HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 - NHS GRAMPIAN ANNUAL REPORT 2025/26

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 Grampian*
Report authorised by:	*Name: Melanie Saunders*
	Designation: Interim Director of People and Culture
	Date: 16 April 2026
Location where report is published:	www.nhsgrampian.org/hcsa

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: • Impacts and outcomes of real -time staffing assessment on workforce/workload planning • How the outputs of the Staffing Level Tools and the application of the CSM have informed you workforce planning activity. • Impact of the Health and Care Staffing Act has led to safe and efficient staffing.
The ongoing use of SafeCare to undertake real-time staffing assessments in many areas across the system, supports identification of gaps, trends, and areas of pressure within the workforce, ensuring that future plans are aligned with service priorities. Where SafeCare is not yet in place, processes to determine and analyse workforce data varies however all information accessible to teams does inform strategic decisions on recruitment, retention, and workforce development, supporting a sustainable and resilient workforce that meets the evolving healthcare system. As part of the response to the External Diagnostic Report and the escalation to Stage 4, an Integrated Service Planning Process is being developed. This process is cognisant of the Health and Care Staffing (Scotland) Act (hereafter shortened to HCSA) requirements and will support a coordinated, multi-professional approach to workforce, service, and financial planning. Using the Standard Operating Procedure (SOP): Staffing Establishment Management through Application of Common Staffing Methodology (CSM) has resulted in the rebasing of nursing establishments within prioritised, non-delegated areas; ensuring more appropriate staffing within these areas. The process to determine the approach and backfill requirements associated with the final reduced working week Agenda for Change non-pay reforms has sought information, where applicable, on the outputs generated through application of the CSM. The process has highlighted the impact at local team level and the need for service redesign, while ensuring ongoing compliance with HCSA requirements. Public Health teams have developed Staffing Frameworks as a single document to demonstrate HCSA compliance and have been successfully used in real-time and prospective scenarios.

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.

Following our escalation to Stage 4 of the NHS Scotland Support and Intervention framework early 2025, we can evidence progress is being made on our targeted improvement plans to reduce our longest waits, strengthened collaborative and system working and the delivery of value-based care. Whilst there is evidence of progress, we continue to face considerable challenges across national standard performance and that which we aspire to provide for our patients and the communities we serve.

For many teams across the organisation, strengthened real-time staffing risk assessment and structured escalation processes have enhanced patient safety by ensuring continuity of care and reducing, as far as possible, unmitigated staffing risks. Over 331 units are using SafeCare to provide a system-wide visual representation of real-time staffing risks, enabling us to document risk assessments, mitigations and decisions in a clear and transparent way.

In recognising the link between increased staff wellbeing and the safety and quality of care provided to service users, ultimately leading to improved outcomes, NHS Grampian continues to offer a range of staff wellbeing initiatives including:

- NHS Grampian showed commitment to supporting staff living with migraines by signing ‘The Migraine Trust’s workplace pledge’ in the summer of 2025, the first Health Board in Scotland to sign. As part of NHS Grampian’s work with The Migraine Trust, a public webinar took place and additional training was provided to over 80 pharmacy staff, to improve their knowledge and understanding of migraines.
- ‘Wellbeing, Culture, and Development Wednesday’ has continued throughout 2025 with a weekly slot in the staff Daily Brief signposting colleagues to both external and in house support, such as: Migraine Trust resources, mental health resources and confidential advice via We Care, promotion of the Managers Development Forum, facilitation of Wellbeing Talks covering topics including sleep, migraine, menopause, and financial support as well as TURAS sessions on crucial conversations, courageous conversations, spaces for listening, understanding your resilience, guided journaling, retirement planning and wellbeing in the workplace for managers training.
- NHS Grampian is striving to recognise and reward the dedication and commitment shown to NHS Grampian by their hard-working staff members. One way we hope to achieve this is with NHS Grampians’ Long Service Award Programme which during 2025, celebrated 342 staff totalling 10,275 years of service.

We have also developed a comprehensive Rewards and Recognition Programme that celebrates the outstanding contributions of our staff. The awards below, open to all roles in scope, are nominated by staff, for staff:

- STAR Award - designed to recognise both individual and team achievements from across all roles in NHS Grampian.
- Green Star Award - introduced to help recognise the fantastic work colleagues are doing to take action on climate change.

Further rewards are also specifically available for our Nursing, Midwifery and Allied Health Professional (NMAHP) staff, including:

- DAISY Award - in partnership with the DAISY Foundation, this is an opportunity for patients and their loved ones to nominate an extraordinary nurse or midwife whose compassionate contributions go above and beyond expectations.
- NoSCAR Award - An annual award open to all NMAHPs.
- Executive Nurse Director Award - awarded by the Executive Director of Nursing, with those NMAHPs who share their work at our Celebrating Excellence Days being considered for this award.
- Inspiring NMAHPs - An annual award open to all NMAHPs who are nominated by colleagues, for their inspiring contribution in line with the NMAHP professional practice model.

Although not formally a role in scope of the Act, the Mental Health and Learning Disability (MHLD) Practice Education and Development Team also celebrate the dedication and brilliance of student nurses via their REACH awards. REACH stands for Recognising Excellence, Achievement, Contribution, and Hard Work, with the inspiring tagline, Reaching for Excellence. This award reflects the MHLD Service's journey toward achieving ANCC Pathway to Excellence accreditation in 2026 - a milestone everyone is working towards together. Celebrating students through the REACH award seeks to shine a light on our continued investment in developing the future workforce, recognising the vital role that students will play in shaping the future of NHS Grampian.

The ANCC Magnet Recognition Programme® is a globally recognised designation for care excellence which our children's hospital is currently pursuing, while colleagues across MHLD Services are working towards the Pathway to Excellence Programme®, which supports the development of a positive practice environment. 63 nurses within the MHLD Service have been involved in submitting evidence for each of the evidence-based standards that form Pathway to Excellence, namely: shared decision-making, leadership, safety, quality, wellbeing and professional development. Joining the Pathway to Excellence programme means the team is committed to creating a positive practice environment to empower and engage staff.

In December 2025, Royal Aberdeen Children's Hospital and The Royal Hospital for Children in Glasgow have become Scotland's first paediatric units to receive the prestigious Tessa Jowell Centre of Excellence for Children designation. This accolade recognises outstanding standards of care for children diagnosed with brain tumours and places both hospitals among only six paediatric centres across the UK to achieve this honour. The Tessa Jowell Centre of Excellence for Children designation follows a rigorous assessment by the Tessa Jowell Brain Cancer Mission, a convening body with over 13 member organisations and delivers transformative national programmes supporting the NHS neuro-oncology services in the UK.

As we plan for 2026/27, our compliance with HCSA has informed a clear set of workforce priorities aimed at improving both staff wellbeing and experience, and service delivery. These include the implementation of a new organisational culture programme, underpinned by leadership, wellbeing and equality; strengthened staff involvement and transparency in decision-making; and improved appraisal, mandatory and statutory training completion rates. Progress in these areas is expected to enhance staff engagement, capability and wellbeing, supporting a more sustainable workforce and, in turn, improved outcomes for service users across Grampian.

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.	Limited Assurance
Duty 12ID: Duty To Have Risk Escalation Process in Place.	Limited Assurance
Duty 12IE: Duty To Have Arrangements to Address Severe and Recurrent Risks.	Limited Assurance
Duty 12IF: Duty To Seek Clinical Advice on Staffing.	Reasonable Assurance
Duty 12IH: Duty To Ensure Adequate Time Given to Clinical Leaders.	Limited Assurance
Duty 12II: Duty To Ensure Appropriate Staffing: Training of Staff	Reasonable Assurance
Duty 12IJ: Duty To Follow the Common Staffing Method (CSM)	Reasonable Assurance
Duty 12IL: Training And Consultation of Staff	Limited Assurance
Planning And Securing Services	Limited Assurance
PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE	
Limited 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 Grampian's Putting People First approach focuses on frontline staff by valuing the insight they gain through everyday interactions and empowering them to shape how care is designed based on what people say matters most. It gives staff more flexibility, strengthens partnerships with communities and the third sector, and supports more meaningful, person-centred practice.
In the past year, the following has been delivered:

- Testing of real-time feedback loops has begun in one clinical area, with plans to expand to ten areas in 2026 thanks to NHS Grampian charity funding. Feedback is gathered at the bedside, anonymised, and returned to frontline teams within 48 hours, giving them timely insight into what is working well and early opportunities to address issues that matter most to patients. This approach has been positively received by both staff and the public, and as it grows, themed feedback from multiple areas will be shared across the organisation to support decision-making rooted in people's experiences of care at NHS Grampian.
- A range of Community Appointment Days have been delivered supporting many patient groups including people living with Chronic Pain, COPD, people recently diagnosed with Dementia, people on waiting lists for Podiatry as well as events focusing on men's

wellbeing and women's menstrual health. A Community Appointment Day (CAD) brings services directly into local venues, offering one-stop, non-medicalised access to education, advice, and support from clinical teams, third sector partners, community groups, and peers all in one place. They are designed and developed with frontline staff from across the system, also involving input from people with lived experience. CADs have evaluated positively, with patients valuing the unhurried access to holistic care and staff valuing being able to network and learn about other services available in the community whilst delivering care. Plans for the year ahead include continuing to support local teams to develop effective CAD responses, whilst also using data to identify which population group who are waiting for care may benefit most from a CAD approach.

- A core part of Putting People First is ensuring staff have the skills, confidence, and autonomy to work creatively to achieve the best outcomes for people. In 2025, the Getting it Right for Everyone (GIRFE) toolkit was introduced to strengthen person-centred practice, and in Grampian we have brought GIRFE, Putting People First, and Realistic Medicine together under the Hope Collaborative to help teams use the range of tools available consistently to deliver high-quality care. The Hope Conference took place in November 2025, bringing over 100 staff and people with lived experience together to share good practice and spark new collaborations that we will continue to build on in 2026.

Cervical screening is an important way to detect early changes that could prevent cervical cancer. NHS Grampian recognised that it can be difficult to find time to attend appointments outside of work so in order to support staff, we have been piloting weekly cervical screening clinics at the end of 2025-early 2026. Clinics were available at Aberdeen Royal Infirmary, Dr Gray's Hospital and Maryhill Group Practice in Elgin, with staff welcome to attend these clinics during work hours, with no requirement for time to be given back.

NHS Grampian recognises the link between increased staff wellbeing and the safety and quality of care provided to service users. 76% of colleagues strongly agreed, agreed or slightly agreed with the statement 'I feel my organisation cares about my health and wellbeing' in the 2025 iMatter, reporting an average score of 70 within the green 'strive and celebrate' range. This is a 3-point decline from 2024 and could suggest staff perceive a lack of holistic support from the organisation itself, beyond their immediate manager.

64% of respondents in 2025 iMatter agreed or strongly agreed with questions mapped to the Staff Governance Standard strand 'Provided with a Continuously Improving and Safe Working Environment, Promoting the Health and Wellbeing of Staff, Patients and the Wider Community'. A further 20% slightly agree with questions mapped to this strand of the Staff Governance Standard. Responses equated to an average score of 77 for this strand of the standard, placing it within the green 'strive and celebrate' range.

A new Culture Programme Board was established at the end of 2025 to help drive positive workplace culture and staff wellbeing. The Board have agreed a number of projects against each of the three "Improving Wellbeing and Working Cultures" guidance, including:

- Focus on Fundamentals of Leadership and Management;
- Taking reasonable steps to reduce sexual harassment in the workplace;
- Ensuring our facilities are accessible to all and recognise the needs of a variety of people; and
- Supporting managers to support staff who have suicidal ideation.

A programme was established early 2025 to integrate acute pathways across Grampian for equal access to care and to stabilise services and how workforces work across Aberdeen and Elgin. This was commissioned for the whole of Acute, however three pathways were accelerated - Orthopaedics, Cardiology and Endoscopy. An integrated service model focusing on implementation of single point of referral, integrated vetting, single waiting list and single governance was achieved. The key benefit of this Programme is having single waiting lists where patients will be taken in order in line with their clinical condition across Grampian, ultimately ensuring they are provided with safe, high-quality care and improved outcomes, regardless of their location within Grampian. The next pathways for further integration are yet to be determined at the time of writing this report.

Dialysis patients across NHS Grampian are being given the option of moving to at-home treatment following a successful pilot of home haemodialysis. The set up involves a period of education and training - and converting an area within people's homes so specialist equipment can be installed, before treatment can begin. For patients who would typically have to attend a dialysis unit three times a week for around four hours at a time, and who may have lengthy commutes to and from their local unit, the chance to be treated at home can provide them with much more flexibility in their lives.

Care Opinion data, along with feedback and complaints, is regularly provided to the Clinical Risk Management meeting and the Clinical Governance Committee. There has been an improvement in the percentage of complaints closed within the Model Complaints Handling Procedure Target of 20 days, increasing from 35% in April-September 2024, to 47% for the same period in 2025. Work is ongoing to ensure consistent timely responses to patients and families and to evidence our learning from complaints. In addition to this, Scottish Public Services Ombudsman acknowledged that our performance has improved, indicating improved complaint handling and system learning is having a positive net effect.

Being the first Health Board in Scotland to collaboratively develop and publish an Anti-Racism Plan with the University of Aberdeen and NHS Grampian's Staff Equalities Network, has previously been acknowledged at a national level. In September 2025 a workshop called 'Leading the Change', led by members of our Anti-racism Oversight Group, once again focussed attention on what we can do individually and collectively to foster an inclusive environment for all patients and staff. This workshop covered our emerging future plans and ongoing commitment to training and awareness raising activities.

Three frameworks were developed, in part, to support and demonstrate compliance with HCSA duties. They include the roles in scope for the Public Health Directorate and have been written to include workforce planning and escalation and also include the training for assurance of competent and up-to-date practitioners and professional regulation. The frameworks help to ensure the correct staffing is maintained through workforce planning to address attrition and turnover of staff due to retirement and supported the clarity of service needs though the reduction of the working week for example. They also help support the business continuity plans and impact assessments and will be treated as live documents to be updated and agreed when there are changes that affect their implementation, such as redesign of roles. The frameworks have enabled clarity regarding an agreed standard level of appropriate staffing which includes skill mix and training considerations. They have

operational escalation steps that detail the process to undertake when this is not met, or the workload increases substantially. These standards for the workforces are essential to maintain safe and satisfactory operational delivery for real-time challenges as well as the recurring workforce or workload risks and are used to support recruitment, future modelling and redesign of the workforces in order to maintain quality of input and improved outcomes for service users and staff.

Published in October 2025, 'The Health and Wellbeing of people living in Grampian in 2024' brings together information to describe the population characteristics of Grampian and the evidence base to provide context for the 2024 Director of Public Health Annual Report. This provides greater insight into understanding the local Grampian context, considering the number and needs of patients. The purpose of the document is to provide additional detail for patients and staff seeking more information about the Health and Wellbeing in Grampian and the key themes discussed in the Director of Public Health annual report.

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

Day-to-day compliance with this duty is monitored through a range of operational systems, processes and governance arrangements. There are many examples of good practice following on from the first year of commencement which is primarily driving the overall reasonable assurance for 2025/26. Some approaches to monitoring are inconsistent and there is variation between different professions and areas of the organisation. During the latter half of 2025/26, the Chief Executive Team commenced a review of revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report.

At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three Board Level Clinicians (BLCs). This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board.

Additional assurance is also sought by Staff Governance Committee from each Sector/Partnership on a rotating 12-18-month cycle via their assurance reporting template. This template seeks information on compliance of the Staff Governance Standard, in turn connecting to the Guiding Principles, how delivery of the Standard is encouraged as well as a new section added during 2025 seeking assurance about compliance with this Duty under the HCSA.

Deviation from recognised service standards of practice and delivery is identified as a very high organisational risk which has broadened during a wider risk register update in December 2025. The risk recognises the impact to quality care along with staff experience, health and wellbeing when workload exceeds workforce availability. Mitigations, including use of supplementary staffing for short term gaps, are in place. Organisational oversight of the risk includes a full risk review at Chief Executive Team meetings every eight weeks and Clinical Governance Committee twice per year. The discussion at Clinical Governance Committee is informed through the use of a risk dashboard which includes quality measures (patient feedback and complaints, adverse events). This and all organisational strategic risks are

visible to the workforce via the internal Risk Management SharePoint site, further evidencing transparency and keeping colleagues well informed.

To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, application of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level of risk.	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, continue the roll out of eRostering across the organisation, using learning from areas that have already implemented.
Culture Programme Board established. [All roles in scope - all NHS functions]	• The new Culture Programme Board will provide a mechanism for delivery of our culture programme and staff engagement and experience activity.	• Culture programme will become a strengthened focus as we look to 2026/27. • Preparation of a system-wide development plan for roll out from April 2026 onwards, setting clear expectations for managers.
Putting People First approach. [Patients; all roles in scope - all NHS functions]	• The Putting People First approach begins a systemic shift in how we welcome, involve and invite all colleagues and service users to contribute to improving services and help shape the future of health and care in Grampian.	• Putting People First principles to be embedded in both unscheduled and planned care pathways, reinforcing NHS Grampian's ambition to be a population health organisation.
Development of the Flow Navigation Centre Mental Health and Police Scotland 'Place of Safety' pathway. [Patients; all roles in scope - MHLD Services]	• This is a project led by Consultant/Clinical Director along with Lead Nurse and others to improve patient experience in accessing secondary care mental health assessment, whilst reducing resource burden to Police Scotland during Place of Safety occurrences. • This work aligns itself to Police Scotland's national strategy, and with the NHS	• Continued monitoring of the 'Place of Safety' pathway.

	Grampian Unscheduled Care Program Board 'upstream' element.	
Discharge without Delay MHLD joint improvement work with Healthcare Improvement Scotland (HIS). [Patients; all roles in scope - MHLD Services]	• The significant improvement to patient and carer experience in the reduction of delayed discharges and occupied bed days has been nationally recognised for enhancing flow through our system. • Lead Nurse has led this improvement project with colleagues across the three Health and Social Care Partnerships (HSCPs), collaborating with HIS colleagues, and sharing our learning at local and national events, ably supported by Senior Charge Nurse in Muick Ward. • This work is linked to the First Ministers' commitment to reducing delayed discharges within hospital settings and doing a deep dive into the MHLD experience. • This work is also aligned to the 'downstream' element of Grampian's prioritised work under the Unscheduled Care Program Board.	• Continued monitoring and improvement to patient and carer experience in the reduction of delayed discharges.
Staff Health and Wellbeing. [All roles in scope - MHLD Services]	• MHLD leadership teams facilitate many opportunities to focus on staff health and wellbeing, with ongoing support within staff partnership and workforce governance meetings, in addition to many unplanned occasions hearing from staff in supporting opportunities to improve our experience at work. • Members of the Senior Leadership Team have continued to arrange weekly 'lunch and natter' sessions in the RCH canteen	• Heightened awareness around mental health related absence remains a focus in 2026.

	and have reinstated the monthly health and safety walkabouts. • Internal opportunities include the RCH Wellbeing room, staff use of the physiotherapy gym within the Recovery Resource Centre, access to Values Based Reflective Practice, and Trauma support post significant adverse events i.e. TRiM.	
Launch of HCSA SharePoint site, available to all on networked devices to improve knowledge, understanding and responsibilities within the HCSA. [All roles in scope - all NHS functions]	• The launch of HCSA SharePoint site, with dedicated pages for each duty has provided a repository of internal and external (Staff Governance Standard, Health and Social Care Standards, Healthcare Staffing Programme (HSP) and NHS Education for Scotland (NES)) resources available to colleagues 24/7. • A dedicated page for appropriate staffing is available including a competency definition from NHS Grampian's Health and Safety Toolkit for managers.	• Maintaining currency and accuracy of resources and definitions within the SharePoint site.
Updated HCSA Psychology SOP. [Psychology - all NHS functions]	• Grampian's Psychology Service have refined and further developed their initial real-time staffing and risk escalation SOP to incorporate all Act requirements.	• Shared learning opportunities via multi-professional Implementation Team. • Explore hosting on HCSA SharePoint site.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with recruiting a particular staff speciality or recruitment in a remote / rural location.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in recruiting in a particular speciality or remote / rural location, the relevant organisation may have investigated retire and return schemes or upskilling and career development for

		existing staff. It may also have looked at how the service could be redesigned.
Competing priorities and demands on teams. [All roles in scope - all NHS functions]	• In a busy healthcare system that is progressing other organisational priorities, colleague availability and resource hinders the ability to consider, develop and implement the necessary processes for this duty, separate to all other duties.	• Use of risk escalation processes when planned time to consider, develop and implement the necessary processes is unable to be achieved.
Ongoing pause of Optima roll out. [All roles in scope - all NHS functions]	• While compliance of the Act does not necessitate the use of electronic rostering systems, the use of Optima is considered a significant enabler. With the ongoing lack of interface between Optima and Payroll systems resulting in manual transfers, NHS Grampian has continued its pause of Optima roll out to new areas in 2025/26.	• Plans are currently in development to support the transition of rosters from SSTS to Optima by March 2028 although at this time it is unlikely that full functionality for end users will be available by that date.

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.

SafeCare continues to be the preferred electronic system used to support real-time staffing risk assessments within NHS Grampian. Nursing continues to be the primary staff group for roll out with teams live in all hospital sites and across District/Community Nursing, Health Visiting and School Nursing teams in Aberdeen City and Aberdeenshire HSCPs. Midwifery services have transitioned from Real-Time Staffing Resource on TURAS and are now live on SafeCare. SafeCare is also live within a range of Allied Health Professional (AHP) teams across Acute and MHLD sites and Aberdeen City HSCP. Plans are in place for roll out for District/Community Nursing, Health Visiting and School Nursing teams in Moray HSCP before progressing with the remainder of AHPs. The impact of ongoing roll out and increased number of live units can be evidenced by having 23,161 real-time staffing risk assessments completed on SafeCare in Q3 of 2025/26. This is more than 9000 more real-time staffing risk assessments compared to the same period last year.

For areas not currently using SafeCare, there are a range of mechanisms for determining real-time staffing risks, although it is acknowledged that these are not consistently documented and/or are documented through a variety of means. Grampian Operational Pressure Escalation System (G-OPES) continues to be used to ensure a consistent terminology of levels of pressure across all operational areas; levels span from one to four. Each area's levels are independently set, and an overall combined level describes the overall system pressure. The levels are set based on metrics to maintain as much consistency as possible and to minimise subjectivity. The ability to overrule the levels suggested by

these metrics based on professional judgement will remain, as every scenario cannot possibly be captured by metrics alone. This includes consideration of real-time staffing risks.

The development of three service specific Staffing Frameworks within Public Health Directorate (Health Protection, Healthpoint and the Dental Information and Advice Line) have been essential to maintain safe and satisfactory operational delivery for real-time challenges, while maintaining quality of input and improved outcomes for service users and staff.

The Real-Time Staffing Checklist developed during the first year of commencement is still promoted and readily accessible to all roles in scope not currently using SafeCare via the HCSA SharePoint site; the checklist has been accessed almost 400 times over the course of nine months. The checklist has been developed to support teams in reviewing their current processes in managing real-time staffing (assessment and consideration of mitigation and/or escalation) and risks. The checklist should help teams identify any gaps in processes or areas where further development is required, particularly around identifying and managing severe and recurrent risks. The self-service checklist should be completed once to create a baseline per service/team and then the frequency thereafter is determined by individual teams, depending on the required actions to reach compliance. This checklist will be used as a tool to help inform the transition onto SafeCare.

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.

Day-to-day compliance with this duty is monitored through a range of operational systems, processes and governance arrangements. While there are examples of good practice following on from the first year of commencement, approaches to monitoring remain inconsistent and there is variation between different professions and areas of the organisation. This is primarily driving the overall limited assurance for 2025/26. During the latter half of 2025/26, the Chief Executive Team commenced a review of revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report.

At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board.

To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area	**Details** This should describe the situation: what is the success, achievement, or learning?	**Further action** This should describe how the success, achievement or learning could be used in the

of success, achievement or learning relates to.	For example, areas that have implemented and are using SafeCare are able to accurately record risks that are identified and the mitigation measures implemented, and clinical advice received. Reports extracted from the system are demonstrating an auditable trail of decision-making.	future. For example, this success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation.
Launch of HCSA SharePoint site, available to all on networked devices to improve knowledge, understanding and responsibilities within the HCSA. [All roles in scope – all NHS functions]	• The launch of HCSA SharePoint site, with dedicated pages for each duty has provided a repository of internal and external (HSP and NES) resources available to colleagues 24/7. • A dedicated page for real-time staffing assessment and risk escalation is available including links to eRoster SharePoint site (including SafeCare), Real-Time Staffing Checklist and Red, Amber, Grey, Green (RAGG) status definitions.	• Maintaining currency and accuracy of resources and definitions within the SharePoint site.
Launch of eRoster SharePoint site, available to all on networked devices with a dedicated page to SafeCare. [All roles in scope – all NHS functions]	• The launch of the SafeCare SharePoint site provides a single point for all associated resources, including locally produced videos on TURAS, user guides along with links and reference to HCSA.	• Maintaining currency and accuracy of definitions within the SharePoint site.
Use of SafeCare in areas not currently on Optima eRoster. [NMAHPs - all NHS functions]	• Continued roll out of SafeCare to teams not yet using Optima eRostering to support compliance with real-time staffing risk assessments. 50% of units using SafeCare do not currently use Optima eRoster. • Almost all Nursing and Midwifery patient care delivery teams are now using the system.	• Completion of District/Community Nursing, Health Visiting and School Nursing Teams. • Continued roll out within AHPs across organisation.

	• AHPs within main Adult Acute site, main MHLD site and Aberdeen City HSCP are now live on the system.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with encouraging and enabling certain professional groups to use the systems and processes.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in engaging certain professional groups, what measures have been put in place with regard to increasing this such as using professional networks, staff representatives etc.?
Transition of staffing level tools from SSTS to SafeCare. [Nursing - MHLD Inpatient Services only]	• Real-time staffing RAGG status in SafeCare can be impacted by the addition of retrospective entries in SafeCare as part of the new staffing level tool. • Real-time staffing RAGG status is not affected if Optima reports are used. • With visualisation typically taking place on SafeCare, this will affect users if they wish to review decisions made about staffing on a previous shift.	• Continue to monitor local impact and engage with HSP as necessary. • The impact on RAGG status has been raised through the national SafeCare Expert Working Group with a decision to make no changes to configuration at present. • Ensure relevant Clinical Leaders are aware of the differences and any potential impact this may have. Promote the use of Optima for real-time staffing reporting during staffing level tool runs. • Consider lessons learnt and communicate these to relevant teams as other staffing level tools transition to SafeCare.
Competing priorities and demands on teams. [All roles in scope - all NHS functions]	• In a busy healthcare system that is progressing other organisational priorities, colleague availability and resource hinders the ability to protect time to develop, implement and receive training on the processes.	• Use of risk escalation processes when planned time to develop, implement and receive training on the processes is unable to be achieved.

Ongoing pause of Optima roll out. [All roles in scope - all NHS functions]	• While compliance of the Act does not necessitate the use of electronic rostering systems, the use of Optima is considered a significant enabler. Unfortunately, with the ongoing lack of interface between Optima and Payroll systems resulting in manual transfers, NHS Grampian has continued its pause of Optima roll out to new areas in 2025/26.	• Plans are currently in development to support the transition of rosters from SSTS to Optima by March 2028 although at this time it is unlikely that full functionality for end users will be available by that date. • SafeCare has continued to be rolled out in non-rostered areas, recognising this supports compliance with real-time staffing risk assessments, albeit without the full functionality and the full benefits of the Optima system are not realised.

COMPLIANCE ASSURANCE LEVEL
Limited 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.

Risk Management is part of the Management Development Programme. A recent recording of one of these sessions has been shared on the Intranet page which is accessible to all on a networked device 24/7. This gives a basic overview of risk, risk management and some key responsibilities and practical applications.

Bimonthly Workforce flash reports, including workforce risk escalations, are completed and shared at NHS Grampian's Nursing Workforce Council meetings, and help is offered to try and reduce/mitigate some risks by the group.

Ward areas, Minor Injury Units, Prison and Custody teams meet daily (seven days per week) to provide real-time staffing information; this allows discussion and support for any areas with suboptimal staffing, creating a full picture of clinical staffing profile across Aberdeenshire daily.

Public Health's Staffing Frameworks detail service staffing requirements and skill mix, risk analysis, escalation plans and links to service specific resources. These sit alongside and are complementary to the business continuity plans, which supports the workforce via training, planning and managing immediate risk from an increased workload or a decreased workforce, or longer-term recurring risks and decision-making. The Frameworks have already been used in real-time scenarios to ensure appropriate staffing levels where the business continuity plans needed to be enacted. The framework supported the need for clarity with escalation and actions to ensure appropriate staffing levels and skill mix requirements for service users.

The Real-Time Staffing Checklist developed during the first year of commencement is still promoted and readily accessible to all roles in scope not currently using SafeCare via the HCSA SharePoint site; the checklist has been accessed almost 400 times over the course of nine months. The checklist has been developed to support teams in reviewing their current processes in managing real-time staffing assessment and risks, which includes consideration of operational/professional escalation routes. In clearly identifying and documenting these escalation routes via the checklist, they can be readily accessible to inform all staff within a department.

A NMAHP Workforce Dashboard has been developed to extract workforce data from multiple sources and is due to launch early 2026. Analysis of data will support the identification of risk for escalation. A draft composite risk scoring framework has been developed and phase one of this supports the Nursing and Midwifery Workforce Governance Framework that assists monthly local reviews and quarterly sector/operational reporting. It is anticipated that escalations from the reviews will map into the existing workforce governance and operational risk management structures. A Nursing & Midwifery Assurance Framework for Clinical Leaders is also in development for launch in 2026/27, enabling easier identification, management and escalation of risks while demonstrating robust grip and control and good financial governance.

It is recognised that while significant focus has been on the development/documentation of risk escalation processes for real-time staffing risks, the processes are not currently being consistently used for escalating risks relating to other duties of the HCSA.
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.
While the monitoring of compliance with Public Health's Staffing Frameworks are managed on a day-to-day basis within the service level governance structures, the oversight is with the directorate Public Health Monitoring and Governance Group. Any specific areas that cannot be resolved are further escalated to the Public Health Coordinating Group that reports to Chief Executive Team through the Director of Public Health. Elsewhere in the organisation, day-to-day compliance with this duty is monitored through a range of operational systems, processes and governance arrangements. While there are examples of good practice following on from the first year of commencement, approaches to monitoring remain inconsistent and there is variation between different professions and areas of the organisation. The variation and inconsistencies are primarily driving the overall limited assurance for 2025/26. During the latter half of 2025/26, the Chief Executive Team commenced a review of revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report. At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board. Development of organisational dashboards are in the process of being implemented following approval from Information Governance. These dashboards will support oversight and monitoring of staffing across all sectors and divisions, providing accessible workforce information including short and long-term absences and turnover. Embedding these will support risk identification and appropriate actions within operational and professional structures. To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area	**Details** This should describe the situation: what is the success, achievement, or learning? For example, senior decision-makers in paediatric	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, The procedures for

of success, achievement or learning relates to.	nursing were identified and a chain of escalation communicated to all personnel. Individuals are now much better aware of who to contact during any particular shift in the event that a risk needs to be escalated.	identifying the chain of escalation that were used in paediatric nursing are now being trialled and rolled out across other areas.
Service specific Staffing Frameworks. [All roles in scope - Public Health Directorate]	• Risk escalation processes, detailed within the Frameworks were used both in real-time and prospective scenarios. • Framework supported colleagues to consider the level of risk, appropriate mitigations and reasons for escalation.	• Shared learning opportunities via multi-professional Implementation Team.
SOP: Staffing Establishment Management through Application of CSM. [Nursing, Midwifery across all NHS functions and Medical staff in Emergency Department]	• Determination of risk-based prioritisation and decision-making routes as part of the CSM.	• Summary of governance routes will be available on the CSM SharePoint site, accessible 24/7 on a network device from end of 2025/26.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating, or giving clinical advice on a risk are notified of decisions made and the reasons for them.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes?
Variability in use of SafeCare system. [All roles in scope – all NHS functions, where SafeCare is in use]	• Variable practice results in incomplete data sets, especially where senior decision-maker follow-up or closure of mitigations is not recorded.	• Robust pre and post SafeCare implementation support from SafeCare Team. • Locally produced videos available on TURAS for senior decision-makers.
Operational teams are not consistently demonstrating the use of trend data or	• Although real-time staffing data is available for many teams and recurrent risks should be reviewed and incorporated	• Consider what can be facilitated during 2026/27 to enable trend data and

identifying recurring risks within their decision-making processes. [All roles in scope - all NHS functions]	into local governance arrangements, there is limited visible evidence that this is happening in practice. • The absence of clear trend analysis and risk-informed actions creates uncertainty about whether emerging patterns are being recognised, escalated, or addressed effectively across operational areas.	recurring risks be used in future decision-making processes. • NMAHP Workforce Dashboard for trend analysis has been developed and is due to launch early 2026.
Further work is required to strengthen and empower the use of risk-escalation processes when other duties in the Act are not being fully met. [All roles in scope - all NHS functions]	• At present, if clinical leaders do not have systems and processes to determine and implement adequate leadership time or if planned training is continually cancelled, it is not always triggering appropriate escalation or formal recognition of non-compliance with other duties required under the Act. • This limits the organisation's ability to respond proactively and maintain clear accountability for all duties within the Act.	• Strengthening understanding, confidence and consistency in using risk escalation routes will be essential to support effective governance.
There is currently no training and development programme for risk management practices. [All roles in scope - all NHS functions]	• Currently, there is no training and development programme for staff in NHS Grampian specifically related to risk management practices, although this is part of long-term planning for this significant area of governance.	• A Health and Safety Toolkit for Managers was endorsed in 2024, including a risk assessment module, with monitoring of completion via NHS Grampian's Health and Safety Committee. • A recent recording of a Risk Management session via the Managers Development programme has been provided on the Intranet page accessible to all NHS Grampian staff on a networked device 24/7, which gives a basic overview of risk, risk management and some key responsibilities and practical applications. • NHS Borders have kindly given permissions to utilise their suite of YouTube videos which cover some key

		aspects of risk and risk management which are accessible via the Intranet.

COMPLIANCE ASSURANCE LEVEL
Limited 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.

Risk Management is a key element of our internal controls. The Risk Management Policy outlines that all identified risks with potential to cause harm should be managed in line with Risk Management Protocol, which includes the use of DATIX for Risk Registers. Staffing risks can be reported via DATIX with automatic escalations depending on risk classification, enabling managers to close the loop and feedback to colleagues who report incidents. Risks are initially managed at the lowest operational point as possible, however can be escalated up to Board Committees through relevant governance structures including Clinical Governance, Staff Governance, Population Health, and Performance, Assurance, Finance and Infrastructure Committees. The Chief Executive Team also review strategic risks frequently.

In addition to supporting transparent risk-based decision-making on a shift-by-shift basis, the SafeCare system can support improved workforce governance due to the availability of trend data. These risks are presented quarterly to NHS Grampian Clinical Risk Management meeting to support process assurance and the identification of risk patterns across clinical sites and the organisation. The management structures within the various NHS functions are required to manage severe and recurrent risk, within their own local risk management structures.

Within Specialist MHLD Nursing, a key achievement has been the establishment of a structured process to identify, escalate, and manage severe or recurrent staffing risks. Risks are detected through real-time SafeCare data, voiced care concerns, and staff escalation. Once identified, they are escalated to senior leadership and recorded on the risk register to ensure visibility and accountability. Action plans are

developed collaboratively with the clinical nursing team, supported by ongoing risk assessment and review. Clear communication of actions and outcomes with staff is prioritised to maintain transparency, build confidence, and promote shared learning across the service. Clinical risk management meetings focus on the risk register every three weeks. Future actions will include conducting a comprehensive review of current escalation pathways and compliance gaps to identify areas for improvement.

In non-delegated services, the Accountability and Assurance (A&A) process reviews risks twice per year. Measures are generally at ward/speciality level; managed by service and Divisional teams (or equivalent). Unit and Divisional teams can manage a complex and high degree of risk; the A&A process in general works on an assurance basis, with escalation when necessary. Red line metrics have been introduced to define the degree of risk that we are comfortable that Divisional and operational teams can manage themselves. If the measures/metrics go beyond a certain point (the red line); the outcome of the A&A process will be a requirement for a written response to the Executive Lead, Head of Performance Management, Acute Nurse Director and Acute Medical Director from the relevant Divisional team outlining why the situation has arisen; their assessment of the risk this represents; and, their actions and timelines for resolution.

Across delegated NHS services, new and/or escalating high and very high risks are discussed at local Clinical and Care Governance (CCG) structures for awareness and support with mitigations. These are further escalated/reported to the appropriate CCG Committee as necessary.

Public Health's Staffing Frameworks detail staffing and operational pressures aligned to G-OPES levels and the RAGG definitions used on SafeCare. Their Frameworks clearly define local actions required when risks are detrimental to service delivery and they sit alongside and are complementary to the business continuity plans which support management of immediate risk, and longer term or recurring risks and decision-making.

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.

Day-to-day compliance with this duty is monitored through a range of operational systems, processes and governance arrangements. While there are examples of good practice following on from the first year of commencement, approaches to monitoring remain inconsistent and there is variation between different professions and areas of the organisation. Across the organisation, the terms recurring and enduring in relation to risks are still being used interchangeably, leading to a lack of clarity about which risks require strategic oversight versus those that should be managed through routine operational processes; limited progress has been seen on the use of recurring risks trend data to inform local short, medium or longer term workforce planning. All of which is primarily driving the overall limited assurance for 2025/26. During the latter half of 2025/26, the Chief Executive Team commenced a review of revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report.

Deviation from recognised service standards of practice and delivery is identified as a very high organisational risk which has broadened during a wider risk register update in December 2025. The risk recognises the impact to quality care along with staff experience, health and wellbeing when workload exceeds workforce availability. Mitigations, including use of supplementary staffing for short

term gaps, are in place. Organisational oversight of the risk includes a full risk review at Chief Executive Team meetings every 8 weeks and Clinical Governance Committee twice per year. The discussion at Clinical Governance Committee is informed through the use of a risk dashboard which includes quality measures such as patient feedback, complaints and adverse events. This and all organisational strategic risks are visible to the workforce via the internal Risk Management SharePoint site, further evidencing transparency and keeping colleagues well informed.

At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board. A separate Quarterly SafeCare Severe and Recurrent Risk Report is also considered by the Clinical Risk Management meeting.

To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, a recurrent risk was identified in the capacity of one laboratory, leading to a delay in testing samples and communicating sample results. Following investigation, the process for booking in samples was streamlined and an admin coordinator was appointed. This has improved performance, and the lab is now meeting its targets.	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, the organisation is now looking at whether the changes implemented in one lab could be applied to other labs, to improve wider performance.
Establishment of structured processed to identify, escalate and manage severe and recurrent staffing risks. [Nursing - MHLD Services]	• Identified risks are reviewed by senior leadership, added to the risk registers and managed through collaboratively developed action plans, regular clinical risk meetings and clear communication to ensure visibility, accountability, and shared learning.	• Further review of current escalation pathways and compliance gaps to identify areas for improvement.

SOP: Staffing Establishment Management through Application of CSM. [Nursing, Midwifery across all NHS functions and Medical staff in Emergency Department]	• The launch of the SOP enabled clarity and transparency of the various roles and responsibilities, including governance and escalation routes.	• Review of SOP and its application after 12 months.
Quarterly reporting at Clinical Risk Management meeting. [All roles in scope using SafeCare - all NHS functions]	• SafeCare trend data on severe and recurrent risks are reported to NHS Grampian's Clinical Risk Management meeting each quarter. These reports provide an overview, analysis by site and comparison with previous quarterly reports and an updated risk profile for the appropriate quarter.	• Further work required to facilitate and enable ownership of reporting through local structures, to supplement organisational reporting.
NMAHP Workforce Dashboard. [NMAHPs - all NHS functions]	• NMAHP Workforce Dashboard development including data sets that will allow for the review of real-time staffing risk with outcome measures and how this can be applied for CSM.	• Awaiting final sign-off prior to system-wide communication and ownership.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, collation of information in a particular NHS function has identified a risk that materialises frequently, however identification of actions to prevent future materialisation has not improved the situation.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, if identification of initial actions to prevent a recurring risk has not improved the situation, further steps may include establishing a working group to investigate and make recommendations, observing practice in the area, interviewing staff, addressing the staff skills mix, allocating additional assistance, redesigning the service etc.
Across the organisation, the terms recurring and enduring in relation to risks are still being used interchangeably. [All roles in scope - all NHS functions]	• It is recognised that recurring risks continue to be referred to interchangeably with enduring risks, across various roles in scope and NHS functions.	• This continues to be considered as part of ongoing HCSA implementation and awareness raising on the specific requirements of this duty.

	• NHS Grampian has an Enduring Risk Management Protocol however it is acknowledged that from a HCSA perspective, the requirement is on recurring risks.	
Variation in knowledge and understanding of recurrent risk element of this duty. [All roles in scope - all NHS functions]	• Local evidence suggests operational focus is typically on addressing severe risks with limited evidence on considering and addressing recurrent risks.	• Local definitions of severe and recurrent risks are accessible 24/7 on network devices via HCSA SharePoint site. • Definitions are further supplemented with local examples and tailored considerations at all HCSA engagement sessions or in meetings when this duty is discussed. • Maximise engagement opportunities to support wider understanding and recognition of recurrent risk element of this duty. • SafeCare definitions are defined within the national reporting document. NHS Grampian is an active participant in the SafeCare Expert Working Group, contributing to the review of current definitions.
Operational teams are not consistently demonstrating the use of trend data or identifying recurring risks within their decision-making processes. [All roles in scope - all NHS functions]	• Although real-time staffing data is available via SafeCare for many teams and recurrent risks should be reviewed and incorporated into local governance arrangements, there is limited visible evidence that this is happening in practice. • The absence of clear trend analysis and risk-informed actions creates uncertainty about whether emerging patterns are being recognised, escalated, or addressed effectively across operational areas.	• Consider what can be facilitated during 2026/27 to enable trend data and recurring risks be used in future decision-making processes.

Competing priorities and demands on teams. [All roles in scope - all NHS functions]	• In a busy healthcare system that is progressing other organisational priorities, colleague availability and resource hinders the ability to further develop knowledge and understanding of this duty.	• Use of risk escalation processes when planned opportunities are unable to be achieved.

COMPLIANCE ASSURANCE LEVEL
Limited Assurance

Duty 12IF: Duty to seek clinical advice on staffing

Duty Summary	**Duty to Seek Clinical Advice on Staffing.** **(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for-** (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL, (b) recording and explaining decisions which conflict with that advice. **(2) The arrangements under subsection (1) must, in particular, include-** (a) where a Health Board or the Agency (as the case may be) reaches a decision on a matter which conflicts with the clinical advice it has received- (i) a procedure for the identification of any risks caused by that decision, (ii) a procedure for the mitigation of any such risks, so far as possible, (iii) a procedure for the notification of any such decision, and the reasons for it, to any individual who gave clinical advice on the matter, (iv) a procedure for any such individual to record any disagreement with the decision made on the matter, (b)a procedure for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the Health Board or the Agency (as the case may be), on at least a quarterly basis, about the extent to which that individual considers that it is complying with the duties imposed by- (i) this section, and (ii) sections 12IA to 12IE and 12IH to 12IL, (c) a procedure for such individuals to- (i) enable and encourage other employees to give views on the operation of this section, and (ii) record such views in reports made in accordance with the arrangements put in place under paragraph (b), (d) raising awareness among individuals with lead clinical professional responsibility for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (c), and (e) ensuring that such individuals receive adequate time and resources to implement those arrangements. **(3) Every Health Board and the Agency must have regard to the reports received in accordance with the arrangements put in place under subsection (2)(b).**
Please provide information on the steps taken to comply with Duty 12IF. 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 Grampian has three BLCs: Executive Nurse Director, Executive Medical Director and Director of Public Health. Staff Governance Committee receive internal quarterly reports by BLCs (professional assessment of HCSA compliance) on behalf of NHS Grampian's Board. These reports also include qualitative and quantitative data from the external quarterly high-cost agency reports. BLCs are encouraged to involve, engage and consult their Clinical Professional Directors and relevant professional structures to help inform their individual views of	

compliance and therefore the preparation of their internal quarterly reports. Professional Clinical Leaders can also share views via Clinical Professional Directors Forum. The professional assessment undertaken by each BLC is easily identifiable within the internal quarterly reports.

A review and engagement process was undertaken with each BLC after the completion of the fourth Internal Quarterly Report (2025/26); with a new Director of Public Health and along with a fairly new in post Executive Medical Director, the opportunity was taken to incorporate some induction and general updates of progress so far within the relevant roles in scope under their professional leadership.

More widely, views of colleagues are gained annually through iMatter with NHS Grampian recording a 59% response rate for 2025, two percent higher than the national average and overall response rate in Scotland.

NHS Grampian has a number of Area Professional Advisory Committees, representing many of the regulated roles in scope where the voice and views of colleagues can also be sought and heard. Clinician views and perspectives are being engaged through weekly meetings between Chief Executive, Executive Medical Director, Executive Nursing Director, Chair of Area Clinical Forum and chairs of the different Professional Advisory Committees. These meetings have been introduced as a mechanism to improve communications following Stage 4 escalation.

Professional leadership and accountability structures across all regulated roles in scope are described in the NHS Grampian Professional Assurance Framework. Non-delegated services operate a triumvirate system with senior Nursing, Medical and Operational/General Manager as the managerial and leadership team for all roles in scope within the service area. These operational escalation processes provide access to clinical advice from decision makers within relevant services both within and outside the structure, and at a number of levels if required. These processes are available during the working day and via on-call systems, as seen within the daily Acute Sector Morning Brief, cross-system Daily System Connect and Rota Watch. Delegated services operate slightly different leadership models however there are senior leadership roles for a range of those in scope including AHPs, Nurses and Doctors.

The requirement for clinical advice is explicit within the SOP: Staffing Establishment Management through Application of CSM. Clinical advice was sought and provided (Executive Nurse Director, Nurse Director and Chief Nurses) during the prioritised Staffing Establishment Management through Application of CSM resulting in the rebasing of some nursing establishments.

Clinical advice was provided by Executive Nurse Director, Director of AHPs and others key professional leaders as processes were developed in line with necessary supplementary staffing (agency) controls as detailed within DL(2025)22 and 23.

Clinical advice is sought promptly when SafeCare data or voiced care concerns indicate significant risk. This collaborative approach with senior clinical leaders ensures that decisions are clinically informed, prioritising patient safety and continuity of care.

Within Psychology services, there are clear professional reporting structures where all staff are encouraged to take a view on appropriate staffing for their respective services via line management and professional forums. This information is detailed in the service specific HCSA SOP.

Across many of NHS Grampian's functions, local daily bed and staffing huddles take place ahead of the wider Daily System Connect meetings, providing clinical leadership to support ward and other areas on staffing levels and support to mitigate any issues or concerns.

Non-clinical managers have access to clinical leaders during working hours and via on call rotas for professional clinical advice out of hours. Details on those on call is accessible via Rota Watch and shared via the Acute Sector Morning Brief, which details the following leads: Site Manager, Nurse on Call, Aberdeenshire Senior Manager On Call (SMOC), Medical Director, Dr Gray's Hospital Duty Manager, Moray SMOC, Aberdeen Royal Infirmary Duty Manager, City SMOC and Mental Health.

The BLCs have a significant role within the Quality Impact Assessment process as part of work under our Value and Sustainability Programme, which demonstrates commitment to clinical engagement in decision-making where services and workforce could be impacted.

Within Nursing and Midwifery, there is an established Workforce Council to ensure professional workforce matters are understood and appropriate actions taken.

Processes to document a disagreement where actions conflict with advice requires further work to ensure consistency and alignment with Act requirements. This will remain paused until further progress has been achieved in embedding the necessary systems and processes to ensure risk escalation processes are in place and consistency used across all roles in scope and NHS functions.

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.

Day-to-day compliance with this duty is monitored through a range of operational systems, processes and governance arrangements. There are many examples of good practice following on from the first year of commencement and meaningful progress has been made with this duty since the last Annual Report, which is primarily driving the overall reasonable assurance for 2025/26. There is variation between different professions and areas of the organisation specifically in relation to consistent recording of conflicts/disagreements with the clinical advice received, and therefore the monitoring of these disagreements. During the latter half of 2025/26, the Chief Executive Team commenced a review of revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report.

At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to

provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board.

External monitoring of compliance with this duty is undertaken by HSP Monitoring and Compliance Team (HSPM&C). Internal Quarterly reports are shared with HSPM&C colleagues following discussion at Staff Governance Committee meetings and inform the Board Review Call discussions as well as HSP's Key Lines of Enquiry.

To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, the views of employees included in the reports prepared by individuals with lead clinical professional responsibility for a particular type of healthcare identified a potential improvement in working practices in one area.	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, the potential improvement is being trialled in the one area and if successful will be rolled out across other areas in the organisation.
Continued engagement with BLCs. [All roles in scope - all NHS functions]	• Early 2025/26, an engagement process was undertaken individually with each BLC to reflect on 2024/25 Internal Quarterly Report processes and agree processes for year ahead. • Early 2025/26, induction session for the newly appointed Director of Public Health and an overview and refresh for recently appointed Executive Medical Director were undertaken by Programme Team. • Attendance and active participation by BLCs with HSPM&C Board Review Calls.	• Continued engagement and open dialogue between BLCs and Programme Team. • Review of processes, achievements and challenges following fourth (2025/26) Internal Quarterly Report.
SOP: Staffing Establishment Management through Application of CSM.	• The need to seek clinical advice as part of the CSM is explicit within the newly launched SOP.	• As the SOP is embedded, further processes will be necessary to ensure Executive Nurse and Medical Directors are

[Nursing, Midwifery across all NHS functions and Medical staff in Emergency Department]	• Clinical advice was sought and provided to inform risk-based, prioritised decision-making within prioritised areas (Nursing, non-delegated services).	assured that clinical advice is sought and regarded as part of the methodology.
Establishment of weekly meetings between Chief Executive, BLCs, chairs of Grampian Area Partnership Forum/Area Clinical Forum and Professional Advisory Committee representatives. [All roles in scope - all NHS functions]	• Weekly meetings established, in part as a response to Stage 4 escalation. Opportunity for clinical advice and clinical perspective to be sought.	• To be considered as part of de-escalation discussions.
Launch of HCSA SharePoint site, available to all on networked devices to improve knowledge, understanding and responsibilities within the HCSA. [All Roles in Scope – all NHS functions]	• The launch of HCSA SharePoint site, with dedicated pages for each duty has provided a repository of internal and external (HSP and NES) resources available to colleagues 24/7. This includes a dedicated page for Clinical Advice on staffing which includes local definitions of clinical leadership and clinical advice.	• Maintaining currency and accuracy of definitions within the SharePoint site. • Future resources to support disagreements when decisions conflict with clinical advice will be hosted on this site.

Areas of escalation, challenges, or risks

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

Where staffing decisions conflict with clinical advice received. [All roles in scope - all NHS functions]	• Currently no consistent process to ensure the documenting of disagreements when decisions are made which conflict with clinical advice. • The lack of consistent processes means there are limited mechanisms to support/facilitate BLCs ability to reference the frequency of decisions made that conflict with clinical advice. • Within Nursing and Midwifery, conflicts are escalated via hierarchical structure to support decision-making.	• Work to progress this will recommence when further progress has been achieved in embedding the necessary systems and processes to ensure risk escalation processes are in place and consistency used across all roles in scope and NHS functions.

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.

To support local operational and professional teams in their understanding and application of requirements, local Board definitions were created from first level to Board level clinical leadership during the first year of commencement, and these are now widely signposted during all engagement sessions and can be accessed via HCSA SharePoint site.

NHS Grampian's Wellbeing Culture and Development (WCD) Team offer training specifically for leaders via Daily Brief updates and the Managers' Development Forum. The Forum has continued to support current and aspiring managers in Grampian on their leadership journey by highlighting relevant and current development opportunities. The forum is also a space where managers connect with each other to learn and grow with their peers.

A new Leadership Toolkit was launched October 2025 as a new resource for managers and leaders to utilise to hold up a 'mirror' to leadership styles and practices. The aim is to promote self-awareness which enhances the ability to lead through change but also strengthens relationships within teams.

To support clinical leaders across the organisation, examples of the training offered is listed below:

- Making Appraisals Work: A Manager's Guide for practical tips to make appraisal conversations smoother and less stressful.
- Performance Appraisal Training - Bitesize refresher sessions for managers and reviewers.
- Time Management - A course designed to help you take control of your time. Learn to spot the signs of poor time management, set clear goals, and use practical tools to plan and prioritise effectively.
- Wellbeing Talks - These online sessions take place the last Thursday of every month, with topics including sleep, migraine, menopause, and financial support.
- Coaching Skills for Managers - A blended learning programme for colleagues in all roles and bands, who have a line management responsibility. The programme consists of an induction session, five self-directed elearning modules and two coaching practice sessions in a small group facilitated by an accredited Coach.

- Crucial Conversations for Accountability - Transform tough conversations into powerful moments of accountability and opportunities for improved collaboration, accountability, and outcomes. Priority is given to those working at Band 8A and above or in clinical leadership positions.

With leadership and governance's inclusion in the plan for sustainability and performance improvement in response to Stage 4 escalation, along with other internal action plans, a 'Focus on Fundamentals' approach to leadership was commissioned in 2025/26. The vision of the commission was to be clear and consistent in the expectations we have of ourselves and our leaders throughout the system; have a consistent way of identifying what development each of our leaders needs to help deliver upon those expectations; have a clear and consistent way to provide those development needs and build leadership confidence and capability across the system. A launch is anticipated early 2026/27.

Within Nursing and Midwifery, a three day, in-person, Leading Excellence in Care (LEiC) Programme was launched earlier in 2025; three cohorts are expected to have been completed within 2025/26 with a further two already planned for 2026/27. Initial priority was given to first level line managers. The Programme's primary focus was on professional leadership, Excellence in Care (EiC) and building and maintaining structure for effective practice. It was also to create supportive conditions, realistic expectations and a culture that fosters learning, development and opportunity for improvement. The following content was identified as critical to enable leaders to:

- Understand the fundamental principles of the EiC Strategy and how their role can impact the delivery of high standards of care.
- Learn how the LEiC Education and Development Framework supports the implementation of EiC into practice.
- Understand the principles of effective rostering, managing planned leave and how the Optima system can aid in roster management.
- Gain confidence in understanding and managing budgets and how to balance clinical leadership and financial accountability.
- Understanding their leadership roles responsibilities as required by the HCSA.
- Understand their responsibilities while sharing and embedding business continuities and where the civil contingency team can support.
- Initiate and implement a supportive plan for a staff member.
- Explore the principles of clinical supervision and preceptorship.
- Discuss the difference in mentoring and coaching and resources available. Signposting to other useful resources within Wellbeing, Culture and Development team.
- Gain a better understanding of a quality management system and how EiC resources fit within this structure.
- Explore ways of empowering a system of continuous learning. With a practical focus, explore how models support teams to gather feedback in a way that helps inform the improvements most likely to make a difference to people's experiences of their service.

Leadership development is well recognised as an essential component of safe and effective care, improved staff satisfaction, succession planning and staff retention. Within NHS Grampian, the internationally recognised Leading an Empowered Organisation (LEO) programme is open to Nurses, Midwives, AHPs, Psychology and Healthcare Scientists. It is an intense three-day program with a one-day follow-up 2-3 months after completion of the course where participants showcase their improvement project. Over 300 colleagues from the listed roles in

scope have completed the course in NHS Grampian in 2025 with expectations of similar in 2026. A decision regarding long-term sustainability of the programme is awaited.
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.
Day-to-day compliance with this duty is monitored through a range of operational systems, processes and governance arrangements. While there are examples of good practice following on from the first year of commencement, approaches to monitoring remain inconsistent and there is variation between different professions and areas of the organisation. There is greater visibility in areas that use Optima eRoster, as the system facilitates a means of recording when leaders are deployed into the team, however Optima is not currently available for all roles in scope. Although there are significant opportunities provided to support staff with their leadership and managerial responsibilities as described above, escalation and remedial actions are varied and not consistently documented when leadership time is cancelled/unable to be achieved, which is primarily driving the overall limited assurance for 2025/26. During the latter half of 2025/26, the Chief Executive Team reviewed revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report. At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board. To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project was a determination of time and resources for	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, the positive outcome experienced as a result of the working group has led to this model being extended to other AHP areas and trialled to see applicability.

	different team leaders, and feedback so far has been positive.	
Active Manager Development Forum. [All roles in scope - all NHS functions]	• Membership of over 1000 aspiring and current managers across NHS Grampian. • Access to monthly meetings to support learning and knowledge of key topics relevant for all system managers. • Access to a range of resources to develop leadership skills including LEO, Manager Development Programme, Coaching for Managers.	• Continued promotion of this forum through organisational communications, professional and peer networks.
WCD Wednesday. [All roles in scope - all NHS functions]	• Weekly, organisation wide, communications to promote training and leadership opportunities.	• Continued promotion of the resources though organisational communications, professional and peer networks.
Launch of a three day in-person LEiC Programme for Nursing and Midwifery leaders. [NMAHP - all NHS functions]	• Delivery of an extended face to face programme that supports the implementation of Excellence in Care into practice by providing guidance for the education and development of NMAHP leaders as well as improving the knowledge and skills highlighted in self-assessments and organisational priorities. • Two cohorts have been delivered in 2025/26 for Nursing and Midwifery leaders.	• Three cohorts per year (~90 delegates) to continue improved knowledge and skills of the LEiC Educational and Development Framework.
Continuation of Shared Learning Events. [All roles in scope - all NHS functions]	• An open monthly forum where information related to the management of adverse events or service improvements are shared. • At the time of compiling this Annual Report, seven events have taken place with topics including Treatment Escalation Plans, Just Culture and Human Factors, Unconscious Bias and Active Bystander	• Continued promotion of this forum though organisational communications, professional and peer networks.

	and the Introduction to the role of Scottish Public Services Ombudsman. • Presentations and event recordings available on intranet for 24/7 access.	
LEO Programme. [NMAHPs, Psychology and Healthcare Scientists - all NHS functions]	• The internationally recognised LEO programme is open to Nurses, Midwives, AHPs, Psychology and Healthcare Scientists. Over 300 colleagues from the listed roles in scope have completed the course in NHS Grampian in 2025 with expectations of similar in 2026.	• A decision regarding long-term sustainability of the programme is awaited.
NHS Grampian Nursing and Midwifery Assurance Framework for Clinical Leaders. [Nursing and Midwifery - all NHS functions]	• An NHS Grampian Nursing and Midwifery Assurance Framework for Clinical Leaders is in development. • The Framework aim is to easily identify, manage and escalate risks while demonstrating robust grip and control and good financial governance.	• Launch of the Framework in 2026/27.
Exploration of current practice to understand how Nursing teams are meeting this duty. [Nursing - all NHS functions]	• A questionnaire was undertaken with Community Team Leaders and Senior Charge Nurses within one HSCP. • While the responses informed local intelligence and future action plans to comply with this duty, it was recognised this should be shared with Nursing and Midwifery teams across all NHS functions. • Further multi-professional shared learning was enabled via the HCSA Implementation Team members.	• A high-level summary was shared with key stakeholders within People and Culture Directorate to inform wider data intelligence sharing. • This is to be a focus within Nursing and Midwifery for 2026/27 through the Value and Sustainability Programme. Decisions on ensuring clinical leaders have adequate time to lead will be undertaken in partnership.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, the process in place to identify the roles, and	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, if the process in place

	therefore individuals, with lead clinical professional responsibility for a team of staff does not consistently identify who these individuals are, and therefore sufficient time and resources for these individuals to discharge their responsibilities has not been considered.	to identify the roles, and therefore individuals, does not consistently identify who those individuals are, what measures have been taken to address this? This could involve working with all staff groups, clinical areas, and teams to identify job titles / roles, utilising HR processes, and information and or utilising eRostering to identify team leaders etc.
Competing priorities and demands on teams. [All roles in scope - all NHS functions]	• In a busy healthcare system that is progressing other organisational priorities, colleague availability and resource hinders the ability to undertake all necessary leadership requirements. • Planned leadership time is used as mitigation for real-time staffing risks.	• Use of risk escalation processes when planned leadership time is unable to be achieved.
Impact of financial pressures, efficiency savings and reduced working week. [All roles in scope - all NHS functions]	• Challenge to balance the necessary leadership responsibilities of all roles in scope to ensure delivery on the three key elements within an environment of efficiency savings and reduction in available working hours. • Impact of these constraints on corporate services integral to supporting clinical leaders to deliver their responsibilities. • The BLCs have a significant role within the Quality Impact Assessment process as part of work under our Value and Sustainability Programme, which demonstrates commitment to clinical engagement in decision-making where services and workforce could be impacted.	• Use of 'Finding Balance' methodology which considers the need to find balance between clinical, staff wellbeing, financial and prevention priorities. • Use of risk escalation processes when planned leadership time is unable to be achieved.
Inconsistent use of risk escalation processes. [All roles in scope - all NHS functions]	• Anecdotal evidence that risk escalation processes are not considered as an appropriate route for raising recurrent occurrences and the impact of them where	• Programme Team utilise every opportunity when engaging with teams to highlight the need to escalate when planned leadership

	planned leadership time is cancelled to support the mitigation of real-time staffing risks. • Redeployment of colleagues from leadership time to mitigate real-time staffing risks can be recorded within the Optima system. However, this is not currently available for all roles in scope.	time is cancelled, reasons for the cancellation and the impact of it. • Optima will be available to all roles in scope by March 2028 although at this time it is unlikely that full functionality for end users will be available by that date.

COMPLIANCE ASSURANCE LEVEL
Limited 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 consider 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.

NHS Grampian's WCD Team offer training widely across NHS Grampian via Daily Brief updates and the Managers' Development Forum. The Forum has continued to support current and aspiring managers in Grampian on their leadership journey by highlighting relevant and current development opportunities. The forum is also a space where managers connect with each other to learn and grow with their peers. In addition to our internal resources, WCD also signpost to external resources such as Leading to Change, a national leadership development offering support for health, social care and social work leaders. Local training is offered including Performance Appraisal and Getting the Best from Your Appraisal, offering sessions for both appraiser and appraisee.

A core part of Putting People First is ensuring staff have the skills, confidence, and autonomy to work creatively to achieve the best outcomes for people. In 2025, the Getting it Right for Everyone (GIRFE) toolkit was introduced to strengthen person-centred practice, and in Grampian we have brought GIRFE, Putting People First, and Realistic Medicine together under the Hope Collaborative to help teams use the range of tools available consistently to deliver high-quality care. The Hope Conference took place in November 2025, bringing over 100 staff and people with lived experience together to share good practice and spark new collaborations that we will continue to build on in 2026.

Following a period of review by NHS Grampian's Practice Education Team, a brand new digital HCSW Band 4 Competency Framework was launched in February 2026 on TURAS. The HCSW Development and Education Framework and Competencies supports the development of core knowledge, skills, and behaviours in the four pillars of practice and enables profession specific and specialist knowledge, skills and behaviours to be added for all NMAHP HCSWs working at Levels 2-4. The competency framework is to facilitate practitioners to demonstrate they have achieved the level of competence required by NHS Grampian.

Within Psychology services, all staff have monitored supervision and training plan to comply with HCPC registration and access training through TURAS, departmental and NHS Grampian wide CPD programmes and NES training. This is co-ordinated through a Psychological Therapies Training Co-ordinator funded by NES.

Ahead of the nine mandatory Once for Scotland (OfS) eLearning modules going live on 2 March 2026, NHS Grampian has agreed and promoted five methods for Protected Learning Time (PLT) to be undertaken within contracted working hours, in order to achieve a consistent

approach across the Board. Frequently asked questions and the 'five agreed PLT methods in NHS Grampian' have been shared widely and are accessible to all staff via the Intranet. The only new mandatory module for NHS Grampian is 'OfS - Fraud awareness', which all staff must complete by 2 September 2026.

NMAHP bank workers have protected paid time to complete the required mandatory and statutory training, however there is no compliance with the Personal Development Planning and Performance Review Policy due to conflict with worker contractual arrangements, financial implications, operational complexities and resource. This has been considered within Policies Sub-group for escalation to Area Partnership Forum. NMAHP Agency workers are required to complete the necessary mandatory and statutory training in advance of commencing any clinical shifts.

TURAS reports, covering mandatory and statutory training as well as appraisal progress, are available to all clinical leaders through a self-service model. Additional resources and support for clinical leaders can be accessed via the Wellbeing, Culture and Development Team.

Ongoing monitoring of mandatory and statutory training compliance is accessed through TURAS and is reported and considered through various operational reporting mechanisms. Within Acute services, A&A meetings are undertaken at service level, sharing detail of training compliance and any supportive actions required. Organisation wide, engagement in statutory and mandatory courses falls below the thresholds of 80% for statutory and 70% for mandatory courses, but plans are in place to improve this going into 2026/27.

Comprehensive induction and training programmes are in place for pharmacists and technicians. All pharmacists and pharmacy technicians are registered professionals with the General Pharmaceutical Council and are required to undertake Continuing Professional Development and revalidation processes to maintain professional standards. Similar processes are in place for other roles in scope who also need to undertake revalidation processes.

The Acute Sector Medical Leadership are working with corporate support services to develop a medical workforce specific staff governance data set. Data is already available for Consultant and staff grade medical staff training compliance, however the Resident Doctors data is not available at this time. The local TURAS team are working on addressing this.

The HCSA SharePoint site, available 24/7 to everyone on a networked device, has a range of internal and external resources with dedicated pages for each duty to improve knowledge and understanding of responsibilities within the HCSA. The SharePoint site is regularly signposted via the all staff Daily Brief and throughout all engagement and training sessions. User statistics are shared with HCSA Implementation Team and Programme Board members, evidencing that we are averaging 200 new users accessing the site each month. Staff implementing SafeCare to support real-time staffing risk assessment and escalation are offered bespoke training, including Senior Review functionality specific training to support and understand requirements of the Act.

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.
Day-to-day compliance with this duty is monitored through a range of operational systems, processes and governance arrangements. While details at time of compiling HCSA Annual Report are limited, national plans are progressing to consider PLT Assurance Reporting, as indicated in January 2026 PLT update, for Staff, Manager and Board Level Reporting. There are many examples of good practice following on from the first year of commencement which is primarily driving the overall reasonable assurance for 2025/26, however some approaches to monitoring remain inconsistent and there is some variation between different professions and areas of the organisation. During the latter half of 2025/26, the Chief Executive Team commenced a review of revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report. At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board. Sector Staff Governance Standard Assurance Reports also seek assurance updates on the current situation with compliance of the Staff Governance Standard; this includes appropriately trained and developed staff/workforce. Where no or partial assurance is offered, a summary of mitigation measures is required. To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, the psychology department in conjunction with HR, has just completed a project to promote more accurate capturing of information relating to continued professional development for psychology colleagues. Feedback from employees is that they have	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, AHP colleagues have now expressed interest in the new system and are undertaking a project to establish whether they could implement something similar.

	found the new system much easier to use and are now recording relevant CPD.	
Launch of HCSA SharePoint site, available to all on networked devices to improve knowledge, understanding and responsibilities within the HCSA. [All roles in scope – all NHS functions]	• The launch of HCSA SharePoint site, with dedicated pages for each duty has provided a repository of internal and external (HSP and NES) resources available to colleagues 24/7. • Quarterly reporting to Programme Board on SharePoint site usage including top pages and documents visited and top documents visited. • Resources support consistent language for teams/services when developing local procedures; this has been evident as NHS Grampian Psychology have developed their HCSA SOP.	• Trend data from quarterly SharePoint site usage reports can help inform future Board wide communications.
Active PLT Group considering and implementing all relevant aspects of Agenda for Change non-pay reforms. [All roles in scope - all NHS functions]	• Active membership that includes relevant Agenda for Change roles in scope and medical colleagues. • HCSA Programme Team represented on the group, ensuring alignment with HCSA requirements. • Influencing national PLT workstreams from local knowledge, experience and understanding of related information. • Eight of the nine OfS mandatory modules are existing modules for NHS Grampian colleagues. • Identification of five methods to ensure learning time is protected and undertaken within contracted working hours.	• Only one new module for NHS Grampian staff when OfS modules launched in early 2026. • Internal socialisation of identified methods to ensure learning time is protected and undertaken within working hours.
Active Manager Development Forum. [All roles in scope - all NHS functions]	• Membership of over 1000 aspiring and existing managers.	• Investment of time, knowledge and skills in aspiring and current managers.

	• Access to Monthly meetings to support learning and knowledge of key topics relevant for all system managers including, Appraisals, Finance, Health and Safety, Occupational Health, Using Automation, Workforce Planning, eRoster and HCSA. • Access to a range of resources to develop leadership skills including LEO, Manager Development Programme, Coaching for Managers.	
Wellbeing, Culture and Development Wednesday. [All roles in scope - all NHS functions]	• Weekly, organisation wide, communications to promote training, leadership and wellbeing opportunities.	• Range of opportunities include Spaces for Listening, Guided Journaling and Mindfulness.
Access to range of training materials for colleagues using any of the Optima Health roster products. [All roles in scope - all NHS functions]	• eRostering and SafeCare teams provide a range of resources for colleagues using any of the products; this includes webinars, locally produced TURAS modules, virtual/in-person training and 1:1 SafeCare “Book with me” training. This can be evidenced within Nursing, Midwifery and AHPs as part of the ongoing roll out of SafeCare.	• The range of resources ensures staff can access training and support that meets their needs. • Attendance at Senior Decision Maker Webinars and completion of local TURAS modules are logged within TURAS system. This supports monitoring and decision-making in advance of “go-live” dates.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, clearly defined processes and procedures exist for some groups of staff, e.g. nursing and midwifery, but do not exist for other groups of staff, e.g. healthcare scientists.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, if procedures and processes are not in place for healthcare scientists, please list the measures which need to be put in place to address this, such as working with HR and healthcare scientist representatives to define an appropriate training programme, assess training needs of

		employees and plan for required training to be undertaken.
Competing priorities and demands on teams. [All roles in scope - all NHS functions]	• In a busy healthcare system that is progressing other organisational priorities, colleague availability and resource hinders the ability to undertake all necessary training requirements (statutory, mandatory, profession/service specific and/or HCSA related). • Planned training time is used as mitigation for real-time staffing risks.	• Use of risk escalation processes when training is unable to be achieved.
Impact of financial pressures, efficiency savings and reduced working week. [All roles in scope - all NHS functions]	• Challenge to balance the training needs of all roles in scope to ensure and maintain competence within an environment of efficiency savings and reduction in available working hours. • Impact of these constraints on corporate services integral to the delivery of training.	• Use of 'Finding Balance' methodology which considers the need to find balance between clinical, staff wellbeing, financial and prevention priorities. • Use of risk escalation processes when training is unable to be achieved.
Inconsistent use of risk escalation processes. [All roles in scope - all NHS functions]	• Anecdotal evidence that risk escalation processes are not considered as an appropriate route for raising recurrent occurrences and the impact of them where planned training is cancelled to support the mitigation of real-time staffing risks. • Redeployment of colleagues from planned training to mitigate real-time staffing risks can be recorded within the Optima system. However, this is not currently available for all roles in scope.	• Programme Team utilise every opportunity when engaging with teams to highlight the need to escalate when planned training is cancelled, reasons for the cancellation and the impact of it. • Optima will be available to all roles in scope by March 2028 although at this time it is unlikely that full functionality for end users will be available by that date.

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.	

While the SOP: Staffing Establishment Management through Application of CSM was collaboratively developed to meet internal structures, its design was to ensure the various requirements of this duty are considered and evidenced within the NHS Grampian CSM Establishment Requirements and Assessment of Staffing Risk Template. This is primarily driving the overall reasonable assurance for 2025/26.

Using the Staffing Establishment Management through Application of CSM has resulted in the rebasing of nursing establishments within prioritised, non-delegated areas.

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.

Local governance arrangements across the delegated and non-delegated services have been established specifically for primary oversight and monitoring of this duty.

Organisational oversight of this duty is through:

- NHS Grampian Sustainable Nursing Workforce Operational Group meetings (as part of Value and Sustainability Programme)
- NHS Grampian Nursing and Midwifery Workforce Council

Organisational compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board. Annual monitoring is also undertaken by NHS Grampian Board via this Annual Report.

To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, application of the common staffing method in adult inpatient provision identified some areas where the staffing establishment needed to be changed, and some areas with potential for service redesign. These changes are now in progress and will be trialled to monitor the outcomes.	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, following completion of the trials regarding changes in staffing establishment and service redesign, decisions will be taken about their formal adoption. A summary of this exercise could then be used as case studies to inform training for staff about the use of the common staffing method.

Launch of HCSA SharePoint site, available to all on networked devices. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• The launch of HCSA SharePoint site, with dedicated pages for CSM and staffing level tool groupings has provided a repository of internal and external (HSP and NES) resources available to colleagues 24/7. • Structure of CSM pages reduces time and effort for colleagues while sourcing the relevant information -> CSM page and then Speciality Specific staffing level tool within which, Professional Judgement Tool information, preparatory guidance, user guides, data capture templates and guidance on selecting the appropriate BOXI report are available. The subsections within each page are based on HSP's Quality Assurance Checklist. • Quarterly reporting to Programme Board on SharePoint site usage including top pages and documents visited.	• Maintaining currency of information will be critical as staffing level tools transition from SSTS to SafeCare. • Trend data from quarterly SharePoint site usage reports can help inform future Board wide and/or targeted communications.
Launch of SOP: Staffing Establishment Management through Application of CSM. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Targeted and Board wide Communication Plan executed in Q2 as SOP launched. • SOP available 24/7 on SharePoint site with over 1,400 views within first four months and over 2,000 views to date. • Risk-based prioritisation and decision-making routes have been determined for a consistent approach and improved management of risk governance processes. • Transparent governance arrangements to support staff awareness of and being involved in staffing discussions and decisions.	• Review of SOP and its application after 12 months. • Development of NHS Grampian Nursing and Midwifery Assurance Framework for Clinical Leaders to easily identify, manage and escalate risks while demonstrating robust grip and control and good financial governance.

Prioritised CSM process for specific areas. [Nursing in some non-delegated services]	• Application of CSM has enabled financial decisions to rebase nursing budgets (within prioritised non-delegated inpatient services) to reflect current requirements, aligning budgets with actual service demand, reflecting changes in staffing and activity and supported NHS Grampian strategic priorities (e.g. sustainability and efficiency). • Aggregated review (Unit/Division) of CSM more meaningful for decision-making rather than per roster.	• Introduction of additional control measures at roster level to support efficiencies and effectiveness of increased establishment. This includes Optima permission changes for creating additional duties and updated Optima Roster demand templates.
Development of a new NMAHP Workforce Dashboard. [Nursing and Midwifery - all NHS functions]	• Collaborative development of the dashboard to support a single point of access for workforce and quality data. This will support understanding of performance and risk in clear, consistent and easy to interpret format.	• Due to launch in 2026. Will improve CSM reports through consistent application and use of quality information. • Provide further education sessions to coach colleagues with responsibilities to increase CSM understanding and ownership in line with the wider HCSA legal requirements.
Staffing level tool schedule (2025/26). [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Schedule launched prior to April 25 adhering to minimum once per year frequency for approximately half of staffing level tools and twice yearly for SCAMPS, Neonatal, MHLD Inpatient Nursing, Adult Inpatient and Small Ward Tools.	• Stakeholder engagement and review of compliance against locally determined frequency to inform staffing level tool frequency in 2026/27. • Staffing level tool schedule (2026/27) approved in January 2026 and will be launched during Q4 of 2025/26.
Development of Board level staffing level tools SSTS BOXI report. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Collaborative working with HSP as they developed a SSTS BOXI report that enables pan Grampian reporting format for all tools. • Development of internal reference file of all relevant SSTS/SafeCare rosters and aligned staffing level tools.	• The use of this report will be considered when reviewing consistency, effectiveness and impact of automated emails in advance of 2026/27 Schedule.

	• Collectively these support internal monitoring of compliance of staffing level tool runs.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provision and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc.
Launch of NMAHP Workforce Dashboard. [Nursing and Midwifery - all NHS functions]	• Time delays addressing DPIA concerns and receiving final sign-off has delayed an earlier launch of the dashboard.	• Concerns addressed and now awaiting final sign-off prior to launch.
Following of CSM with Emergency Care Provision Tool. [Nursing and Medical – Emergency Departments only]	• CSM following application of the Emergency Care Provision Tool is undertaken uni-professionally (Nursing) only.	• Additional training and guidance required to ensure bi-professional (nursing and medical staff) application.
Competing priorities and demands on teams. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• In a busy healthcare system that is progressing other organisational priorities, colleague availability and resource hinders the timely progression through each step of the CSM. • Planned leadership time (Nursing and Midwifery) is used as mitigation for real-time staffing risks.	• Use of risk escalation processes when CSM components unable to be achieved.
Prioritised CSM process for specific areas. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Prioritised process has limited the embedding of the SOP: Staffing Establishment Management through	• Will be considered as part of the review of SOP and its application after 12 months.

	Application of CSM and delayed the finalisation of governance routes.	

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.

While the "SOP: Staffing Establishment Management through Application of CSM" was collaboratively developed to meet internal structures, its primary design was to ensure the requirements of this duty are incorporated and evidenced within the "NHS Grampian CSM Establishment Requirements and Assessment of Staffing Risk Template". The SOP will be reviewed after 12 months and the "NHS Grampian CSM Establishment Requirements and Assessment of Staffing Risk Template" will continue to evolve to meet service and decision-making needs; while maintaining Act requirements.

In the absence of dedicated subject specialist, training resources for the CSM process and staffing level tools are delivered through signposting to internal CSM SharePoint site, automated emails pre and post staffing level tool run, single point of contact via generic email account and externally to HSP materials. The lack of consistent organisational understanding, continued volume of clarification requests and the high level of dependency on reactive support is primarily driving the overall limited assurance for 2025/26.

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.

Organisational oversight of this duty is currently through:

- NHS Grampian Sustainable Nursing Workforce Operational Group meetings (as part of Value and Sustainability Programme)
- NHS Grampian Nursing and Midwifery Workforce Council

Organisational compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board. Annual monitoring is also undertaken by NHS Grampian Board via this Annual Report.

To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, key personnel who were very experienced in using the common staffing method were engaged to train and mentor other personnel involved in the process.	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, those key personnel have now decided to meet regularly in a forum to discuss shared learning and to ensure the common staffing method is used consistently across all relevant areas in the organisation.
Launch of HCSA SharePoint site, available to all staff on networked devices. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• The launch of HCSA SharePoint site, with dedicated pages for CSM and staffing level tool groupings has provided a repository of internal and external (HSP and NES) resources available to colleagues 24/7. • Structure of CSM pages reduces time and effort for colleagues while sourcing the relevant information -> CSM page and then Speciality Specific staffing level tool within which, Professional Judgement Tool information, preparatory guidance, user guides, data capture templates and guidance on selecting the appropriate BOXI report are available. The subsections within each page are based on HSP's Quality Assurance Checklist.	• Maintaining currency of information will be critical as staffing level tools transition from SSTS to SafeCare. • Trend data from quarterly SharePoint site usage reports can help inform future Board wide and/or targeted communications.

	• Quarterly reporting to Programme Board on SharePoint site usage including top pages and documents visited.	
Launch of SOP: Staffing Establishment Management through Application of CSM. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Targeted and Board wide Communication Plan executed in Q2 as SOP launched. • SOP available 24/7 on SharePoint site with over 1400 views within first four months and over 2,000 views to date. • Consistent approach to CSM with improved decision-making and management of risk governance processes. • Transparent governance arrangements to support staff awareness of and being involved in staffing discussions and decisions.	• Review of SOP and its application after 12 months. • Development of NHS Grampian Nursing and Midwifery Assurance Framework for Clinical Leaders to easily identify, manage and escalate risks while demonstrating robust grip and control and good financial governance. • Agreed governance arrangements to be accessible on SharePoint site and included in future iteration of SOP.
NHS Grampian Sustainable Nursing Workforce Project. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Enablers of the SOP: Staffing Establishment Management through Application of CSM were critical to creating the conditions for success of the SOP. Enablers included resources to support implementation, streamline process to improve access to required accurate data, socialisation and use of SOP, engagement and communication, assurance and establishment setting. • Resources included use of automated emails pre and post staffing level tool run with gentle reminders and summary of high-level data quality concerns to be addressed in advance of remainder of CSM process.	• Review consistency, effectiveness and impact of automated emails in advance of 2026/27 Schedule launch. • Transition to business as usual for the Sustainable Nursing Workforce Project - CSM.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, issues were identified with a lack of training on the CSM for personnel in emergency care provision due to time constraints.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, arranging and delivering training; the provision of mentoring from experienced personnel; or the adoption of job planning which ensures adequate time is available for designated personnel to undertake training on the common staffing method.
Insufficient internal specialist knowledge across the entire suite of staffing level tools. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Substantive subject expert currently seconded resulting in temporary redesign of role. • Although post redesigned, it will take time for new post holder to develop knowledge and competence in staffing level tools across both SSTS and SafeCare.	• Self-service model with signposting to national HSP resources will continue. • Redesigned post-holder will be supported and managed by substantive subject expert.
Limitations of external resources and platforms to enable self-service reporting of SSTS staffing level tool output reports. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• No national resources available to assist users in exporting relevant SSTS staffing level tool reports and/or how to interpret outcome reports. • Interim internal resources created to provide to support colleagues; this includes summaries of the content and differences between each available staffing level tool report.	• Internal investment of time and effort to develop further resources unlikely given competing priorities and the planned transition from SSTS to SafeCare over next two years. • NHS Grampian will utilise all opportunities to influence future resource development to support colleagues export and interpret outcome reports.
Limitations of external resources and platforms to enable self-service reporting of SafeCare staffing level tool output reports. [Nursing - MHLD Inpatient Services only]	• Currently (with no likely launch date) no platform for staffing level tool output reports from SafeCare. • SafeCare staffing level tool report processes, has resulted in unplanned for increased workload for internal SafeCare Team. • Interim SafeCare staffing level tool reports via HSP Team.	• NHS Grampian included in membership of eRostering National Reporting Forum to influence future direction. • Lessons learnt on internal processes from the new MHLD Inpatient Nursing Tool in advance of transition of Neonatal, Maternity and Emergency Care Provision Tools in April 2026, one other tool in October 2026 and final six tools in 2027.

	• Reports currently in PDF format; the use of excel would enable the relevant data to be incorporated into CSM Workforce Dashboard. • SafeCare staffing level tool raw data extracted from system at roster level; local quality checks required prior to SafeCare Team submitting Roster reports to HSP. This equates to 21 rosters currently, with a further approximate of 20 rosters in April, a further five rosters in October and finally a further 265 rosters in 2027 unless a reporting platform launched in the interim. • Interim processes remove local ownership by Senior Charge Nurses with subsequent delays due to internal and external communications.	
Limited internal CSM and staffing level tool training capacity. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Finite resource available to support all colleagues/teams which are mandated through the Act to apply the CSM. • Prioritisation of mandated areas has resulted in the deprioritisation of, and limited support for, other roles in scope that wish to undertake the Professional Judgement Tool. • Substantive subject expert currently seconded resulting in temporary redesign of role. • Although post redesigned, it will take time for new post holder to develop knowledge and competence to train colleagues on CSM and staffing level tools.	• Maximise use of training capacity through proactive communications in advance of scheduled staffing level tool runs. • Using trend data from frequently asked questions to the single point of contact generic email account to inform future internal communications and resource development.
Competing priorities and demands on teams. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• In a busy healthcare system that is progressing other organisational priorities, colleague availability and resource hinders	• Use of risk escalation processes when CSM components unable to be achieved.

	the timely progression through each step of the CSM. • Planned leadership time (Nursing and Midwifery) is used as mitigation for real-time staffing risks.	
Challenges of local complexities and nuances for CSM and staffing level tool application. [Nursing and Midwifery - all NHS functions; Medical – Emergency Departments only]	• Questions arising from local complexities and nuances are not adequately resolved in generic User Guides or training (internal and/or external) resources. • Electronic discussion and signposting to available resources are the first line of support. • Significant time required from service and subject experts to understand the issues, possible impact on staffing level tool data gathering/output reports and how to capture within NHS Grampian CSM Establishment Requirements and Assessment of Staffing Risk Template.	• Engagement with teams to understand the rationale for advice provided and potential implications for service outputs. • Using failure demand principles to consider changes to internal resources. • Provide further education sessions to coach colleagues with responsibilities to increase CSM and staffing level tool understanding and ownership.

COMPLIANCE ASSURANCE LEVEL
Limited 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.

With a strong embedded culture of Staff Governance and Partnership working, the guiding principles and appropriate staffing arrangements are considered when planning services from others and the Board continues to support Fair Work First criteria. However, it is challenging to evidence it is explicitly included in all new arrangements, agreements or contracts as they are often managed and arranged operationally, not solely through NHS Grampian's Procurement Team.

NHS Grampian continue to be supportive of a Once for Scotland approach that this duty could be fulfilled through an agreement with Chief Executives that one part of NHS Scotland procuring services from another part of NHS Scotland can reasonably assume that the provider Board will be following their legal responsibilities, rather than clauses stating this being introduced into every single Service Level Agreement. The revised Mutual Aid Framework, commissioned by Centre for Sustainable Delivery, to support Planned Care Waiting Times, is one such example that has been identified in Board.

Key stakeholders/commissioning officers within NHS Grampian, including MHLD Services, are aware of this duty and it should be considered when planning or securing the provision of services from independent health care providers as part of the improvement plan for planned care services.

Primary Care Contracts Team have adapted their processes to include the HCSA requirements to any new contracts when planning or securing new services with Independent Contractors, requesting confirmation that the provider can meet them. Evidence of this is limited

given the low numbers of new contacts each year. HCSA also continues to be considered at the pan-Grampian Primary Care Operational Management Team meeting as and when required, to ensure continued visibility. Work has been agreed with Aberdeenshire's legal team to embed in all tender documentation that any bidder must answer a mandatory question on staffing and would not receive a winning score without this clarification; their published template contract also refers to agreeing with all relevant legislation.
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.
Approaches to monitoring remain inconsistent and there is variation between different professions and areas of the organisation. This is primarily driving the overall limited assurance for 2025/26. During the latter half of 2025/26, the Chief Executive Team commenced a review of revised operational governance arrangements to support more inclusive decision-making, which are still under consideration at the time of writing this report. At an organisational level, annual monitoring is undertaken by NHS Grampian Board via this Annual Report. Compliance is also monitored through the HCSA internal quarterly reports (professional assessment) completed by the three BLCs. This includes opportunity for the BLCs to provide their view of compliance with this duty. These reports are considered by Grampian's Chief Executive Team and subsequently by the Staff Governance Committee on behalf of the Board. To inform the assessment of organisational assurance levels, services across the organisation participated in a three-step intelligence-gathering process. This process captured successes and achievements during 2025/26, as well as identifying barriers to full compliance.

Areas of success, achievement, or learning

Area of success / achievement / learning This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**Details** This should describe the situation: what is the success, achievement, or learning? For example, when procuring from private hospitals, the organisation has incorporated the requirements of the Act into the tender process.	**Further action** This should describe how the success, achievement or learning could be used in the future. For example, the learning from tendering with private hospitals is now being used to implement arrangements in other types of procurement.
Maximising opportunities to raise the profile of this duty. [All roles in scope – all NHS functions]	• As knowledge and awareness increases, the specialist knowledge of the Programme Team is being sought, including when healthcare is being	• Continue to seek and maximise internal opportunities to raise profile of this duty. • Maintain active engagement with network to identify shared learning opportunities.

	provided in other parts of the United Kingdom. • System-wide updates on the Planned Care Improvement Plan have created opportunities to remind key stakeholders of this duty when engaging private healthcare providers and influence the inclusion of HCSA requirements within the Mutual Aid Framework (for Planned Care Waiting Times). • Maintenance of support and engagement by Programme Team with Primary Care Contracts Teams. • Use of HCSA Workshops with operational teams to explore service specific examples where HCSA requirements must be considered when planning and securing services in the future - for example MHLD Services.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**Details** This should describe the situation: what is the challenge or risk identified? For example, there may have been difficulties in planning or securing services in a speciality area due to a lack of assurance around the appropriateness of staffing arrangements.	**Further action** This should describe what actions have been / are being / will be taken to address the situation. For example, engaging with service providers to ensure that they understand what information and assurance is required, seeking alternative service providers etc.
A mixed model of centralised and delegate procurement processes for planning and securing services from third party healthcare providers. [All roles in scope - NHS functions]	• The mixed model of centralised and delegate procurement processes creates a challenge to ensure all relevant stakeholders are aware of the HCSA requirements.	• Continue to seek and maximise internal opportunities to raise profile of this duty.

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