgement tools, as well as decisions made following CSM cycles, are shared with staff through team meetings and digital updates. This has increased transparency and staff understanding of the process.	Plans are in place to develop a digital dashboard for staff to access CSM results and related information in real time.

Area of Escalation / Challenge / Risk	Details	Further Action
Lack of Training on the Common Staffing Method (CSM) for Emergency Care Personnel	Issues were identified with a lack of training on the CSM for personnel in emergency care provision, primarily due to time constraints and service pressures. This resulted in some staff not being fully confident or able to participate in CSM tool runs and related activities.	Arranging and delivering targeted training sessions for emergency care staff, including the provision of mentoring from experienced personnel. Job planning is being reviewed to ensure adequate time is available for designated personnel to undertake CSM training and participate in tool runs.
Inconsistent Engagement with CSM Training (Community Nursing, AHPs)	Some staff groups, particularly in community nursing and AHPs, have shown lower engagement with CSM training, leading to gaps in knowledge and inconsistent application of the method.	Engagement initiatives are underway, including tailored workshops, regular communication, and involvement of staff representatives in planning. Feedback is being used to adapt training content and delivery to better meet the needs of these groups.
Protected Time for CSM Activities Not Consistently Available (All Services)	Staff in some areas report difficulty accessing protected time for CSM activities due to workload and staffing pressures, impacting their ability to fully engage with training and consultation processes.	eRoster is being used to allocate and monitor protected time for CSM activities. Managers are being reminded of the importance of ensuring staff have sufficient time for training and participation in CSM cycles.
Communication of CSM Results and Decisions (All Services)	There have been challenges in ensuring all staff are informed about the results of CSM tool runs, decisions made, and changes implemented as a result.	Plans are in place to develop a digital dashboard and enhance communication channels so staff can access CSM results and related information in real time. Team meetings and digital updates are being used to share outcomes and gather feedback.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance

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

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

Please provide information to demonstrate compliance.

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

1. Overview of Section 2(2) Duty

Section 2(2) requires that, when planning or securing health care provision from another person (e.g., via contract or agreement), NHS Boards must:

- Have regard to the guiding principles for health and care staffing.
- Ensure that the contracted provider has appropriate staffing arrangements in place.

2. Steps Taken to Comply with Section 2(2)

A. Embedding Guiding Principles in Contracting

- **Quality Standards in Contracts:** All primary care service contracts specify quality standards, which are evaluated through inspections and annual audits by the contracts team within the Health and Social Care Partnerships (HSCPs). Clinicians employed by the Health Board attend inspections and verify contractor-submitted documents to ensure high standards of care continue to be delivered.
- **Person-Centred Approach:** Contractors are required to demonstrate a person-centred approach, engaging with cluster leads in the GP community to ensure quality in patient care. Enhanced services are offered to bring care closer to home, supporting the guiding principles of safe, high-quality, and person-centred care.
- **Governance and Oversight:** There is a governance structure within the Health Board to investigate and resolve issues reported via contractors, ensuring compliance with the Health and Care Staffing (Scotland) Act.

B. Ensuring Appropriate Staffing Arrangements

- **Contractor Responsibility:** Contractors are responsible for their own workforce planning, recruitment, retention, roster management, and staff management. However, the Health Board retains responsibility for ensuring continuity of primary care services.
- **Support and Escalation:** The Health Board provides support for recruitment, advertising, and locum cover when contractors face staffing challenges. Issues are escalated through the Programme Board and risk teams as needed.
- **Compliance Monitoring:** Each contract requires practices to comply with the Health and Care Staffing (Scotland) Act. Guidance is shared with contractors, and compliance is monitored through audits and governance structures.

C. Multi-Disciplinary and Integrated Services

- **Multi-Disciplinary Teams (MDTs):** Primary care contractors and allied health professionals work in MDTs to ensure patients access the right care at the right time. Board-funded Primary Care Improvement allocations support this integration.
- **Enhanced Services:** Allied Health Professionals provide support to hospital services through enhanced services, furthering the aim of integrated, high-quality care.

D. Feedback and Continuous Improvement

- **Staff and Service User Feedback:** Mechanisms are in place for collecting and reviewing feedback from both staff and service users, which informs ongoing improvements and ensures services meet the needs of those served.
- **Transparency and Communication:** Open communication regarding staffing decisions is prioritised, fostering trust and collaboration among staff and service users.

3. Demonstrating Compliance: Evidence and Assurance

- **Audit and Inspection:** Regular audits and inspections of contractors ensure adherence to quality standards and appropriate staffing.
- **Governance Structures:** Issues are escalated and resolved through established governance processes, including the Primary Care Programme Board and risk registers.
- **Support Mechanisms:** The Health Board provides practical support to contractors facing staffing challenges, ensuring continuity of care.
- **Training and Guidance:** Contractors receive guidance on compliance with the Act, and their processes are reviewed during audits.
- **Feedback Loops:** Staff and patient feedback mechanisms are embedded in service delivery and improvement cycles.

Conclusion

NHS Forth Valley demonstrates compliance with section 2(2) of the Duty by embedding the guiding principles in all contracts, ensuring contractors have robust staffing arrangements, providing governance and support, and maintaining continuous monitoring and improvement processes. These systems collectively ensure that both the letter and spirit of the Health and Care Staffing (Scotland) Act are upheld in all contracted health care provision.

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

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

Methods of Monitoring Compliance

1. Contractual and Governance Oversight

- **Quality Standards in Contracts:** All contracts for primary care and other commissioned services specify clear quality standards. These are monitored through regular inspections and annual audits by the contracts team within the Health and Social Care Partnerships (HSCPs).

- **Clinical Verification:** Clinicians employed by the Health Board attend inspections and verify contractor-submitted documents to ensure high standards of care and compliance with staffing requirements.

2. Routine Auditing and Reporting

- **Annual and Ad Hoc Audits:** Audits are scheduled annually and as needed to review compliance with contractual obligations, including staffing arrangements.
- **Service Reviews:** Service redesigns and reviews are conducted to ensure that staffing levels and service delivery remain aligned with statutory requirements.

3. Feedback and Data Collection

- **Staff and Service User Feedback:** Mechanisms such as surveys, focus groups, and feedback forms are used to gather input from staff and service users. This feedback is reviewed regularly to identify areas for improvement.
- **Incident Reporting:** Systems like Safeguard (IR1) are used to report adverse events, including those related to staffing. These reports are analysed for trends and compliance issues.

4. Real-Time Monitoring Tools

- **eRostering and Safecare:** These digital tools provide live analysis of staffing data, enabling real-time monitoring of staffing levels and compliance. They are being rolled out across nursing, AHP, and medical teams.
- **Twice Daily Huddles:** Inpatient nursing and other teams hold regular huddles to review staffing levels and risks, ensuring immediate action can be taken if issues arise.

Local Arrangements for Monitoring Compliance

- **Governance Structures:** Issues of compliance are escalated through established governance processes, including the Programme Board, Workforce Governance Groups, and Senior Leadership Teams.
- **Risk Registers:** Severe or recurring risks are recorded on risk registers and reviewed regularly at governance meetings.
- **Escalation Pathways:** Clear escalation pathways are in place for addressing non-compliance. For example, sustainability risks with contractors are escalated through the Health Board's governance structure, and support is provided (e.g., locum cover, recruitment drives).

- **Reporting Templates:** The Common Staffing Method (CSM) reporting template is used to triangulate findings and escalate concerns as needed.

Mechanisms for Escalating and Addressing Non-Compliance

- **Escalation to Senior Teams:** Issues identified during audits, inspections, or routine monitoring are escalated to senior clinical and operational leads for resolution.
- **Support and Intervention:** The Health Board provides practical support to contractors and internal teams facing compliance challenges, such as additional recruitment resources or temporary cover.
- **Continuous Improvement:** Feedback loops ensure that lessons learned from incidents or audits are incorporated into future planning and service delivery.
- **Risk Mitigation:** Where risks cannot be fully mitigated at the service level, they are escalated to Board level for strategic intervention.

In summary: NHS Forth Valley uses a combination of contractual oversight, routine audits, real-time digital tools, feedback mechanisms, and robust governance structures to monitor compliance when planning and securing services. Clear escalation pathways ensure that any areas of non-compliance are addressed promptly and effectively.

Area of Success / Achievement / Learning	Details (NHS Function / Professional Group)	Description of Situation	Further Action / Future Use
Embedding Act Requirements in Contracts	Contracts Team, Primary Care, HSCP	When procuring from primary care contractors (e.g., GPs, dentists, pharmacies), requirements of the Health and Care Staffing (Scotland) Act are explicitly included in contracts and monitored through audits and inspections.	The approach and contract templates are being adapted for use in other procurement processes, such as with private hospitals and third-sector providers, ensuring consistency in compliance.

Area of Success / Achievement / Learning	Details (NHS Function / Professional Group)	Description of Situation	Further Action / Future Use
Governance and Escalation Structures	Contracts Team, Programme Board, Risk Team	Clear escalation pathways are in place for addressing non-compliance or sustainability risks with contractors. Issues are escalated to the Programme Board and risk registers, with support provided as needed.	The escalation model is being shared with other directorates to standardise risk management and escalation across all commissioned services.
Audit and Inspection Processes	Contracts Team, Clinical Leads	Annual and ad hoc audits of contractors' compliance with staffing and quality standards, including site visits and document verification.	Audit frameworks are being refined and standardised for use in all procurement and contracting activities, including new service models.

Area of Escalation / Challenge / Risk	Details (NHS Function / Professional Group)	Description of Situation	Further Action / Actions Taken
Assurance on Contractor Staffing	Contracts Team, Primary Care, HSCP	Difficulty in obtaining timely and robust assurance from some independent contractors regarding their staffing arrangements and compliance with the Act.	Engaging directly with service providers to clarify requirements, providing guidance and templates, and escalating persistent issues to the Programme Board. Alternative providers considered if assurance cannot be obtained.
Feedback Mechanism Engagement	All Clinical Services, Contractors	Variable engagement with staff and service user feedback mechanisms, especially among contractors and in newly procured services.	Ongoing communication and training to emphasise the importance of feedback. Sharing best practice examples and integrating feedback requirements into contracts.
Escalation of Sustainability Risks	Contracts Team, Programme Board	Sustainability risks identified with some contractors (e.g., GP practices) due to workforce shortages or financial pressures.	Risks escalated through governance structures, support provided (e.g., locum cover, recruitment drives), and contingency plans developed, including potential Board intervention.

COMPLIANCE ASSURANCE LEVEL
Reasonable Assurance