



Public Board meeting

30 September 2026

Item 14

THIS PAPER IS FOR DISCUSSION

Health and Care Staffing Act Q1 2026/27 Board report

Lead Directors	Emma Stirling, Director Care Quality and Professional Development
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Action required	To discuss the information provided in this paper and confirm that it provides assurance that SAS is meeting its duties under the Health and Care (Staffing)(Scotland) Act 2019 (hereafter known as the "Act").
Key points	- Reports received from all areas (first from NRRD). - SAS has established systems and processes in place that are able to accurately describe its position. - Quarterly reports moved to use of RAG statuses as encouraged by Healthcare Improvement Scotland. - The overall position in continues to remain stable. - The Real-Time Staffing reporting tool is now available via InPhase with evidence of use.
Timing	This paper is presented as part of the duties under section 121F of the Act for individuals with lead clinical professional responsibility to report to the Board on at least a quarterly basis on the extent to which SAS is complying with the duties of the Act.
Associated Corporate Risk Identification	Risk Ids - Please see Appendix 1
Link to Corporate Ambitions	Compassionate safe and effective care; Great place to work, focusing on staff experience, health and well-being; Innovate to improve care and enhance resilience and sustainability of services; Deliver net zero climate targets.
Link to NHS Scotland's Quality Ambitions	Safe Effective Person-centred
Benefit to Patients	Promotes the delivery of high-quality healthcare to support the health, well-being and safety of patients.

Equality and Diversity	No adverse impact has been detected.
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SCOTTISH AMBULANCE SERVICE BOARD

HEALTH AND CARE (STAFFING)(SCOTLAND) ACT 2019 Q3 2025/26 REPORT

DAVID FITZPATRICK, LEAD PRACTITIONER FOR HEALTH AND CARE STAFFING/EXCELLENCE IN CARE

SECTION 1: PURPOSE

To provide a quarterly compliance report to the Board by the individuals with lead clinical professional responsibility.

SECTION 2: EXECUTIVE SUMMARY

Reports have been received from all areas, who continue to implement and report on initiatives intended to support compliance with the Duties set out in the Act.

NHS system wide pressures, continue to impact SAS's ability to be appropriately staffed at all times.

SAS's overall RAG status remains 'yellow'; reasonable assurance.

SECTION 3: RECOMMENDATIONS

- The Board is '*reasonably assured*' that appropriate systems and processes are in place to ensure ongoing compliance with the Act.

SECTION 4: BACKGROUND

The Act provides the statutory basis for the provision of appropriate staffing in health and care services and is applicable to call takers, dispatchers, ambulance care assistants, technicians, paramedics, nurses and medics within SAS. Many of the Act requirements (Appendix 2) are not new concepts however they must now be applied consistently within all the named roles to:

- Enable safe, high-quality care and improved outcomes for people
- Support the health, well-being and safety of patients and the well-being of staff

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The Act's Guiding Principles (Appendix 3) are applicable to all duties and responsibilities and are equally important.

The Act's accompanying [Statutory Guidance](#) describes the internal quarterly reporting requirements as:

- Quarterly (minimum) reports by Board Level Clinical Leaders (Executive Directors of Medicine and Care Quality and Professional Development) to members of the Board on their individual views of compliance of the relevant roles in scope under their leadership against all Act requirements to ensure appropriate staffing.

Appendix 4 details the information required within these reports of which the Board must take regard.

SECTION 5: DISCUSSION

Table 1: Overall Level of Assurance - Area ratings

Area	Prev. Report	Overall level of Assurance: Duty to Appropriate Staffing	
West	●	●	Reasonable Assurance
East	●	●	Reasonable Assurance
North	●	●	Reasonable Assurance
Advanced Practice	●	●	Reasonable Assurance
ACC	●	●	Reasonable Assurance
Scheduled Care	●	●	Reasonable Assurance
ScotSTAR	●	●	Reasonable Assurance
ICH	●	●	Reasonable Assurance
EPDD	●	●	Reasonable Assurance
NRRD	N/A	●	Substantial Assurance

Rationale for ratings

Please see Table 1 for individual areas overall levels of assurance. For this first quarter of 2026/27 April to June, 9/10 regions responding recorded a rating of '**reasonable assurance**' with regards to '**overall level of assurance**' for the Health and Care (Scotland) (Staffing) Act 2019 with NRRD reporting '**substantial assurance**'. Many regions and departments continue to report that robust governance and systems for safe staffing are in place, but there remain a number of complex system pressures that prevent '**substantial assurance**' from being recorded.

West Region - There is a high level of assurance overall; however, a small number of areas remain rated Yellow (reasonable assurance), meaning it is not possible to consider the Region as Green overall. While governance, leadership and workforce

arrangements remain robust, these areas continue to require improvement and ongoing monitoring.

East Region - There is a high level of assurance overall; however, a small number of areas remain rated Yellow (reasonable assurance), preventing an overall Green (substantial assurance) rating. Workforce and leadership capacity continue to experience pressure from workforce growth, recruitment initiatives and staff absence. During the review period, sickness absence affected abstraction activity on a limited number of days, resulting in cover levels falling below plan across several areas, most notably Fife and Forth Valley. Impacts were seen across both operational and managerial staff groups; however, mitigation measures were implemented and the Region remains committed to reviewing leadership arrangements to ensure they are aligned with future service and workforce needs.

North Region - assesses itself as providing Reasonable Assurance (Yellow). Robust governance, workforce planning, risk management and clinical governance arrangements are in place to support compliance with the Act, alongside established processes for workforce wellbeing, staffing risk escalation, clinical leadership, training and professional development. However, ongoing operational pressures, particularly hospital turnaround delays, vacancies and workforce abstractions, continue to impact ambulance availability, staff wellbeing and the ability to release staff for leadership, development and training activities. The Region also recognises that workforce growth does not always align with increases in leadership capacity and continues to review leadership workload, protected management time and workforce planning arrangements to ensure staff remain appropriately supported.

Advanced Practice - Whilst Advanced Practice staff do not have line management responsibility, there is confidence that professional and clinical development is being effectively maintained and supported across the team. The service continues to provide clinical leadership, supervision and development opportunities; however, it is recognised that the current staffing and support ratio may require review to ensure it remains appropriate as service demands evolve.

EPDD - There is a generally sound system of governance, risk management and control within EPDD to support compliance with the duties of the Act. Clearly defined processes are in place for identifying training requirements, planning and delivering education, allocating learning time, assessing competence, recording completion and escalating identified risks, supported by established governance and quality assurance arrangements. However, operational pressures have affected the timely release of some staff for training, and delays in establishing the full planned PMVA and manual handling educator workforce have contributed to outstanding LiP activity. Catch-up delivery will therefore continue alongside the next programme cycle. While these challenges may affect the achievement of some training objectives, the risks are recognised, monitored and subject to mitigating actions, supporting an overall assessment of reasonable assurance.

Scheduled Care - Based on the evidence gathered for this reporting period, Scheduled Care is satisfied that established systems and processes are in place to support compliance with the duties of the Health and Care Staffing (Scotland) Act. These arrangements are embedded within operational practice and supported through

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workforce planning, real-time staffing assessment, regular review of staffing levels, clear escalation and risk management processes, and ongoing staff engagement and development. Where staffing pressures are identified, mitigation measures are implemented and monitored to support safe and effective service delivery, providing ongoing assurance that statutory duties continue to be considered and applied across Scheduled Care.

ICH - At the time of writing, the Integrated Clinical Hub (ICH) has been approved substantively within SAS; however, during the reporting period the service remained supported through temporary funding arrangements. The Demand and Capacity recommendations have been accepted and will progress as soon as possible. A further recommendation from the Demand and Capacity review is to undertake a full review of the fit and function of the ICH to ensure the service is appropriately configured to meet current and future demand.

NRRD - NRRD maintained safe and effective service delivery throughout the quarter; however, there were occasions when a full complement of competent and qualified staff was not available due to recruitment challenges within specialist roles, abstractions for organisational priorities, sickness absence, training commitments and annual leave. These challenges are routinely monitored through departmental governance processes. Training, development and leadership continue to be supported through established appraisal, supervision, workforce planning and governance arrangements. Appraisal completion stands at 34%, with a further 62.5% underway, supported by a structured seven-week protected learning cycle for mandatory training, specialist skills maintenance, CPD and leadership development. The department also recognises that growth in workforce numbers, specialist capabilities and service demand can place additional pressure on leadership capacity. Workforce and management pressures are routinely reviewed through operational huddles, REAP processes and governance arrangements to support staff wellbeing, supervision, workforce development and operational readiness, with ongoing workforce planning and organisational development activity helping to ensure leadership capacity keeps pace with service requirements.

The contents of this report are based upon self-assessment reports provided by operational regions East, West and North, Scheduled Care, ScotSTAR, EPDD, ACCs and Advanced Practice. NRRD has not been included in previous reports but has been contacted to provide an update for Q1 2026/27; the total number of areas included from 2026/27 onwards will be 10. **NRRD are included in this 1st quarterly report for 2026.**

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The structure of this report will follow Appendix 4 - Internal Quarterly Report requirements.

For each of the duties, areas are asked to rate their 'assurance' that the services in their area have defined systems and processes that are aligned with the duty defined in the Act and embedded in practice.

For each of the duties, areas are asked how assured they are that the services in their area have defined systems processes that are aligned with the duty defined in the Act and embedded in practice. HIS Have recently updated their guidance for assurance levels and they will be reported by the following:

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.

12IA - Duty to ensure appropriate staffing

Table 2: Duty IA – Duty to ensure Appropriate Staffing area ratings.

Area	Prev. Report	12IA: Duty to Appropriate Staffing
West	●	● Substantial Assurance
East	●	● Substantial Assurance
North	●	● Reasonable Assurance
Advanced Practice	●	● Reasonable Assurance
ACC	●	● Reasonable Assurance
Scheduled Care	●	● Substantial Assurance
ScotSTAR	●	● Reasonable Assurance
ICH	●	● Reasonable Assurance
NRRD	N/A	● Substantial Assurance

Table 2 (above) presents each areas level of assurance. **East** and **North** Regions, **NRRD** and **ScotSTAR** reported that they were not able to demonstrate that, ‘at all times, enough suitably qualified and competent individuals were available’ during the reporting period. This reflects ongoing workforce capacity and skill mix challenges, which continue to require active management and mitigation through established workforce planning, recruitment and governance processes.

To provide some additional context, **East Region** report some impact on staffing on specific days due to sickness absence with most areas impacted, but more so Fife and Forth Valley. The impact was felt across all staff grades including managerial. Notably shift cover was above the recovery aim at 96.3% and 95.3% for April and May. Notably uptake of overtime in Forth Valley was low. **North Region** reported safe service delivery throughout Q1, however, staffing challenges occasionally impacted the ability to provide desired staffing levels across all areas. Despite progress, innovative approaches and engagement with territorial health boards, the Division continues to be significantly affected by hospital turnaround delays, impacting crew availability. Workforce challenges remain, particularly in rural areas where single-crewed resources and uncovered shifts affect response capability. Workforce wellbeing remains a focus, particularly through early intervention and support. Despite these challenges, risks were actively mitigated through established systems and processes, alongside escalation with partner organisations to improve patient flow and ambulance availability. **ACC** report at all times having enough suitably qualified and competent individuals working in such numbers to meet legislative requirements. They also detail ongoing recruitment for vacant posts. Similar is reported by **Advanced Practice** report on recruiting a further 22 trainee AP’s who will commence training Sept 2026. **ScotStar** report continued challenges in the provision of safe

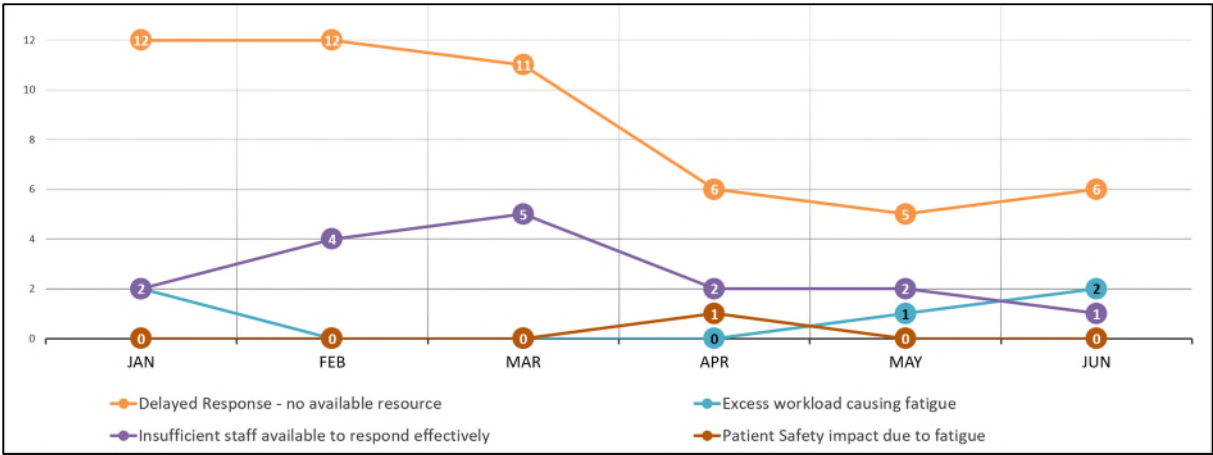
staffing, highlighting the shifts there went uncovered. These are broken down into clinical grade and specialism and totalled n=79 Day Shifts and n=45 Night Shifts. **Scheduled Care** report ‘substantial reassurance’ but continue to review workforce capacity and whilst has been challenged with sickness absence a range of measures have been implemented to mitigate these and support staff. Some examples include regular review of workforce establishment with targeted recruitment, implementation of regular one-to-one meetings, team briefings and communication forums on staff engagement, wellbeing and development and action planning on iMatter feedback.

Evidence offered in support includes data from the GRS rostering system, recruitment trackers, operational huddles and recorded daily Teams calls, predictive demand models, SAERs, Finance Records, **Sickness Absence**, **iMatter**, **GREATix**.

In our quarterly Board engagement Healthcare Improvement Scotland asked SAS to consider how it can measure staff well-being from quarter to quarter. Evidence offered from across the organisation includes staff absence rates, PULSE surveys and partnership meetings. All areas reported staff wellbeing is being actively considered and monitored through a mix of formal and informal processes including regular engagement, wellbeing groups, and support tools.

InPhase: The embedded use of the InPhase risk management system by staff provides useful triangulation. **Chart 1** presents data on Q1 2026/27 and, for comparison, also includes data from the preceding quarter (Q4 2025/26).¹ In Q1 of 2026 (April to May) a notable decrease in InPhase reports on ‘*delayed response no available resource*’ while the other three areas fluctuate but remain relatively stable. InPhase reporting by clinicians on these key areas remain low.

Chart 1: InPhase Fatigue and Resourcing Incidents by month



¹ Caution must be exercised in interpreting these Charts 1 and 2. The investigation process can result in small changes in absolute numbers after initial reporting as they are recategorized. These data are provided by our Risk Management support Team and are correct at time of extraction from the InPhase Dashboard 31/08/2026.

NB. All regions reporting on this part of the Act note the importance of staff wellbeing with various reporting mechanisms described. Notably, **East Region** has been collaborating with the University of Stirling on a cornerstone study to measure self-reported hydration habits among ambulance staff. As hydration is vital for physical, mental and cognitive wellbeing, the findings - now under analysis - will inform future staff wellbeing initiatives. The study results are now being collated, interpreted and prepared for sharing with SAS to inform future wellbeing initiatives before submission to a scientific journal for peer review and publication.

Chart 2: Rest Break Issues on InPhase by Month

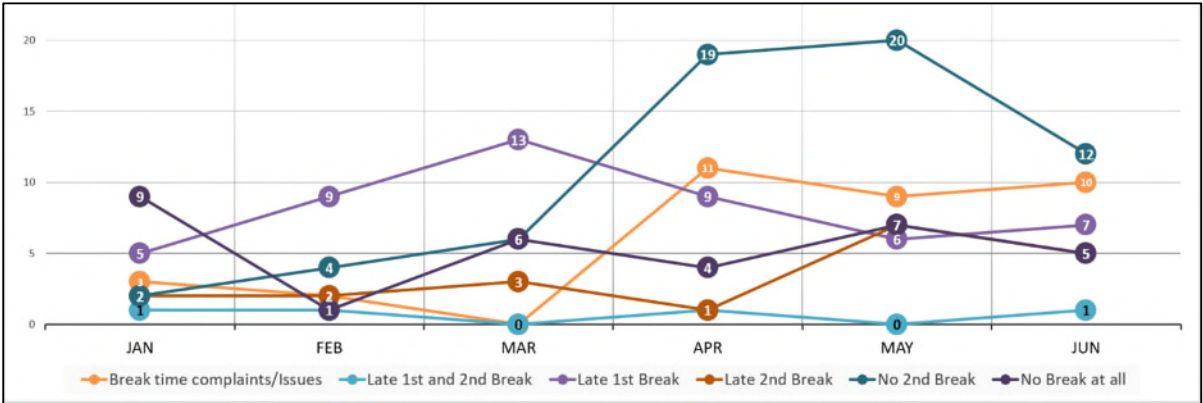


Chart 2 presents the aggregated monthly InPhase data for Missed Meal Break reports across Q4 (2025/26) and Q1 (2026/27) – permitting sequential analysis/comparisons. Reports of break-related issues fluctuated across the six-month period. The most notable trend was a substantial increase in reports of No 2nd Break, rising from low levels at the start of the year to a peak in May before declining in June. Late 1st Break reports increased to a peak in March before gradually reducing, while Break Time Complaints/Issues also rose sharply from April onwards. Reports of No Break at All decreased from a high in January and then remained relatively stable. Reports of Late 2nd Break and Late 1st and 2nd Break remained comparatively low throughout the reporting period. Overall, the data indicate that difficulties in accessing a second break became the predominant break-related issue during the reporting period.

Significant Adverse Events

There were 5 Significant Adverse Events identified that occurred between April - June 2026. Of the 5 SAERs, 3 are considered to have staffing as a contributory factor. In all 3 cases there was reduced operation cover in the local area, and although demand was lower than forecast, prolonged hospital turnaround times were noted. In 1 case it was also considered that ICH staffing had an impact on patient outcome, due to delayed remote clinical assessment.

12IB Duty to ensure appropriate staffing: agency workers

Table 3: Duty IB – Duty to ensure appropriate staffing – agency workers area ratings.

Area	Prev. Report	12IB: Duty to ensure Appropriate Staffing: Agency Workers
West	●	● Substantial Assurance
East	●	● Substantial Assurance
North	●	● Substantial Assurance
Advanced Practice	●	● Substantial Assurance
ACC	●	● Substantial Assurance
Scheduled Care	●	● Substantial Assurance
ScotSTAR	●	● Substantial Assurance
ICH	●	● Substantial Assurance
EPDD	●	● Substantial Assurance
NRRD	N/A	● Substantial Assurance

The Act requires a separate report to the Scottish Government quarterly listing high-cost agency use. Work with Procurement and Finance has indicated that area reporting will best identify usage. **No areas report employing any Agency Staff during the Q1 (2026/27) period.** As with Q2, the SAS did not employ any agency staff meeting the reporting criteria in Q3 2025/26. SAS did not employ any agency staff meeting the reporting criteria in Q2 2025/26. This position is expected to remain. There is high confidence that our systems and processes are consistently collecting accurate data.

Our RAG status **remains** green (substantial assurance).

12IC/D/E Duties to have real-time staffing assessment; risk escalation; and arrangements to address severe and recurrent risks

Table 4: Duty IC/D/E – Duty to have real-time staffing assessment area ratings

Area	Prev. Rep	12IC: Duty to have real-time staffing assessment in place	Prev. Rep	12ID: Duty to have risk escalation in place	Prev. Rep	12IE: Duty to have arrangements to address severe and
West	●	● Substantial Assurance	●	● Substantial Assurance	●	● Substantial Assurance
East	●	● Substantial Assurance	●	● Substantial Assurance	●	● Substantial Assurance
North	●	● Reasonable Assurance	●	● Substantial Assurance	●	● Reasonable Assurance
Advanced Practice	●	● Reasonable Assurance	●	● Reasonable Assurance	●	● Reasonable Assurance
ACC	●	● Reasonable Assurance	●	● Reasonable Assurance	●	● Reasonable Assurance
Scheduled Care	●	● Substantial Assurance	●	● Reasonable Assurance	●	● Substantial Assurance
ScotSTAR	●	● Substantial Assurance	●	● Reasonable Assurance	●	● Reasonable Assurance
ICH	●	● Reasonable Assurance	●	● Limited Assurance	●	● Substantial Assurance
NRRD	N/A	● Substantial Assurance	N/A	● Substantial Assurance	N/A	● Substantial Assurance

SAS leverages its current systems and processes to deliver an accurate, real-time overview of demand and capacity. This is continuously managed by operational managers, strategic operational managers and Directors, as well as through regional and national escalation plans. Historical data is utilised to identify severe and recurrent risks, allowing for the modelling and planning of future demand levels. Additional resources are scheduled to adapt to fluctuating demand. There is an established practice for staff to promptly report any staffing concerns through their team leaders or managers, and to file an InPhase incident report if necessary.

A staffing concern was formally raised by a staff member within East Region during Q1 (2026/27) under the Health and Care Staffing (Scotland) Act. This is the first concern to be raised through the Act's statutory process and has initiated a formal review of the circumstances. The review is being led by the Lead Practitioner for Health and Care Staffing in partnership with the East Regional Clinical Lead.

12IC ‘real-time staffing assessment in place’ – For this 1st Quarter of 2026/27 four areas report ‘reasonable assurance’ for this Duty; **Advanced Practice, ACC and ICH. North Region** continues to experience challenges associated with hospital turnaround delays, which present an ongoing operational risk, although these are being actively managed through established operational and workforce governance processes. Recruitment challenges, particularly in some rural and remote areas, continue to impact the ability to consistently achieve the desired staffing establishment and skill mix. However, the recent recruitment of VQ Technicians is expected to have a positive impact on workforce resilience and staffing capacity once training has been completed and staff are fully operational. The absence of line management responsibility within **Advanced Practice** limits the ability of Advanced Practitioners to provide full assurance, as they do not have direct authority over staffing, performance management, or implementation of corrective actions. **ACC** report on various systems and processes that support their management of staffing requirements with the addition of a weekly staffing summary of actions required which is sent from Operational Managers and Business Support to Senior Leaders in ACC. **ICH** provide limited reassurance as high AP abstraction rates are influenced by alignment to regional management structures, where abstraction performance is reviewed at station and sub-regional levels rather than through a national approach. In addition, competing organisational priorities can drive increased AP abstractions, which in turn reduce frontline patient-facing capacity and impact available operational time for live service delivery.

12ID ‘risk escalation in place’ – ‘reasonable assurance’ is provided by four areas; **Advanced Practice, ACC, Scheduled Care and ScotStar**, with **ICH** reporting ‘Limited assurance’. **Advanced Practice** highlighted that, without line management responsibility, their capacity to provide Substantial Assurance is limited. **ScotStar** advised that safe staffing concerns are sometimes recorded within the SAS Safe Staffing Tool but are consistently escalated to senior decision-makers, with subsequent recording in InPhase. Within **ACC** their REAP document now included ACC triggers and actions for escalation (including staffing levels). REAP levels are reported daily on the splash reports that are updated 4 x daily by the Realtime Team. **Scheduled Care** report, within the context of ‘Risk escalation’ that staff concerns are being recorded ‘sometimes’ within the InPhase system. This suggesting that compliance cannot be demonstrated consistently and preventing ‘substantial assurance’ from being recorded. **ICH** report on requiring further work to embed safe staffing into current process and that while Staffing risks are consistently escalated to senior decision-makers. Recording of these concerns occurs ‘sometimes’ within both the SAS Safe Staffing Reporting Tool and the Datix risk recording system. Please see page 10 for additional context on ICH and rationale for their rating.

12IE ‘severe and recurring risks’ – **North Region, Advanced Practice, ACC and ScotStar** all recorded reasonable assurance, consistent with the previous quarterly report (Q3 2025/26) (see table 5). **North Region** continues to make progress in addressing recurrent staffing risks associated with hospital flow, ambulance lost hours and workforce resilience. Collaborative working has been key in supporting

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improvements in hospital flow, reducing turnaround delays and increasing ambulance availability through HALO. The region has also expanded the use of the Integrated Clinical Hub, Flow Navigation Centres and alternative care pathways to reduce unnecessary conveyance. The Technician Training programme continues to strengthen future workforce capacity – they note the most severe and recurring risk continues to be the impact of prolonged hospital turnaround. **Advanced Practice** again note that without line management responsibility, their capacity to provide Substantial Assurance is limited. There is no specific information from ACC on their rating. **ACC** report that limited HR support for absence management, together with continued recruitment challenges, is impacting workforce capacity and impacting efforts to maintain stable and sustainable staffing levels across services. **ScotSTAR** report on the recurring risk associated with SPRS consultant staffing levels. While a decision on the business case is awaited, interim funding has been secured and recruitment to 1.0 WTE Consultant and 1.0 WTE Clinical Fellow posts has been completed. Staffing levels are therefore expected to improve significantly by the middle to end of Quarter 2. In addition, maternity leave cover for the SPRS nursing team has been secured, and all neonatal nurse vacancies have now been filled. No other areas report any severe or recurrent risks.

Table 5: Areas reporting identified severe or recurring risks area ratings.

Area	Previous report	Have any recurrent and/or severe risks been identified this quarter? (Q1 2026/27)
West	No	No
East	No	No
North	Yes	Yes
Advanced Practice	No	No
ACC	No	No
Scheduled Care	No	No
ScotSTAR	Yes	Yes
ICH	No	No
NRRD	n/a	No

The reductions in the working week and protected learning time introduction have the potential to impact service capacity. This is being mitigated through roster design and workforce planning.

There is a requirement for real-time staffing concerns to be risk assessed and escalated as required. All individuals involved must be informed of the outcome and be given the chance to disagree and to request a review of the decision. National tools provided rely on the use of the RLDatix SafeCare software or on TURAS. Both require onboarding of staff. Within SAS we have implemented this process via the InPhase system. To date we have had no requests for reviews in staffing submitted in SAS.

The move to InPhase increases opportunities for staff to report risk as the system does not need to be accessed via an intranet computer. Staff will be informed of the outcome, and the desire is to link our in-house tool to the InPhase report number.

ACC report the development of REAP Escalation triggers and actions are in progress for their area, which includes staffing levels. This will address having risk escalations in place. ICH recognise that there is further work required to embed safe staffing and risk escalation into current processes.

The identification of severe and recurrent risks is accomplished through analysis of risk reports and our risk register. It is recognised that Partnership also contributes through regional and national forums to identification. This will be supplemented by the Real-time Staffing reporting tool. North has reported the ongoing recurrent risk of lost hours to delayed hospital handovers. Mitigating actions include the use of additional HALOs, the implementation of the High Escalation Plan and the use of the offload SOP to free up ambulance resources for immediately life-threatening calls. These actions are in conjunction to the collaborative work between Boards.

Discussions have taken place with the Patient Safety Manager, who will strengthen the visibility of Safe Staffing-related factors within adverse event reporting. These will be reported on a quarterly basis and are included within this Q1 report (page 11). Detailed information is not provided here as adverse events are reported and scrutinised through established organisational governance and assurance processes.

SAS have had no requests for reviews therefore we have been unable to test the process. In the coming months we plan to do a mock request for review to give assurance we have the processes in place. The overall RAG status across these duties is yellow, reasonable assurance.

12IF Duty to seek clinical advice on all staffing decisions

Table 6: 12IF Duty to seek clinical advice on all staffing decisions area ratings.

Area	Prev. Report	12IF: Duty to seek clinical advice on staffing
West	●	● Substantial Assurance
East	●	● Substantial Assurance
North	●	● Substantial Assurance
Advanced Practice	●	● Reasonable Assurance
ACC	●	● Reasonable Assurance
Scheduled Care	●	● Not Applicable
ScotSTAR	●	● Substantial Assurance
ICH	●	● Substantial Assurance
NRRD	N/A	● Reasonable Assurance

All areas **continue to** report **on** clear and established systems to ensure appropriate section clinical advice is accessible on staffing.

Rosters have, and continue to be, developed through a data-driven demand and capacity programme in collaboration with staff and with clinical input. Our workforce planning teams adhere to the Business Rules for rostering staff and consult directly with operational managers when clinical input is required. These rules are under review, with the legislation being considered in the process. As not all operational managers have a clinical background, advice is sought from appropriately qualified staff who are available 24/7.

West Region report on Clinical support for staffing decision-making being available where required via ICH or FNCs.

Within the **East Region** there is currently one report of disagreement under review. This relates to a recurring concern raised through three InPhase reports regarding the Health and Care Staffing legislation. The Region is currently testing the Safe Staffing Tool to further explore and understand the issues identified. The submission of InPhase reports suggests an increasing awareness of the Health and Care Staffing legislation amongst staff. This is further supported by growing completion rates of the associated TURAS learning module through onboarding and induction processes, as well as the wider organisational focus on e-learning compliance.

North Region continues to utilise established clinical governance, operational management and staffing escalation arrangements to ensure appropriate clinical advice informs staffing decisions. The Regional Clinical Quality Lead remains embedded within governance and operational processes, contributing to workforce resilience, patient safety and operational risk discussions. Whilst no staffing decisions required formal recording through the Safe Staffing Reporting Tool during the reporting period, staffing challenges continued to be managed through established governance arrangements. Ongoing work is required to raise awareness of the Safe Staffing Reporting Tool and support its consistent use across services.

ACC site the National Clinical Quality Lead who is available for clinical advice if needed.

Due to the nature of the team configuration, **ScotSTAR** has access to Clinical Leads, Advanced Practitioners and Clinical Service Managers, all of whom contribute to operational and staffing decision-making. Senior clinical staff within duty teams can liaise with clinical colleagues on duty, with Clinical Leads and the Associate Medical Director (AMD) available to provide advice and support in particularly challenging or unusual situations. In addition, work continues with the Scottish Government on the business case for SPRS, while the business case for STNS is being finalised to support future service development and sustainability.

NRRD provided specific examples of the clinical input sought during staffing decision-making. This included consideration of staff training and competency, the clinical

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impact of vacancies, workforce abstractions, and operational readiness before any decisions were made. NRRD also supplied information on reduced staffing resilience and highlighted any associated risks to patient safety and the quality of care to ensure these factors were fully considered during the decision-making process.

Advanced Practice expressed uncertainty in this duty as a division exists between clinical professional lines and managerial responsibility for the team. This requires further consideration to ascertain the role of clinical input into staffing decisions in this area. This challenge persists in Q3 2025/26. Early conversations have taken place regarding accountability arrangements and reporting lines associated with this reporting requirement, with further work planned to clarify roles, responsibilities and governance oversight.

Consequently, overall the RAG status for this duty is yellow, reasonable assurance.

12IH Duty to ensure adequate time given to clinical leaders

Table 7: 12IH Duty to ensure adequate time given to Clinical Leaders, area ratings.

Area	Prev. Report	12IH: Duty to ensure adequate time given to clinical leaders
West		 Reasonable Assurance
East		 Reasonable Assurance
North		 Reasonable Assurance
Advanced Practice		 Reasonable Assurance
ACC		 Reasonable Assurance
Scheduled Care		 Not Applicable
ScotSTAR		 Reasonable Assurance
ICH		 Reasonable Assurance
NRRD	N/A	 Reasonable Assurance

Overall, progress is reported across all areas with a specific focus on strengthening appraisal processes, clinical leadership and workforce development. Appraisal completion rates continue to improve, supported by increased focus on staff participation, supervisor and manager training, and protected leadership time. Clinical leaders continue to be supported through a range of governance, supervision and workforce management arrangements, with dedicated leadership roles and protected time reported across most areas. While operational and workforce pressures continue to present challenges, regions remain committed to prioritising appraisal activity, staff development, leadership responsibilities and statutory training compliance.

West Region - Team Leaders are given 40% of their time to carry out leadership-specific roles, although the clinical leadership element should extend to 100% of their time. There is a regional focus on ensuring staff take part in appraisal discussions, and the region has recruited to a WTE Clinical Area Service Manager (ASM) post with a clear focus on clinical leadership. The region will continue to prioritise Development for Front Line Management (DFLM) time to maintain a strong leadership presence. There has been significant focus and effort across the West Region, with 45.5% of staff now holding a current appraisal. Further work is required to ensure all staff have objectives and Personal Development Plans (PDPs) in place as part of the appraisal process. Statutory and Mandatory Training compliance is currently 75%.

East Region - recognises the important role appraisals play in supporting staff development and wellbeing. Historically, appraisal completion rates have been low across the Service; however, significant focus and effort within the region has resulted in 55% of staff now having a completed appraisal. Further work is planned to ensure all staff have agreed objectives and Personal Development Plans (PDPs) in place as part of the overall appraisal process moving forward. Clinical leadership is delivered through a range of roles, including Paramedics, Advanced Practitioners (APs), clinicians within the Integrated Clinical Hub and Clinical Team Leaders. Mechanisms are in place to support AP participation in clinical supervision. Team Leaders are given 40% of their time to undertake leadership-specific responsibilities, although the clinical leadership element extends throughout their role. Ongoing progress is being made with appraisal training for supervisors and managers, alongside improvements in mandatory e-learning compliance. The region has also recruited to a whole-time equivalent (WTE) Clinical Area Service Manager (ASM) post, which has a dedicated focus on clinical leadership and staff development, with no specific operational management responsibility. Protecting leadership and DFLM time remains a regional priority.

North Region - continues to support clinical leaders through protected DFLM time, governance arrangements and workforce management support. Clinical Team Leaders, Area Service Managers and the Resource Planning Team work collaboratively to facilitate supervision, appraisals, staff wellbeing, professional development and leadership activities. Progress is being made in improving TURAS appraisal completion, workforce development processes and management support resources. Clinical leaders remain actively involved in workforce planning, quality improvement, patient safety and governance activities. Ongoing operational pressures, including hospital turnaround delays and workforce challenges, continue to impact protected leadership time; however, efforts remain focused on maintaining essential leadership, governance and staff support responsibilities.

ACC - Ongoing progress is being made with training on the appraisal process for Supervisors and Managers, alongside continued improvements in mandatory e-learning. ACC is reported as a non-clinical setting; however, Clinical Leaders from the

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Integrated Clinical Hub work closely with ACC leaders to provide clinical support and oversight where required. Approximately 25% of appraisals are complete, with a further 50% currently in progress.

ScotSTAR - currently have 23% of appraisals either completed and signed off or actively in progress. However, there are two important factors which mean the recorded figure understates the overall position. Firstly, a significant proportion of staff complete their appraisals using paper-based documentation rather than the electronic system. Secondly, the reported figures relate only to full-time SAS Agenda for Change staff. Medical staff undertake annual appraisal processes through their lead Health Board, with local arrangements in place to ensure all SAS-employed doctors participate. Compliance is expected to be close to 100%, as annual appraisal is a requirement for maintaining a GMC licence to practise. All Clinical Leads have specific PA/SPA time to support the clinical delivery of the service, and Advanced Practice staff have 25% non-clinical time to maintain skills and provide clinical leadership.

ICH - Work is ongoing across the Integrated Clinical Hub (ICH), with 50% of staff appraisals completed. Rostering arrangements through RWW allow protected time to be built in for Clinical Delivery Managers (CDMs) to support and manage their staff. Audit processes are in place, alongside a structured programme of 1:1 meetings, rota planning and workforce management activities, to support clinical leadership, staff development and appraisal completion.

NRRD Team Leaders, like other operational Clinical Team Leaders, are provided with protected leadership and management time through DFLM arrangements. This supports their leadership responsibilities, staff development, governance, workforce management and service improvement, with local monitoring to maintain operational readiness. Such arrangements are supported by structured briefing and debriefing processes and a seven-week protected learning cycle, enabling reflective practice, organisational learning, competency maintenance, leadership development and continuous service improvement. For staff appraisals, 34% are completed, with 62.5% in progress. Compliance is consistently monitored through established performance and governance processes.

Three specific requirements are specified under this duty. Organisational areas were asked to respond whether there were available time and resources in each always, sometimes or never. **Area responses are presented in Table 8.**

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Table 8: Frequency scale reporting area responses to availability of leadership time

Area	Prev. Report	To supervise the meeting of the clinical needs of the patients in their care		Prev. Report	To manage, and support the development of the staff for whom they are responsible		Prev. Report	To lead the delivery of safe, high-quality and person-centred healthcare	
West	●	●	Always	●	●	Always	●	●	Always
East	●	●	Always	●	●	Sometimes	●	●	Always
North	●	●	Sometimes	●	●	Sometimes	●	●	Always
Advanced Practice	●	●	Always	●	●	Always	●	●	Always
ACC	●	●	Sometimes	●	●	Sometimes	●	●	Sometimes
Scheduled Care	●	●	N/A	●	●	N/A	●	●	N/A
ScotSTAR	●	●	Always	●	●	Always	●	●	Always
ICH	●	●	Sometimes	●	●	Sometimes	●	●	Sometimes
NRRD	N/A	●	Always	N/A	●	Sometimes	N/A	●	Sometimes

12II Duty to ensure appropriate staffing: training of staff

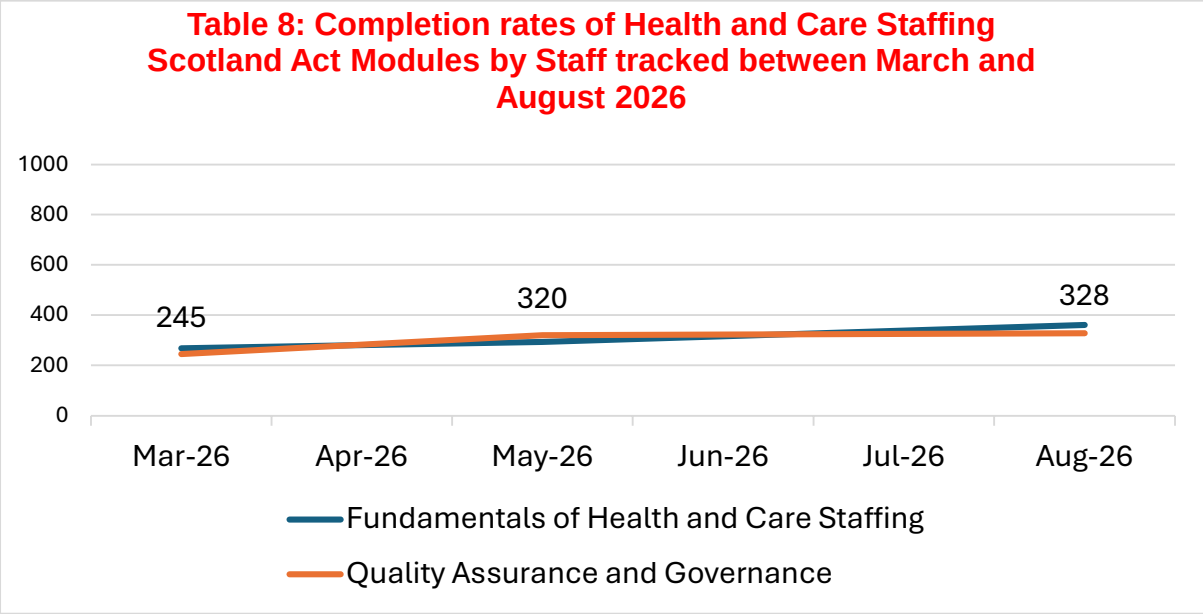
Table 9: 12II Duty to ensure appropriate staffing: training of staff, are ratings.

Area	Prev. Report	12II: Duty to ensure appropriate staffing: training of staff
West	●	● Substantial Assurance
East	●	● Substantial Assurance
North	●	● Substantial Assurance
Advanced Practice	●	● Reasonable Assurance
ACC	●	● Reasonable Assurance
Scheduled Care	●	● Substantial Assurance
ScotSTAR	●	● Substantial Assurance
ICH	●	● Substantial Assurance
EPDD	●	● Reasonable Assurance
NRRD	N/A	● Reasonable Assurance

Advanced Practice, ACC, EPDD and NRRD all report 'reasonable assurance' for this quarter. Key operational regions (North, East and West) report on the ongoing delivery of learning in Practice and Professional Development. **North** regions describe activity supported via close partnership with resource planning teams, Clinical Training Officers, Clinical Team Leaders and local managers. Progress continues with NQP, Trainee Technician and Leadership development programmes but challenges remain in balancing attendance with operation pressures, vacancies, abstractions and hospital flow demands. **East** report on LiP compliance at 73% but note some capacity challenges within Education and Professional Development Department resulting in several late cancelations and **West**, similarly speak of the balance between operational demand while maintaining training delivery. **EPDD** report on challenges on the timely release from regions, delays in establishing the full planned education workforce and disruptions associated with the West Clinical Education Centre from Hamilton to Ayr. Positively they note the strengthening of the PMVA and Manual Handling educator capacity. The EPDD continues to collaborate with the University of Stirling, the University of Glasgow and the Royal College of Paramedics on a research project exploring clinicians' support needs when returning to practice following a period of absence. Data analysis is currently underway, with findings expected to inform future return-to-practice processes and learning support arrangements. Within **NRRD** training needs are identified and reviewed through recruitment, induction, appraisal, supervision, competency and governance processes. Time is provided for learning and development supported by a protected structured seven-week learning cycle that enables mandatory training, professional development, competency maintenance and leadership development. Learning and workforce capability are further supported through briefing and debriefing processes,

real-time capability monitoring, and governance oversight, ensuring training needs, capability gaps and workforce resilience are identified and addressed while maintaining operational readiness and effective service delivery.

The Scottish Ambulance Service provides a range of learning modules on Turas to support staff education on the requirements of the Health and Care (Staffing) (Scotland) Act. As the Act mandates that clinicians receive education in this area, completion of these modules is an important organisational requirement. However, completion rates have remained low, where it has been identified staff may be experiencing challenges in locating and accessing the relevant modules within Turas. The Educational and Professional Development Department (EPDD) has recognised these barriers and is exploring approaches to improve accessibility, engagement, and overall completion rates. Completion rates will now be updated quarterly. Table 8 below:



This duty encompasses training to ensure that staff are qualified and competent in their roles and in executing the responsibilities mandated by the Act. The legislation does not negate the need for registered staff to maintain their own registrations. For HCPC paramedics, this includes continuing professional development (CPD) and reflections on their practice, which should be documented in a portfolio and may be requested during the registration renewal process.

The Learning in Practice (LiP) annual programme is **informed by organisational need; including** organisational learning from SAERs, statutory and mandatory training and from external bodies such as the Joint Royal Colleges Ambulance Liaison Committee (JRCALC). There was no LiP in 2024/25 however in 2025/26 a programme of Manual Handling and Aggression and Violence training will be delivered in person with online modules also requiring completion, including **online** training on the Health and Care Staffing Act.

The challenges surrounding the program centre on the ability to release staff for training while maintaining high-quality services (Risk IDs 5727, 5725). These are being overcome to deliver LiP in 25/26.

Evidence available includes TURAS learning platform data, SAERs, training records, JRCALC app data, and staff development portfolios.

Proactive educational support during Return to Work is vital for maintaining safe staffing levels and reducing reliance on costly overtime. The EPDD has strengthened its processes and support for staff returning after an absence. A forthcoming study in collaboration with the Royal College of Paramedics and the Universities of Stirling and Glasgow will explore clinicians' experiences and learning needs to ensure high-quality education, improved confidence and sustained care quality. **The questionnaire-based study is now closed with data analysis underway. The results will be shared with the SAS prior to submission to a peer reviewed journal for publication.**

Duties when planning or securing the provision of healthcare from others.

This duty does not apply retrospectively but to new, or renewed, agreements. These will include for example SLAs with other boards and healthcare services secured from private providers.

Further work has identified a partnership with the Scottish Charity Air Ambulance and Service Level Agreements with Greater Glasgow and Clyde Health Board pharmacy for drug bags for the Emergency medical Retrieval Service; the Scottish National Blood Transfusion Service for blood products and the movement of blood products by air ambulance. These fall under the legislation and future SLAs will need to include regard to the Health and Care Staffing Act.

SAS procurement has planned to include in future documentation arrangements to ensure regard is given to the guiding principles and appropriate staffing arrangements as part of any tendering process. This will include any tendering arrangements for healthcare services at external events, such as the Commonwealth Games for example.

The rag status for this duty is green, substantial assurance.

SECTION 6: CONSULTATION

This report has been circulated to the contributing authors from across SAS for comment before presentation to the Board.

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APPENDICES:

Appendix 1- Risks

Risk IDs	Description
3733	There is a risk that the Region cannot recruit the number of Paramedics and Advanced Paramedics compounded by the current volume of operational recruitment leading to limited capacity in the Education dept to deliver driver and clinical training, resulting in an inability to meet the current or future strategy.
3737	There is a risk that clinical staff may not have up to date knowledge to deliver safe, effective and person-centred care because they have not completed their learning in practice due to operational capacity to release staff resulting in the Service not meeting the requirements of the staff governance standards and potential risk to patient safety.
3782	There is a risk that the region is unable to maintain the required number of Advanced Paramedics due to staff turnover and expectations of partners resulting in an inability to support National remote triage, support the wider Primary Care system (including contractual obligations) and provide an operational AP response
5174	There is a risk that we will be unable to cover the paediatric rota with a consultant due to a lack of investment in adequate consultant sessions resulting in an impact on patient safety and quality.
5523	There is a risk that we will not be compliant with the Road Traffic Regulations 2023 (formerly known as section 19) because we do not have the capacity and resource to implement the changes (i.e. pre employment driving checks, 5 yearly assessment and PRU Training) resulting in the Service not meeting legislative requirements.
5699	There is a risk that doctors or other part-time ScotSTAR staff with commitments to both hospital and ScotSTAR rotas find their workload unsustainable because of the high acuity and frequency of combined on-call responsibilities, resulting in difficulties in ScotSTAR staff recruitment and retention.
5724	There is a risk of a lack of communication and integration with the Service on the objectives of the Project because of a lack of capacity resulting in a failure to comply with the Act and subsequent public / political scrutiny.
5725	There is a risk of a delay implementing the changes set out in the Act because of a delay in resource development and a lack of engagement and capacity within the Service to complete the education and training required resulting in the Service not complying with the Act and subsequent public / political scrutiny.
5727	There is a risk that the Service is unable to implement the changes because of a lack of backfill resources to allow staff to complete the training resulting in the Service not complying with the Act and subsequent public / political scrutiny.
5728	There is a risk that the Scottish Ambulance Service will be unsuccessful in meeting the requirements of the legislation because of a failure to comply in all aspects of the Act resulting in reduction in levels of trust from the public / stakeholders and increased public / media scrutiny.

Appendix 2- Health and Care Staffing Act: Duties and requirements

Guiding principles: staffing for health care

Guiding principles: staffing for health care (planning and securing of health care from others)

Duty to ensure appropriate staffing in healthcare

Duty to ensure appropriate staffing: agency workers

Duty to have real-time staffing assessment in place

Duty to have risk escalation process in place

Duty to have arrangements to address severe and recurrent risks

Duty to seek clinical advice on staffing

Duty to ensure adequate time given to clinical leaders

Duty to ensure appropriate staffing: training of staff

Duty to follow the common staffing method including Common staffing method: types of health care	Not applicable in SAS
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Training and consultation of staff

Appendix 3- Health and Care Staffing Act: Guiding Principles

- Improving standards and outcomes for service users
- Taking account of the particular needs, abilities, characteristics and circumstances of different service users
- Respecting the dignity and rights of service users
- Taking account of the views of staff and service users
- Ensuring the wellbeing of staff
- Being open with staff and service users about the decisions on staffing

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- Allocating staff efficiently and effectively
- Promoting multi-disciplinary services as appropriate

Appendix 4- Health and Care Staffing Act: Internal Quarterly Report requirements

Reports must include assessment of compliance against various duties

- ensure appropriate staffing
- ensure appropriate staffing: agency workers
- have real-time staffing assessment in place
- have risk escalation process in place
- have arrangements to address severe and recurrent risks
- seek clinical advice
- ensure adequate time given to leaders
- ensure appropriate staffing: training of staff

Reports must also include:

- reference to the steps taken to have regard to the guiding principles when arranging appropriate staffing
- reference to the steps taken to have regard to the guiding principles when planning and securing health care services from third parties
- details of the views of employees on how, operationally, clinical advice is sought
- information on decisions taken which conflict with clinical advice, associated risks and mitigating actions
- conclusions and recommendations following assessment and consideration of all detailed above

Useful Links

The Health and Care (Staffing)(Scotland) Act 2019 can be found [here](#).

The draft guidance can be found [here](#).

A summary of the duties can be found [here](#).

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