HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – THE STATE HOSPITAL ANNUAL REPORT 2025/2026.

Report approval

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

Name of organisation:	The State Hospital
Report authorised by:	Karen McCaffrey
	Director of Nursing & Operations
	22/04/2026
Location where report is published:	https://www.tsh.scot.nhs.uk/wp-content/uploads/2026/04/State-Hospital-Health-and-Care-Staffing-Annual-Report-2025-26-23-Apr-26.pdf

GUIDANCE ON USING THIS TEMPLATE

Purpose

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

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

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

Summary Section

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

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

Individual duties / requirements

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

   Evidence could, for example, include details of the organisational structures, systems and/or processes being used.

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

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

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

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

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

ANNUAL REPORTING TEMPLATE

Summary

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

Please advise how the information provided in this report has been used or will be used to inform workforce plans.
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. To build on the development of the self-assessment and to monitor its progress. To ensure our work plan ties in with the duties of the act identifying areas of good practice as well as areas of learning. The level of assurance attached to each duty will provide us with a focus to prioritise our work plan. Provides a resource for engagement with staff especially out with Nursing. SafeCare has been rolled out across all eleven wards, and we have our first new MHLD workload two-week tool run commencing 23rd February 2026. Significant progress has been made towards compliance within nursing with the investment of improved rostering practice in Optima and the implementation of SafeCare. 36 hour working week has been achieved which will take effect in April 2026.

Please advise how the information provided in this report has been used or will be used to inform workforce plans.
Work to strengthen regular attendance by all Heads of Service continues to ensure all disciplines understand the impact of clinical decisions on nursing resource. A well-established Workforce Governance Group monitors and reports on all Professionals workforce performance.

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. Staff engagement and awareness sessions have delivered across multiple disciplines Staff feedback is gathered via a staff survey, 1:1s with line managers, iMatter, PDPs, and business/departmental meetings and will be captured within SafeCare Robust data analysis of funded and in post establishment identified gaps in workforce in line with current clinical acuity. Board approval to over recruit to 105% of Funded Establishment. Robust systems and processes currently in place to manage rostering along with real time escalation of risk and mitigations taken. Data collection and reporting of trends, training and awareness factored into resourcing decisions.

Please provide information on how your compliance to the Health and Care Staffing Act has led to improved outcomes for service users and workforce
Patient engagement and feedback is crucial in ensuring we are listening to our service users. We have an established Patient Partnership Forum which strives to have a representative from each ward. Outcomes from this group are fed into the wider governance meetings. Staff also seek views from patients annually on ‘What Matters to You’ Patients are also represented on the Scottish Health Council. The Mental Welfare Commission and the Scottish Health Council provide support to this forum and provides assurance the patient/carer voice is heard. Person Centred Improvement Team collates and reports on the patient and carer experience and these are used in the triangulation of CSM. The Workforce Governance Group oversees the compliance of PDPs, Turas, in person training, recruitment and retention etc and identifies areas of risk.

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.

PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE
Substantial Assurance

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

Duty 12IA: Duty to ensure appropriate staffing

Duty Description	**Guiding principles etc. in health care staffing and planning** 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. To ensure appropriate staffing levels TSH have a number of systems and processes in place. These include, but are not limited to: • Daily (Mon-Fri) multidisciplinary pre-planning meetings chaired by ADoN. • Daily (Mon-Fri) multidisciplinary Site Safety meetings (Chaired by ADoN/Interim Director of Security). • Twice daily resource huddles (Chaired by Lead Nurse). • Twice weekly nursing resource planning meetings (Chaired by Lead Nurse). • Pre-weekend safety briefings. • Weekend safety briefings chaired by On-Call Director. The outputs from each meeting have clear escalation routes to ensure the requirements of the duty (121A) are met.

	TSH also receives evidence from those other disciplines named under the Act: AHP, Psychology, Risk & Resilience, Pharmacy, Medical, and Learning and Development. Operational systems and processes are in place for each discipline. This varies according to the size and delivery of the department. Routine updates are reported to Workforce Governance Group and to the Board providing details of our assurance towards compliance. (**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** Workforce planning is agreed for each financial year. Thereafter, a monthly workforce report is produced for all Heads of Service to review, provide comment and consider/raise any areas of concern. The workforce report also outlines a month-month overview of recruitment progress, and vacancies across each of the Directorates within the hospital. Datix is available to all staff to escalate risk, including resource risk. LearnPro and in-person mandatory training is available to all staff. Training compliance is reported through the Operational Management and Workforce meetings to ensure full engagement and compliance with statutory and mandatory training. Staffing requirements within the Nursing Directorate are agreed and determined by level of risk and by the hospital's Clinical Model delivery plan, considering skill and gender mix. Nursing staffing levels can vary in line with clinical acuity (increased with the need for higher nursing input). Resource requirements are reviewed on a twice daily basis to ensure adequate staffing in response to risk assessment. Optima has been rolled out across the organisation and is being used to record day to day staffing activity. Additional benefits of Optima have still to be realised with the further roll out of SafeCare, eJob Plan, Bank, and Loop. The continued roll out of eRostering is monitored by the Director of Workforce. Areas of concern are escalated as required to the Corporate Management Team then the Board.

The newly developed MHLD workload tool has been uploaded into Safe Care. All eleven wards within the hospital have been using SafeCare Part 1 since October 2025, and a “soft launch” of SafeCare part 2 was supported over the months of December 2025 and January 2026.

A two-week tool run is scheduled for 23rd February 2026 across all eleven wards. Whilst TSH evolves its knowledge and skills in the use of SafeCare; to realise all the benefits of the digital platform, we will continue to report real time staffing via the already established and robust twice-daily resource huddles.

Staffing requirements within the Nursing Directorate are agreed and determined by level of risk and by the clinical model delivery plan – taking into account skill and gender mix. Nursing staffing levels can vary in line with clinical acuity (increased with the need for higher nursing input) and regularly reviewed via the weekly clinical team meetings and RMO reviews. The newly developed MHLD workload tool has been uploaded into Safe Care. The 11 wards have been using SafeCare part 1 since October 2025 when a soft launch of SafeCare part 2 was supported over the months of December and January. A two-week tool run is scheduled for 23rd February 2026 across all eleven wards. Whilst we develop our knowledge and skills in the use of Safe care, we will continue to report real time staffing twice daily via the robust resource huddles.

(b) the local context in which it is being provided.

As noted above, the daily Site Safety huddles are routinely attended by all Heads of Service. Before each dayshift and backshifts, the local context of each ward areas staffing compliment is fully discussed and decisions are made to allow dynamic adaptations, with Multidisciplinary Team collaboration when necessary.

(c) the number of patients being provided it.

SafeCare has now been implemented across all eleven wards. The Nurse in Charge documents those staff on duty, records their professional judgement and documents patient levels of care across all three census periods (AM/PM/ND).

The new MHLD Workload Tool is uploaded to SafeCare however we still have to use the SSTS platform to upload the professional judgement. TSH ward-based nursing resourcing is reviewed on a dynamic basis via twice daily huddles and through our dedicated Senior Clinical Cover. (A Senior Nurse who is on each shift and has hospital-wide oversight of resourcing for each ward area).

With regard to consideration of patient numbers, as we provide clinical care within a high secure setting a minimum of 3 staff are required when patients are out with their rooms and a further member of staff is required to be able to respond to incidents across all wards irrespective of patient numbers. This means each wards-based area must have a minimum of four staff for full functioning and execution of daily operations.

(d) the needs of patients being provided it.

Staff feedback is collated via the twice daily resource huddles, iMatter, weekly business meetings, and Staff Surveys with direct feedback coming back to service leads via Staff Bulletins.
The Person-Centred Improvement (PCIT) collate carer and patient feedback on a regular basis via a number of methodologies. This enables the hospital to look at changes to activity or service redesign. We have an established Patient Partnership Group which meets weekly, in addition to the Person-Centred Improvement Group which is chaired by the Director of Nursing.

Patient and Carer feedback feature on the agenda of our Clinical Governance Group and Patient/Carers stories are also a standing agenda item on Board meetings.

The Mental Welfare Commission visit the hospital a minimum of twice yearly provide and provide routine feedback on the patient /staff experience. These visits celebrate areas of success as well as highlighting any areas for improvement. Any such areas are tracked through the development of an action plan which, again, is reported through our Clinical Governance Group.

(e) appropriate clinical advice.

The hospital has robust systems and processes in place to ensure clinical advice is available 24hrs per day, seven days per week:

- In-hours advice is available from all Heads of Service and/or Senior Clinical Cover (and can be escalated to the Associate Director of nursing and/or Director of Nursing).

- Out-of-hours the role of Senior Clinical Cover provides onsite senior clinical advice, which is supported by the hospital's Resident Doctors and the On-Call Psychiatrist, and overseen by the On-Call Director.

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 and processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- **36 hour working week:** We have achieved the reduction to a 36-hour working week which will take effect in April 2026.

- **eRostering Roll Out:** All areas are now using Optima and SafeCare on a day-to-day basis. All staff will manage their leave via Loop by April 2026. Further roll out required, including eJob Planning, the 36-hour week and the challenges this brings will be determined based on how the Business as Usual model develops. Double keying remains a challenge with SSTS and eEES.

- Twice-Daily resource huddle changes: The Hub Co-ordinators (one nurse who represents three wards all located within the same hub building) attend the twice-daily huddles, which has enabled positive development of Charge Nurses. We have observed evidence of problem-solving in relation to ward-based staffing issues by demonstrating flexibility within a hub to minimise the impact directly to patient care.

- Work to strengthen regular attendance by all Heads of Service continues to ensure all disciplines understand the impact of clinical decisions on nursing resource.

- **Workforce Planning:** A well-established Workforce Governance Group monitors and reports on all profession's workforce performance.

Vacancies and recruitment are closely monitored. A significant range and volume of activity aimed at mitigating ongoing challenges includes:

- Rolling recruitment drives to address specific vacancy challenges per Service.
- Positive traction on Agenda for Change job description reviews to aid recruitment.
- Increasing access to nursing training on an "earn as you learn" basis to "grow our own."
- Consideration of Modern Apprenticeships in non-clinical areas.
- Workforce Governance Group reviewing succession planning.

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

- Retire and return is widely used for all professional groups across the Board. Partial retirement is now a further option to retain skilled members of staff.
- Exit questionnaire data is extremely important to the Board in terms of understanding why staff choose to leave our employment, and what can be done to improve the overall staff experience and increase retention rates.

Heads of service Input in relation to HCSA:

- AHP and Psychology are members of national groups and linking into national advancements to develop RSTS. Linking in with HIS to ensure compliance.
- Pharmacy (on an SLA at TSH) have specific resource plans in place to ensure delivery of service. If this is not achievable, resilience planning is in place to draw pharmacy input from NHS Lothian.

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.

Each meeting identified in Section 121A (above) is Chaired by a senior professional and has a set agenda structure for the Chair to follow. This provides a consistent approach and minimises areas for error or omission. The efficiency and impact of the meetings is routinely monitored and adjustments made, as necessary. Both the Corporate Management Team and The Board receive regular updates by the relevant Directors (Medical, Nursing and Workforce) to provide assurances that TSH has robust monitoring arrangements in place to comply with Duty 121A.

The Risk Management Team review all DATIX records which are RAG rated. These are recorded and reported at the Health and Safety Committee. Learning opportunities and trends are reviewed with staff engagement so that improvements can be monitored and feedback is provided directly to those who escalated the risk.

All processes and systems take into consideration staff and patient wellbeing as well as escalation and/or mitigation of risk.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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.**	**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.**
The Human Resource Team provide expertise and support staff in areas of workforce including to all adhering to Once for Scotland and local policies and procedures.	Recruitment and Retention: Work overseen by the relevant professional and workforce programmes, is ongoing. Efforts are impacted by challenges in workforce supply and the continued existence of vacancy gaps across a range of professions. However, a range of concerted improvement activities aimed at mitigating ongoing challenges are underway. These include: • Rolling recruitment drives to address specific vacancy challenges per Department. • Positive traction on Agenda for Change job description reviews to aid recruitment. • Increasing access to nursing training on an “earn as you learn” basis to “grow our own;” • Consideration of Modern Apprenticeships in non-clinical areas. • Workforce Governance Group reviewing succession planning.	• To ensure future attendance at recruitment fayres and online events. • Continue to evolve Social Media Communication Strategy promoting TSH as a positive place to work. • Promote a community presence within schools, colleges, and universities. • Gather feedback on the new corporate inductions. • Survey feedback collated and reported in an action plan. • To monitor themes, escalating risks and taking actions from the exit interview process. • To ensure compliance with Once for Scotland policies for NHS.

Area of success / achievement / learning	Details	Further action
	• Retire and return is widely used for all professional groups across the Board. Partial retirement is now a further option to retain skilled members of staff. • Exit questionnaire data is extremely important to the Board in terms of understanding why staff choose to leave our employment, and what can be done to improve the overall staff experience and increase retention rates. The State Hospital developed a Recruitment and Retention Strategy that was aligned with the three-year workforce plan 2023-2025. The strategy recognised that a robust and efficient recruitment process significantly contributed to the delivery of our services. Equally, The State Hospital remained committed to retaining staff, recognising the resource required to recruit and induct new employees, as well as the skills, knowledge, and support that experienced staff brought to the organisation. The primary goal was to ensure we recruit the right people, in the right roles, at the right time. The strategy focusses on five key areas: • Visibility – Build the State Hospital brand across professions and communities. • Systems – Use data to influence future decisions and upgrade current processes.	• Focusing on the individual nature of a situation by taking a person-centred approach. • Face to face training sessions and a detailed special bulletin.

Area of success / achievement / learning	Details	Further action
	• Workforce Planning – Review workforce needs to ensure we have the right staff in posts. • Recruitment Skills – Develop manager skills and enhancing current staff skills. • Retention – Monitor staff experience and satisfaction through an onboarding survey and developing a proactive approach around leavers through the completion of meaningful Exit Interviews. **Visibility** • As part of our strategy to enhance The State Hospital brand across various professions and communities, we recognised several effective methods to achieve this goal, one of which was increasing our presence on social media platforms. With support from our communications team, all vacancies are now advertised on social media using a standard advert template. Additionally, the communications team developed employee profile posts. These profiles feature volunteers who share information about themselves, including their role at the State Hospital, their tenure, and why they enjoy working here. The State Hospital Facebook page has grown to 1.7k followers with posts reaching up to 8.2k people. Facebook is now the State Hospital's third largest applicant source after NHS Scotland Careers Website and Indeed.	

Area of success / achievement / learning	Details	Further action
	• The State Hospital committed to increasing attendance at community events. We have established a team of employability ambassadors who support events at educational institutions and career fairs. Participating in these events helps enhance our brand visibility and reputation within the community and industry. It has allowed the organisation to showcase what it is like to work in a high secure setting, discuss career opportunities, and provide education on the type of roles available and the benefits for employee, thereby attracting both potential job seekers and future employees. During 2025 we continued to attend educational institutes to promote working at the state hospital. • As part of our efforts to enhance visibility, the recruitment section of the State Hospital website was reviewed to provide potential applicants with more comprehensive information about working at the State Hospital. The main page of the website now includes a link to any current vacancies within the organisation, allowing for easy access for potential applicants. As the communications department continues to develop its services, we hope to add video blogs in the future.	

Area of success / achievement / learning	Details	Further action
	Systems Throughout the strategy period, significant efforts have been made to align the organisation's recruitment processes with national requirements. • The eApproval function on Jobtrain, which went live in late 2022, has been successfully integrated into the organisation, with all job approvals now conducted through this system. The State Hospital remains one of the few boards to have adopted this function. • The adoption of the Yellowfin system has streamlined the recruitment process and significantly improved overall efficiency. • The system also communicates national recruitment KPIs, which are presented in the monthly Workforce Report. **Workforce Planning** • Workforce planning is crucial for NHS Scotland and the State Hospital to ensure that the right people with the right skills are in the right place at the right time to deliver high-quality care. • Effective workforce planning helps address the changing needs of the population, manage workforce demographics, and ensure sustainable staffing levels.	

Area of success / achievement / learning	Details	Further action
	Young People • To ensure young people are provided with employment opportunities at the State Hospital, an organisational position was agreed upon based on a risk assessment. We will welcome applications from individuals under the age of 18 for non-clinical roles. However, to be eligible for clinical roles, applicants must be 18 years or older. A comprehensive guide was also produced to support managers in recruiting young people. This guide includes information on employing young people, employment law considerations, a risk assessment checklist, risk assessment guidance, and a risk assessment template. Work continues on increasing the number of young people within our organisation. **Apprenticeships** • The organisation has relaunched its Modern Apprenticeship Guidance and is committed to increasing the uptake of apprenticeships. The guidance aims to support managers locally in bringing apprentices into the organisation. Further work is currently underway on how the organisation supports foundation apprenticeships, in collaboration with South Lanarkshire Council. These apprenticeships provide valuable opportunities for young people to gain hands-on experience and develop their skills in various fields, such as administration, facilities, and clinical roles.	

Area of success / achievement / learning	Details	Further action
	By supporting apprenticeships, we not only help young people kick-start their careers but also ensure a pipeline of skilled talent for the organisation. This initiative is part of our broader strategy to invest in the future workforce and address the ageing demographics within the organisation. **Work Placements and Demonstrator Programme** • Maximising opportunities for accessing employment at the State Hospital required careful thought due to the organisation's unique nature. The State Hospital has frequently been asked to support work experience requests from students and other interested parties seeking to learn more about forensic mental health or gain experience in specific areas such as administration or human resources. To support managers with these requests and in order to maximise opportunities for people to access employment with our organisation, Work Placement guidance was developed. Work placements can range from brief 'tasters' lasting half a day to programs extending over one or two weeks, or even several months. Some work placements offer hands-on experience, while others provide insights, observation, and work shadowing. All can provide valuable experiences for individuals looking to pursue a career in the health sector and offer significant benefits to the organisation in terms of reputation, visibility, and social responsibility.	

Area of success / achievement / learning	Details	Further action
	Through national employability work, an opportunity arose with our neighbouring health board, NHS Lanarkshire, in developing the Demonstrator Programme between the two NHS boards within the Lanarkshire region. In collaboration with NHS Lanarkshire and South Lanarkshire Council the State Hospital agreed to host two Demonstrator opportunities. The Demonstrator Programme focuses on supporting parents aged 18 and over to re-enter the workforce or upskill within the NHS. This initiative aligns with the Scottish Government's No-One Left Behind agenda, targeting child poverty and reinforcing our commitment as a local employer and Anchor Organisation. The programme is designed with flexibility in mind, accommodating participants childcare needs and new routines. With support from the Workforce team and South Lanarkshire Councils Key Worker, participants are provided with wraparound support in order for participants to build confidence, wellbeing, and personal development with the goal of achieving permanent employment.	

Area of success / achievement / learning	Details	Further action
	Supplementary Staffing Register • The Supplementary Staffing Register for Nursing remains an essential tool for addressing staffing gaps within our service. It is a particularly valuable resource for those planning to retire and subsequently return to work in a more flexible capacity. • There is significant potential for further development of this register within the organisation. Continued efforts from the nursing directorate are required to review and enhance the existing framework. By expanding this initiative, we can provide more opportunities for staff considering leaving the organisation to remain involved. Additionally, extending this resource to student nurses would be highly beneficial, offering them practical experience and easing the transition into professional roles. • To maximise the registers impact, a strategic review and targeted enhancements by the nursing directorate will be crucial. **Succession Planning** • Alongside our strategic work, there was an initiative to develop a good practice approach to succession planning. There has always been a need to develop our staff, but in the past, succession planning often occurred in an ad hoc or unmanaged manner.	

Area of success / achievement / learning	Details	Further action
	In recent years, the changing workforce demographics within the Nursing and AHP community have highlighted the need for more structured thinking regarding succession planning. This has posed challenges for the recruitment and retention of skilled staff, leading to delays in appointing key roles or diluting service quality and provision. To address this, we developed succession planning guidance for managers to understand their roles in this process. This guidance includes information such as guiding principles, tools for supporting succession planning, personal development plans, and other key aspects. **Recruitment** • A training presentation for new hiring managers was developed. This training encompasses a wide range of topics, including legislation, best practices for advertising, shortlisting, interviewing, and onboarding. Moreover, the program addresses legal issues in recruitment such as unconscious bias, equality, diversity, and inclusion, as well as reasonable adjustments within the workplace. This approach ensures that hiring managers are well-equipped to create a fair and inclusive recruitment process. This training is available to anyone involved in the recruitment and selection process to ensure compliance with workforce policies.	

Area of success / achievement / learning	Details	Further action
Nursing Directorate has the responsibility to oversee staff wellbeing and attendance at work as well as ensuring we deliver a high quality of clinical care to our patients.	By equipping our hiring managers with this knowledge, we aim to foster a more inclusive and equitable work environment, ultimately enhancing the overall quality of our hiring practices. **Effective real time staffing assessments -** • The State Hospital has robust oversight and monitoring processes currently in place to determine real time staffing on a daily basis. • This process involves daily resource huddles which are routinely attended by Heads of Service. Before the AM/PM shifts, the local context of each areas staffing levels is fully discussed, and decisions are made to allow dynamic adaptations. **Overarching staff model** Despite more recent overtime pressures, following the opening of the Women's Service at TSH the forecast for the year remains for a breakeven position to be achieved, with a savings target on track. To better understand the contributory factors to overtime, spend within the Nursing Directorate we continue to: • Review of Clinical Acuity • Review of the Nursing Predicted Absence Allowance (PAA)	• To continue to develop collaborative working amongst the multidisciplinary team, ensuring good working relationships • Provide a forum for sharing areas of concern and risk escalation and what actions have been taken.

Area of success / achievement / learning	Details	Further action
	• Review of resourcing use within the new Clinical Model • Review ongoing efforts to ensure any instances of Daytime Confinement are as a last resort and are only enacted following the agreed escalation and governance processes. • Review of requirements needed to reduce reliance on overtime. • Review impact on nurse resourcing following the introduction of the Women's service. Following a presentation and agreement last year to recruit an additional 10wte above the current funded establishment for 12 months, there has been a further agreement that we can recruit to 105% each year. Recruitment is ongoing and in the last quarter alone we employed over 25 nurses. **Management Redesign – Nurse Directorate** • Following retirals, senior posts within the Nursing Directorate became vacant, which provided an opportunity to revise job portfolios and consider opportunities to use the funding from these posts in a different way. There was an identified need to strengthen the operational management aspects of the Directorate, as well as free up Lead Nurses to increase the focus on supporting the professional and clinical aspects of practice.	• Agreed over recruitment of 105% in progress. • Secure Job Descriptions and progress to advert and interview for Redesigned Structure

Area of success / achievement / learning	Details	Further action
	Therefore, the Nursing Directorate are exploring opportunities to introduce service manager post(s) to the directorate. Recruitment of these posts is planned for early in the new financial year. **Effective roster management – Nursing** • Following a Quality Improvement piece of work to support improved rostering practices, All SCNs and CNs were provided with training and support using an agreed Standing Operating Procedure. This was to ensure a consistent approach was used to create the 6 weekly rosters. We are now seeing the benefit of this investment with an improvement of skill mix and gender balance at the roster creation stage particularly on night shift. Work will continue to progress and improve with the implementation of the reduced working week. **Reduced Working Week – Nursing** • The State Hospital requires to comply with the nationally agreed pay award to reduce the whole time equivalent working week to 36 hours by April 2026. A short life working group has been establishment to engage with the nursing workforce through face-to-face sessions and/or via a questionnaire.	• SLWG established to support progress towards RWW in line with national requirements.

Area of success / achievement / learning	Details	Further action
Medical: The Medical Director has overall accountable for the governance of the Medical Department in the Hospital. Day to day operational management of the Department is through the Associate Medical Director, supported by the PA to the MD/AMD.	This engagement has enabled us to review our current shift systems and explore opportunities for a single approach to eRostering taking into account flexible working and or flexibility within the shift system, improved wellbeing, and more efficiency in the management of the rosters. This will provide additional opportunities to develop a consistent rostering arrangement for all staff and maximise the potential from Health Optima when creating rosters. The engagement sessions have been concluded with a new shift pattern agreed and will be effective by April 2026. **Delivery of Overtime via Optima** • Following a test of change within the Clinical Admin Roster where that group of staff entered their availability into LOOP, and the manager was able to search this availability, thereafter, assigning and notifying staff of overtime allocation. We have progressed this function to Mull Hub and initial reports are positive. Further roll out to all hubs is planned for year 2026. **Medical eJob Planning** • All substantive Medical Staff have a yearly Job Planning Meeting with the Associate Medical Director (or Medical Director in the case of the AMD). Regular reviews of the efficient and effective use of consultants' time are critical during a period of rapid change in both medical technology and healthcare delivery systems.	• Mull Hub Pilot to be rolled out to all other Hubs by Q3 2026 • Ongoing roll out of Optima Products

Area of success / achievement / learning	Details	Further action
	• Systems and processes are in place to ensure that robust medical coverage is in place. This includes out of hours via on call rotation and in the event of unplanned absence. • Medic engagement in daily resourcing huddles to understand the impact of clinical acuity and associated impact of decision making. • Introduction of systems and process in collaboration with pharmacy to ensure safe prescribing • Implementation of clinical model has ensured a progressive pathway through TSH. This service delivery change includes medics chairing newly developed service leadership teams and reviewing the impact of the clinical model on safe staffing/patient care. • Good outcome from NES visit and GMC survey re postgraduate training. • Job Planning now delivered via eRostering.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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.**
Financial Pressures	• The State Hospital continues to rely on overtime to fill nursing staff deficits. As detailed above a piece of work was commissioned to reduce the reliance on overtime within the nursing department and resulted in an additional 9.4WTE being recruited to support safe staffing over the 2025-2026 financial period. • Running in parallel to this recruitment is the noted risk of WTE loss through the Reduced Working Week (RWW). By April 2025, the hospital lost 8WTE hours to support the RWW. This will rise to approximately 12WTE by March 2026.	• Monthly Finance meeting continues to monitor nursing spend. These meetings are chaired by the Associate Director of Nursing along with the Associate Finance Director and are attended by all Senior Charge Nurses and the two Lead Nurses. • A financial review has also recently been undertaken to monitor the cost of the Women's Service.

Area of escalation / Challenge / Risk	Details	Further action
Sickness	• In addition to noted risks associated with the RWW, the introduction of the Women's service in July 2025 was given funding for a 4/4/2 shift pattern, however with the increase of complex admissions with high clinical acuity this service demands at least 10 members of staff dayshift and backshift. This resource pressure directly affects the care provided to our male patients and adds to the current financial pressures. • Sickness remains above 5% despite efforts to reduce this. Within the Nursing Department there are multiple strands of work focused on reducing absence rates. Improvement activities include monthly finance meetings with each Senior Charge Nurse and absence RAG rating meetings which are chaired and supported by the Head of Human Resources.	• Monthly meetings with Director of Nursing, Workforce and CEO. SCNs meet monthly with Head of HR. RAG escalation meetings with Head of HR, Lead Nurse with SCN and HR advisor for the area of concern >5% for 3 consecutive months.

COMPLIANCE ASSURANCE LEVEL
Substantial 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) (g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

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

Please provide information to demonstrate compliance.

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

(1) 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.

- SafeCare has been rolled out across all eleven wards, and we have our first new MHLD workload two-week tool run commencing 23rd February 2026. During this early implementation phase, we will review the ward resourcing on a dynamic basis via daily resource huddles and the role of Senior Clinical Cover alongside the out puts of SafeCare. Discussions have been supported with HIS that our robust operational model currently in place provides reassurance that we are compliant with legislation until we have SafeCare fully embedded.
- No system is currently in place for AHP or Psychology however work is underway with the Workforce Lead, HIS, and other national groups to consider the roll out the MDPJ Tool.
- Appropriate medical care is in place in line with patient numbers to ensure safe delivery of care via the appropriate number of medic sessions. Safecare is currently being explored in consultation with RL Datix and HIS.

(**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,

- All staff have the ability to raise a risk or concern regarding staffing levels through their Charge Nurse/Nurse in Charge, at the twice daily resource huddles, at ward handover discussions and business meetings.

- All staff have access to the Datix risk management system and can raise a Datix under the category of staff and subcategory of staffing levels on the system with a text descriptor of what the risk or concern was.

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

- SafeCare, within the nursing is now also being used to raise, escalate if necessary and mitigate concerns.

- Specifically, within nursing, staff are able to submit unsafe practice forms for review by managers.

(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.

- Systems and processes vary across services. Risk management occurs at team level by a Charge Nurse/ SCN or equivalent. Resourcing risks are reporting via the daily resource huddles and the site safety briefing with membership inclusive of relevant lead professionals. Where safety/resource huddles are not appropriate or routinely used, then individual notification to their lead professional takes place if the risk cannot be mitigated in real time. The Additional Hours Protocol provides a standardised process linked to the resource huddles for daily management of resourcing deficits.
- SafeCare is another system where staff can escalate resourcing risks, however we are in the early stages of this implementation.

(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.

- Dynamic risk assessment is inclusive of risk mitigation. Weekly clinical team meetings review each patient's risk and resource requirements. Where appropriate, these risks are reviewed by the RMO on an individual basis with input from the clinical team. Resource associated risks are reported via the twice daily resource huddle. Any risk not safely mitigated is escalated onto the datix system with the reporting line to the staff member's line manager in the first instance. This provides the first level of escalation to the lead with professional responsibility, first opportunity to mitigate the risk and provide clinical input. Severe risks such as a red datix also escalate directly to the executive leadership team. Via the role of Senior Clinical Cover, 24 hour senior clinical advice is available as required.
- Staff are also becoming more confident in using SafeCare to record and escalate such risks.

(d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c),

- The associated work around creating standardised processes and utilising current reporting, monitoring and risk management systems has supported the communication to staff required within the duty. With the implementation of SafeCare and MHLD Workload Tool all staff have been supported with training delivered by the use of SOPs, videos and probably the most effective, face to face learning. This engagement enabled staff to develop a clear understanding of the processes and systems to be accessed to assist them in the identification of risk. Over time this has allowed us to monitor and report on trends within risk escalation and mitigation.

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

(e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b),

- SafeCare has been rolled out across all eleven wards, and we have our first new MHLD workload two-week tool run commencing 23rd February 2026. During this early implementation phase, we will review the ward resourcing on a dynamic basis via daily resource huddles and the role of Senior Clinical Cover alongside the out puts of SafeCare. Discussions have been supported with HIS that our robust operational model currently in place provides reassurance that we are compliant with legislation until we have SafeCare fully embedded. out of SafeCare.
- SafeCare training will continue support changes in workforce. This is currently being discussed as part of staff induction.
- All staff have access to the Datix risk management system and can raise a Datix under the category of staff and subcategory of staffing levels on the system with a text descriptor of what the risk or concern was. Staff are also able to submit unsafe practice forms to record staff shortages.

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)

- Current H&S learning modules on risk assessment and H&S modules for managers and supervisors are currently in place via LearnPro.
- Internal engagement sessions have been delivered to service and professional leads.
- Face to face, mandatory training for clinical staff in the management of violence and risk prevention/mitigation is in place.
- Actions plans are developed and recorded to mitigate risk within the H&S Control Book. Training for delivery of this is mandatory for all line managers.

(g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

- Current provision to ensure adequate time is established through staff PDPs, Appraisal Reviews, Job Planning, Time built into Job Descriptions etc. Given TSH is a small board the pool of lead professionals to address all systems and processes is limited. The activity of lead professionals and senior decision makers related to management of risk escalation and management of risk is routinely incorporated into daily work activities.

Please 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. Significant progress has been made towards compliance within nursing with the investment of improved rostering practice in Optima and the implementation of SafeCare. The next steps are to support staff during the two-week tool run using the newly named MHLD workload tool in SafeCare. Development sessions are planned to progress SafeCare within Medical, Psychology, and AHP. The board have invested resources to support this, and a work plan is being developed to support all disciplines achieve compliance with the duty.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**This should describe the situation: what is the success, achievement, or learning?** **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.**	**This should describe how the success, achievement or learning could be used in the future.** **For example, this success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation.**
Nursing	**Time for Leaders** • The hospital's review of our Senior Clinical Cover role is ongoing with proposed plans to increase the amount of time available for SCNs to provide ward-based leadership.	• The outcome of these discussions are ongoing.

Area of success / achievement / learning	Details	Further action
	This is in addition to supporting the implementation of organisational initiatives and attendance at various groups/committees to ensure nursing representation. **Charge Nurse engagement with daily resource huddles** • Hub Coordinators continue to provide a key role within the daily huddles. This has provided opportunity for the development of the role of the Charge Nurse. This practice is now embedded within the huddles with their key role to provide a detailed report for their wards nursing resource, unfilled shifts, how these unfilled shifts will be mitigated and a clinical overview of their patients. Collaborative working has empowered this group of staff to make more evidence-based decisions pertaining to safe patient care whilst feeling supported by their peers. • With the improvement in data recording over the last 12 months from the daily huddles and with the development of a live dashboard we are now able to gather all the required data for operational safety and functioning. The dashboard has been fully tested, and it is hoped we will Go Live in Q1 of the new financial year. Data presented on the dashboard will provide the hospital with ongoing visuals and trends of the resource challenges by service, ward, and hub and will be used to make evidence-based decisions.	• Continue to develop the huddle and recording of data in line with HCSA. • Continue to evolve the role of the Hub Coordinators ensuring attendance from all wards. • Empower collaborative working by gaining a greater understanding of each other's role. • Empowered Charge Nurses/Nurse in Charge to make evidence-based decisions to support safe patient care while feeling supported by their peers. • Review out puts from the data collected and monitor trends and themes.

Area of success / achievement / learning	Details	Further action
	Real Time Staffing Resource Training • Real time staffing training continues to be delivered and supported by HIS for all key members of staff. • During these sessions it was evident that we had a robust operational model as detailed above in place. The State Hospital has invested training and development in the use of Optima and SafeCare which will run alongside our operating model providing us with rich data. With the dedicated resource supported by the board and HIS we have made substantial progress in the use of SafeCare within ward rosters. The next step is to provide Senior Charges Nurses will the skills to audit the data entered for accuracy within their own area so that we can start to see consistency across all ward rosters and use this information at the daily huddles.	• Continue to support good rostering practices. • Review data collection with the SCNs from the two-week tool run. • Work towards using SafeCare in huddles to determine staffing levels.
Multidisciplinary Working	• Work has already been undertaken to engage with Medics, Psychology and AHPs in the use of SafeCare. These staff are also represented at external forums where shared learning is crucial.	• Further engagement with other members of the Clinical Teams is being considered to ensure full compliance and will be delivered via training and online sessions.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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.?**
eRostering	**eRostering** • Health Roster does not link with SSTS or eESS resulting in additional workload and errors. The requirement to run dual systems to ensure safe staffing whilst maximising the benefits of eRostering is also a challenge as the preferred / priority system is still SSTS due to its paying function of staff salaries. This again creates additional workload.	• Monitor the efficiency of the Business-as-usual model.
	• The system has limited capacity to report on a site basis – which is current TSH practice. Progress has started to move from a central resourcing management to a ward-based practice with one hub now managing their resources via Optima and SafeCare. This unfortunately adds additional workload until we move completely to ward based management.	• Continue to roll out towards a ward-based management for resourcing.

	• Moving to a customer success model has had its limitations with limited onsite support. • Moving from a dedicated eRostering Project Team to Business As Usual model slowed down the implementation and evolution of Health Optima and other products such as SafeCare, however since September 2025 the board has supported additional resources which has enabled us to prioritise areas of work to be undertaken to meet the needs of the legislation. **SafeCare** • With the support of a dedicated member of staff, we have identified areas of inconsistency in the data outputs. Further exploration of this on the test site and with external experts we have identified issues in changing the demand template alongside increased clinical acuity. This was to prevent us having to create additional shifts. During discussions it became apparent that we had not been given the detailed training required from RL Datix as they had moved on before we started our SafeCare implementation. This has created additional work to make the demand templates align within Funded establishment as well as review our current training towards key member of staff.	• Utilise national eRostering team support. • Utilise dedicated member of staff to identify training gaps to minimise inconsistent data recording in Safe Care.

	Fixed shift patterns • Within nursing we have fixed shifts patterns, this does not lend itself to being able to use Health Optima to its potential. The creation of rosters is workload intensive with additional layers of governance. As stated in the duty 121A The State Hospital requires to comply with the nationally agreed pay award to reduce the whole time equivalent working week to 36 hours by April 2026. Staff engagement enabled us to review our current shift systems and explore opportunities for a single approach to eRostering taking into account flexible working and or flexibility within the shift system, improved wellbeing, and more efficiency in the management of the rosters. This will provide additional opportunities to develop a consistent rostering arrangement for all staff and maximise the potential from Health Optima when creating rosters.	• Continue audits to ensure good Health Roster practise prior to link with payroll etc.

COMPLIANCE ASSURANCE LEVEL
Substantial 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 **<u>of all of the points</u>** detailed in the duty description above by providing detail for each consideration. **(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. The hospital has a clearly defined escalation process to provide guidance and assurance in regard to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery. **Daily Control Measures:** • Daily Resource Huddle Purpose: to pre-plan daily activity and co-ordinate MDT working (participation includes heads of patient led departments (Skye Centre, AHP, Psychology, Nursing), Senior Clinical Cover, Clinical Resource Administrator, Person Centred Improvement Team, and Business Development Manager). Any escalation or issues from this meeting are taken to the next meeting for authorisation if required. • Daily Site Safety Meeting- Purpose: To review operational stability across the whole organisation. To discuss any identified areas of risk across the organisation and implement mitigation measures and agree escalations and adaptations to working. Chaired by the Interim Director of Security, Estates and Resilience /On-Call Senior Manager and all relevant operational heads of department attend. This meeting is minuted and reports to the CEO and Directors.

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

- Pre-Planning meeting takes place Mon-Friday at 16:00hrs. This is chaired by the Associate Director of Nursing and all relevant Heads of Service (or nominated Deputy) attend. This meeting is minuted and gives attendees the opportunity to raise and plan for any impact that may occur within the next 24hrs. The meeting also allows for operational teams to prepare for arrival to site the following day.
- Hub Co-Ordinators meeting - Purpose: To ensure delivery and implementation of agreed daily operations following the two meetings above and also ensure co-ordination of activities and staffing across the site. This meeting takes place AM and PM.

Further Control Measures:

- Tuesday Resource Planning Meeting (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors), ensuring senior oversight and escalation.

- Weekend planning meeting Purpose: Dedicated meeting reviewing the upcoming weekend to highlight/discuss available resources, operational issues, review of escalations for overtime, activity plans, contingency plan if required. (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/ Medical Directors)

- Weekend Site Safety Huddle Purpose: same as Daily Site Safety (consists of On-Call Director, Clinical Security, Liaison Manager, Senior Clinical Cover and On-Call Medical staff). This meeting is minuted and reports to the CEO and Directors.

(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)

- Opportunity for this is covered in the daily resource meeting and the daily site safety as outlined above.

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.

- As above, the attendance at both the resource and the site safety meeting have senior decision makers who provide guidance and expertise in the decision-making process. A minute of discussions is recorded, and any outstanding risks are escalated if necessary.

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

.

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.

- The Site Safety meeting is minuted and sent out each day to the Board of Directors and all relevant Heads of Service, A further update is also provided to the Associate Director of Nursing following the PM huddle, and any outstanding concerns escalated, as necessary.

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.

- Fully outlined in 121D (1).

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.

- The Lead Nurses, who are part of the Daily Site Safety and Daily Resource Meeting take responsibility for any ongoing nurse staffing decisions. If required appropriate escalations will be made to the Director of Nursing/Associate Director of Nursing (in hours) or the On-Call Director (out-of-hours).
- If required, the On-Call Director will brief other Directors, and the CEO, as necessary.

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

f) A procedure for those individuals to record any disagreement with any decision made following the initial report.

- A process is in place to mitigate risk and support the escalation process to effectively manage daily resources, operations, and safety. Daily huddles provide the forum of multidisciplinary discussion of risk and its planning and agreement to mitigate. Incident Reporting is in place to oversee and manage risk appropriately with all staff having access. Unsafe practice forms provide a record of disagreement and operational outcomes. The roll out of SafeCare will provide all the information relating to risk and mitigation in the one place.

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.

- As outlined above 121D (2) f

h) Raising awareness among staff about the procedures described in paragraphs (a) to (f).

- All staff are fully aware of the processes and procedures in place in and feedback and outcomes are given to all operational areas by the operational leads who attend the meetings following any decisions which have been reached at the daily resource and also the site safety meeting, particularly when it affects the patients' day.

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).

- Full training in regard to resilience / business continuity is given to all senior leaders with responsibility in this decision making process**.**

k) **Ensuring that such individuals receive adequate time and resources to implement those arrangements.**

- The Business Continuity Plan clearly outlines the steps to be taken for escalation and de-escalation of risk. Each member of staff who has the responsibility within the decision-making process is aware of this and has been part of Plan's development and review.

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. • Self-Assessment returns from all service leads for all professions and functions are submitted to the Workforce Governance Group and from there an action plan is developed to support and achieve compliance with the duty. • A bench marking exercise will be completed to provide a baseline of compliance across all the professions within the Board - this will be monitored by the Workforce Governance Group on a bi-monthly basis. It should be noted there has been significant progress towards compliance within the nursing workforce. • Development sessions are tabled to progress within Medical, Psychology, and AHP.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**This should describe the situation: what is the success, achievement, or learning?** **For example, senior decision-makers in paediatric 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.**	**This should describe how the success, achievement or learning could be used in the future.** **For example, the procedures for identifying the chain of escalation that were used in paediatric nursing are now being trialled and rolled out across other areas.**
<u>Business Continuity Plan</u>	• The hospital has a clearly defined escalation process to provide guidance and assurance in regard to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery. • Daily Control Measures (as described above) • Further Control Measures (as described above) **Tableau Resource Dashboard** • A resource dashboard has been developed to record escalations of risk and how these are mitigated from the various huddles identified above. This has provided us with rich information regarding resource trends.	• Continue to develop our digital data collection. • Consistent communication with our workforce. • Continue to develop our understanding of workforce challenges.

Area of success / achievement / learning	Details	Further action
	Optima and SafeCare • Nursing resource practice within the State Hospital was managed centrally with staff being moved across the site to minimise the impact directly on patient care. • This practice did not support the implementation of Optima being the primary source to manage operations; however, we have made progress to de-centralise the management of nursing resources to enable Senior Charge Nurses to manage their own nursing resource. • One Hub manages their resources and escalations via Optima with the other 3 hubs planned to follow in Q1 2026.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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?**
<u>eRostering</u>	Some of the challenges that the hospital is working to overcome include: • Health Roster does not link with SSTS or eESS resulting in additional workload and errors. • Rostering demand template in Optima Is linked to the funded establishment for each roster however, there are occasions where the required core shifts are either above or below the funded establishment. Accuracy is reliant on user input and staff are struggling to connect the funded requirement versus the actual resource required via creating/removing additional shifts as needed via a manual process.	• Project Plan has been developed with the key focus being on nursing and significant progress has been seen with the support of a dedicated member of staff. • Further action is for the project plan to include realistic timescales to include Medics, AHPs and Psychology.

COMPLIANCE ASSURANCE LEVEL
Substantial 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). The hospital has a clearly defined escalation process to provide guidance and assurance in regard to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery. **Daily Control Measures:** • Daily Resource Huddle Purpose: to pre-plan daily activity and co-ordinate MDT working (participation includes heads of patient led departments (Skye Centre, AHP, Psychology, Nursing), Senior Clinical Cover, Clinical Resource Administrator, Person Centred Improvement Team, and Business Development Manager). Any escalation or issues from this meeting are taken to the next meeting for authorisation if required. • Daily Site Safety Meeting- Purpose: To review operational stability across the whole organisation. To discuss any identified areas of risk across the organisation and implement mitigation measures and agree escalations and adaptations to working. Chaired by the Interim Director of Security, Estates and Resilience /On-Call Senior Manager and all relevant operational heads of department attend. This meeting is minuted and reports to the CEO and Directors. • Pre-Planning meeting takes place Mon-Friday at 16:00hrs. This is chaired by the Associate Director of Nursing and all relevant Heads of Service (or nominated Deputy) attend. This meeting is minuted and gives attendees the opportunity to raise and plan for any impact that may occur within the next 24hrs. The meeting also allows for operational teams to prepare for arrival to site the following day. • Hub Co-Ordinators meeting - Purpose: To ensure delivery and implementation of agreed daily operations following the two meetings above and also ensure co-ordination of activities and staffing across the site. This meeting takes place AM and PM.

Further Control Measures

- Tuesday Resource Planning Meeting (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors), ensuring senior oversight and escalation.

- Weekend planning meeting Purpose: Dedicated meeting reviewing the upcoming weekend to highlight/discuss available resources, operational issues, review of escalations for overtime, activity plans, contingency plan if required. (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/ Medical Directors),

- Weekend Site Safety Huddle Purpose: same as Daily Site Safety (consists of On-Call Director, Clinical Security, Liaison Manager, Senior Clinical Cover and On-Call Medical staff). This meeting is minuted and reports to the CEO and Directors.

(b) identify and address those risks which are considered to be either or both—
(i) severe,
(ii) liable to materialise frequently.

- Opportunity for this is covered in the daily resource meeting and the daily site safety as defined above.
- Risks are also recorded on the Corporate Risk Register, and these are reported to the Health & Safety Committee. This allows us to monitor and review severe and frequent risks and take necessary steps to further mitigate.

(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).

- As above the attendance of both the resource and the site safety meeting have clinical operational involvement at Senior Level. Escalations are discussed and decisions are minuted in both forums.
- We are also rolling out SafeCare where risks and escalations can also be recorded.

	(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). • The Site Safety meeting is minuted and sent out each day to all senior operational and clinical managers and also reported directly to the directors and CEO. A further update is also given following the PM hub co-ordinators meeting in regard to resources across patient led and clinical areas. Any identified risk is discussed, and mitigation options are considered. Escalation processes are in place if further measures are required beyond the Site Safety process. **(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.** • The Site Safety meeting is minuted and sent out each day to all senior operational and clinical managers and also reported directly to the directors and CEO. A further update is also given following the PM hub co-ordinators meeting in regard to resources across patient led and clinical areas. Any identified risk is discussed, and mitigation options are considered. Escalation processes are in place if further measures are required beyond the Site Safety process. **(d) the identification of actions to prevent the future materialisation of the risk, so far as possible.** • Our Business Continuity Plan clearly defines our process for identification and escalation. Any new identified risk is mitigated, and any learning is taken and plans adjusted accordingly. The level of governance around daily staffing ensures any identified actions are carried out and mitigations are delivered.

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.

- We reviewed our meeting structure and also those who attended to ensure we had the right staff attending with the right knowledge and skills to raise and escalate risks. We revised and updated our Business Continuity Plans to mitigate risk and to support the escalation process.

- All disciplines covered under the act are represented at all meetings and are instrumental is supporting decisions surrounding risk and risk escalation/mitigation.

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.

- Each meeting identified above is chaired by a senior professional and has a set agenda structure for the Chair to follow. This provides a consistent approach and minimises areas for error or omission. The efficiency and impact of the meetings is routinely monitored and adjustments made, as necessary. Oversight at these meetings by Senior members of staff provides the board with assurances that we have robust monitoring arrangements in place to comply with this duty.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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.**	**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 perf to be refreshed annually to ensure risks remain relevant and fit for purpose.**
<u>Business Continuity Plan</u>	• Business Continuity Plan is fully operational. The escalation process outlined within the plan is discussed on a daily basis at several risk related meetings across TSH.	• Reviewed annually to ensure risks remain relevant and fit for purpose.
<u>Patients</u>	• Patient engagement and feedback is crucial in ensuring we are listening to our service users. This enables us to look at changes to activity or service design. We have an established Patient Partnership Forum which is chaired by the Person-Centred Improvement Lead, which strives to have a representative from each ward. Outcomes from this group are fed into the wider governance meetings. Staff also seek views from patients annually on 'What Matters to You' Patients are also represented on the Scottish Health Council.	• To ensure patients and carers are represented in our consultation process in matters which affect their care and treatment.

Area of success / achievement / learning	Details	Further action
Training Compliance	• Key mandatory training is a priority on the organisation's risk register. We are now within a compliant range to meet those targeted training courses such as PMVA & SRK training.	• Ongoing monitoring of Training Compliance
Incident recording platform	• Resource incidents are recorded using our Incident Recording platform. This platform is used to record a variety of incidents, events and/or near misses. As noted above, regular reports are provided to the relevant committees detailing trends noted across staffing, including resource-related incidents. Regular reporting ensures that severe and recurrent risks are managed quickly and effectively. Following an increase in a risk, the relevant risk register will be updated and mitigations put in place to reduce the risk again. • For severe risks, more regular reviews of the risk are required, severe risks are graded as either High or Very High using the national risk matrix and are monitored by the Corporate Management Team and the relevant committees. The hospital also has a Significant Adverse Event Review Process (SAER) which can be utilised to investigate severe incidents to provide learning and ultimately reduce the likelihood of the risk happening again.	• Ongoing monitoring

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. • No concerns to note for this reporting period.	**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.**	**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.**

COMPLIANCE ASSURANCE LEVEL
Substantial 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.

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.

- Professional leads are in place for all services and provide representation on multiple TSH governance groups, service leadership teams, clinical team meetings, and daily resource huddles.

- The Board operates a model of Triumvirate service management: this consists of Nursing Directorate, Security Directorate and Medical Directorate to ensure TSH service decisions (admission, treatment and recovery, LD, Women's Service, and transitions) are jointly discussed and agreed in collaboration.

- The role of senior clinical cover (provided by and on duty SCN) and the duty RMO are available 24 hours a day for senior clinical advice. In other services it is the most senior clinical leader on duty who provides clinical advice.

- There are different mechanisms to evidence clinical advice has been sought via the daily resource and site safety huddles. Clinical advice related to staffing decisions is fed back via the hub coordinator at hub/ward teams. Data from these huddles is and shared with relevant parties including executive level on a daily basis.

- Additionally, a daily 24-hour report is generated each night highlighting clinical advice given for the preceding 24 hours. This document captures clinical decision-making regarding events such as seclusion reviews, observation level reviews, emergency suspension of detention outings, and SRK review.

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

(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,

- Clinical conflicts are managed and documented through clinical pauses which are then uploaded into the electronic patient record. These multi-disciplinary discussions are reviewed by the Associate Medical Director and Associate Nursing Director and mitigated/escalated as required.

- TSH committees and groups provide governance over risks, issues and mitigations which may have arisen from any conflict with clinical advice.

(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,

- All discussions are recorded within various TSH committee/group meeting notes, clinical pauses, meeting minutes or other local processes, and the Associate Medical Director/Associate Nursing Director is sited and involved in that decision making process. Disagreements or concerns would be recorded within these processes to ensure this is auditable and any actions, feedback or further risk assessment can be captured.

(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,

- All clinical leads attend and contribute to the Workforce Governance Group a monthly basis. Risk and issues can be raised at the meetings which are minuted and actions will be generated to ensure compliance. The Workforce Governance Group provides governance to the Board for assurance. The Self-Assessment report is generated by the Senior Nurse Workforce Lead and submitted for feedback/further input prior to submission to HIS or Scottish Government.

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

(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),

- There are a range of ways that we collect feedback form staff, and this will be reflected in compliance monitoring of the different duties in such a report, for example, as detailed in 12IC, 12IH, 12IJ, 12IL.

- There are questions within the staff survey regarding staff opinion on how well they believe their views are listened to and acted upon by the organisation.

- Line Managers also conduct their own staff engagements exercises along professional lines and via iMatter, PDPs, and business meetings.

(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),

- HCSA engagement sessions and training for individuals with lead clinical professional responsibility remain ongoing with support from HIS and the Senior Nurse Workforce Lead.

- Work is commencing on ensuring that the HCSA is introduced to all new starts via their Corporate Induction. SWAY presentation has been shared with all clinical service leads.

- A bespoke online training module has been created and tested and is planned for the roll out to all staff in the new financial year.

(e) ensuring that such individuals receive adequate time and resources to implement those arrangements.

- This duty is linked to implementation of Duty 12IH. Current provision to ensure adequate time to implement is established through staff PDPs, Appraisal Reviews, Job Planning, Time built into Job Descriptions etc. Given TSH is a small board the number of lead professionals to address all systems and processes is limited and workload is an ongoing issue. Group/committee reporting/attendance is under review by each department to avoid unnecessary duplication of attendance/workload. Directorate performance reviews provides a forum for all service leads to report on their priorities and successes as well as highlighting emerging issues.

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

(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).

- The governance structure of the HCSA feeds into the Workforce Governance Group with any risks / concerns escalated to Staff Governance then ultimately the Board.

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

Staff have the mechanism to seek clinical advice through the following routes which provides the assurance that there is an escalation route. All of the meetings detailed below are minuted highlighting risk raised and if it is able to be mitigated/escalated. Feedback is given directly to staff seeking the clinical advice.

- Daily (Mon-Fri) multidisciplinary pre-planning meetings chaired by ADoN
- Daily (Mon-Fri) multidisciplinary Site Safety meetings (Chaired by ADoN/Interim Director of Security)
- Twice daily resource huddles (Chaired by Lead Nurse)
- Twice weekly nursing resource planning meetings (Chaired by Lead Nurse)
- Pre-weekend safety briefings
- Weekend safety briefings chaired by On-Call Director

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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.**	**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.**
Resource team in place	• We are now in the 3rd year of having a resource team to provide operational oversight of clinical resources. This has enabled the SCNs time to focus on their individual clinical area and to foster collaboration with multidisciplinary team members at various forums. SCNs are now invested with time to meet monthly with the Associate Nursing Director and the Senior Management Accountant to develop their knowledge around how their decision-making impacts on their budget. A dashboard has been created for each SCN to be able to monitor in post, vacancy, sickness, overtime, use of supplementary staff etc which is already having a positive impact on their decision making.	• Develop and support SCNs to become responsible for their own staffing within their own ward area. Quarterly performance reviews with the Director of Nursing supported by HR and Finance continue to evolve.

Area of success / achievement / learning	Details	Further action
Senior Cover Review	• A significant amount of work has been undertaken over the last 12 months working in partnership and with the SCN group to provide clarity on the role that is required. Workload and demand has drastically reduced with the resource team in place as well as refocusing on who should be delivering what. We are confident this review will be concluded within Q2 of the new financial year.	• Continue to support the SCNs to develop as clinical leaders. Roll out of Leadership workshop is being co facilitated with OD and Learning and Development departments.
MHLD tool	• The State Hospital was represented in the development of the new MHLD workload tool named in legislation in October 2025. • This tool is the first to be uploaded into SafeCare. All qualified nursing staff have been given training on how to complete this over three census periods per day. Regular audits are carried out to determine compliance completion which in the last month has been reported to be >80%.	• To monitor compliance, data recording and provide feedback to SCNs

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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.**
Introduction of the Women's Service July 2025	• The workforce assumptions on the Funded Establishment required for this service has not been realised. This service continues to put pressure on all the other wards in the hospital. Recruitment is a constant priority.	• To continue to gather workforce information and recruit to all vacancies to minimise the impact on other patient areas.

COMPLIANCE ASSURANCE LEVEL
Substantial 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.

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.

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.

- Job Planning is in place for medical employees.
- All other professions out with medical, have leadership time monitored through one-to-one meetings and the PDPs held between manager and clinical leaders. PDP completion rates are monitored by the Workforce Directorate department.
- All services/professions are benchmarking the duty to ensure adequate time is given to leaders however this can be challenging due to the small nature of the board and the same people tasked with organisational priorities.
- Through the measures outlined above, as well as line management and professional leadership support at all levels, clinical leaders will be supported to have the time and resources to undertake these roles or seek support and highlight risks where this is not sufficient.
- Lead clinicians are identified via multiple TSH systems such as LearnPro, SSTS, eEES, TURAS, and SafeCare. Staff job descriptions reflect the specific leadership responsibilities, requirements and expectations within each role which are managed by relevant line managers. Work has progressed within nursing with skills identified within eRostering to aid staff being allocated in the right place at the right time.

Please provide information on the steps taken to comply with Duty 12IH.
• Job descriptions, job planning, and work plans are all assessed at appropriate times via appraisal, 1:1s and PDP, job planning, development sessions, service change, and redesign. • Job planning sign off completion rates can be monitored through their respective systems. Workforce Governance reports are provided monthly to all service leads to highlight areas of risk such as hard to fill posts, vacancies, onboarding, and leavers. • Access to eRostering systems to support workforce planning is currently being rolled out within. During this transition period, all professional leads have access to annual PDPs/appraisals and medics have access to job planning. Discussion time with line managers to agree levels of time and resource to discharge their responsibilities and clinical workload are a core component of annual appraisal meetings and are escalated as required via board governance structures.

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. The Workforce Governance Group oversees the compliance of PDPs, Turas, in person training, recruitment and retention etc as well as looking at themes or trends for why staff leave the organisation. If areas of risk are identified these will be escalated to the Senior Clinician who will receive a report to address this area of noncompliance.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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 different team leaders, and feedback so far has been positive.**	**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.**
Management Redesign	• Two senior posts within the Nursing Directorate became vacant, which provided an opportunity to revise the portfolios and consider where we required to use the funding from these posts in a different way. There was an identified need to strengthen the operational management within the directorate, as well as free up lead nurses to increase the focus on supporting the professional and clinical aspects of practice. Therefore, we aim to introduce two service manager posts to the directorate, and they will assume line management responsibility for the SCNs and responsible and accountable for the operational service delivery. Recruitment of these posts is planned for early in the new financial year.	• Prepare Job descriptions and advertise posts.

Area of success / achievement / learning	Details	Further action
Nursing director supported absence review meetings.	• Over the last 12 months a significant investment has been made to support our SCNs and CNs develop into their role as clinical leaders. An area of concern was the level of sickness absence and to ensure we had robust systems in place to manage this. Along with the introduction of 'Once for Scotland' Policies and a task and finish group, SCNs now have monthly meetings with Human Resources to ensure staff are being supported appropriately whilst absent. Improvements have been noted however we are still above the 5% P.A.A.	• Continue to develop these meetings, monitor trends, manage absence and tailor to individual needs.
Heads of clinical department development day. Psychology - have held development days to focus on planning for new clinical model. Have also introduced weekly consultant huddles.	• Psychologists will have time allocated as part of their workplan for leadership duties. AHPs will have time allocated as per their job descriptions/work plans. • Development days have taken place to create joined up working and team building. • Each service has an allocated lead for psychology who is also a member of the Service Leadership Teams. They will have oversight of the clinical needs of the service and how these are to be met. Care will be delivered in line with the national psychology specification and the Matrix. Governance of this will be through the HoP.	• Ongoing programme

Area of success / achievement / learning	Details	Further action
AHP Clinical Leads monthly meeting to focus on service planning and delivery.	• AHP dedicated development sessions have taken place with a focus on service planning and delivery. AHPs have senior clinicians allocated to each service and who are members of the SLT. As with psychology they have oversight of the clinical needs of the AHP services and governance via Lead AHP.	• Ongoing programme
Financial Review Meetings	• In preparation for SCNs to have the autonomy to be budget holders for their ward area the Director of Nursing introduced monthly Finance Meetings led by the Senior Management Accountant. Due to the way in which deficits are covered by overtime or excess hrs SCNs needed to have an overview of how this management was having an impact on their budget. A dashboard has been developed for each ward and provides key information re sickness absence, overtime, unfilled shifts etc which can also be monitored over time for trends. These dashboards have been up and running for just over 12 months.	• Continue to develop these meetings, monitor trends, and tailor to individual needs.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**This should describe the situation: what is the challenge or risk identified? For example, the process in place to identify the roles, and 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.**	**This should describe what actions have been / are being / will be taken to address the situation. For example, if the process in place 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.**
Small board	• Small board – majority of organisational tasks become the remit of a small group of the same senior individuals to take forward, can become person-dependent. Due to the size of the board, streamlining of meetings has proved challenging.	• Streamlined reporting processes freeing up staff as best we can, e.g. Lead Nurses have been assigned different key areas of responsibility and meetings to which they are required to attend.
Wellbeing of staff	• Wellbeing of all staff. Lots of good support being provided however, workload makes it very difficult for nursing staff to attend/utilise excellent resources.	• Wellbeing is a focus within the Nursing Directorate, SCN meetings with Director of Nursing have identified a need to consider how we support the wellbeing of a Senior Charge Nurse who due to workload does not find time for themselves.

Area of escalation / Challenge / Risk	Details	Further action
36 Working Week	• Progression towards a 36-hour working week is noted as a risk factor in ensuring protected time for learning however the implications of this are being monitored through the hospitals Workforce Governance Group.	• Engagement and partnership working have resulted in the State Hospital being ready to implement the 36hrs working week in April 2026.

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance

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

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

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

Please provide information to demonstrate compliance.

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

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

- TSH Learning and Development Centre for professions, provides educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) and identified development, learning facilitators in other professions to deliver identified new knowledge and skills requirements. All new employees undergo corporate induction and orientation.
- Workforce Directorate monitor and report on all staff training to ensure compliance. This includes all face-to-face mandatory training, PDP completion, and LearnPro modules. This is reported via local governance routes including Staff Governance, Workforce Governance, partnership forum, and directorate performance frameworks.
- PDP completion is monitored through the TURAS platform along with the completion of mandatory and essential training at one-to-one meetings between managers and staff within all professions.
- Training on legislation delivered to each group of staff named.
- Training within the organisation is clearly determined along the lines of Mandatory, Essential and Development requirements for each profession and role.
- All training is supported with protected time to complete and attend all training requirements.

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

- Protected time is agreed within PDPs.
- Different professions have different set national training curriculums. These are supported through line management and departmental budgets.
- Nursing staff are issued with their off duties every six week and these off duties include rostered shifts for training. All other staff are managed by the learning and development timetable of when they are due to attend training – this is supported by line managers.
- Flexible approach to staff completion of online learning access to training available from multiple devices and locations including areas out with the clinical setting. Access to online learning, Staff can choose when to complete e learning. The learning and development department monitor and report on training compliance and if necessary, risk is escalated to the corporate risk register.

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.

The Workforce Governance Group oversees the compliance of PDPs, Turas, in person training.
If areas of risk are identified these will be escalated to the Senior Clinician who will receive a report to address this area of noncompliance
The Learning and Development Centre work alongside the workforce Governance Group providing an overview of staff attendance at in person training as well as reasons why staff do not attend training. When a member of staff does not attend for training, this is escalated to the service lead/ SCN.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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 found the new system much easier to use and are now recording relevant CPD.**	**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.**
Learning & Development	• Corporate training programme exists and is reviewed annually by service leads to ensure all statutory and mandatory training is current and relevant. Compliance reporting and monitoring is embedded within the directorate performance framework.	• Staff will have their training records uploaded into Health Roster.
	• Courageous conversation training is being delivered to Charge Nurses /SCNs to support them manage absence. This along with the Once for Scotland policies has enabled mangers to understand other available options for absence and how they can be supported make flexible decisions to support staff.	• During the quarterly meetings with SCNs reflect on the use of the policies and learn from shared experience.

Area of success / achievement / learning	Details	Further action
Nursing	• Rostering practices with senior Clinical staff • have improved with training and development. A more consistent picture is being seen when rosters are presented for approval. Learning and development attend the weekly resource planning sessions where any with training/resourcing are discussed and solutions found.	• Continue to work closely with the Learning and Development Team ensuring we are proactively managing staff training.
HR	• Once for Scotland Policies awareness sessions completed and HR department are now actively supporting line managers to utilise the new policies. Each department head has an allocated HR advisor to ensure consistent application of policies. Further organisational training regarding HR matters continues including – investigation training, counter fraud training etc.	• Ongoing review of training delivered and continuing support from HR advisors.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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.**
Increased Clinical Acuity/Introduction of Women's Service	• Training is now considered in the weekly resource meeting, to ensure oversight of our risk escalation processes when training is cancelled. Training is generally cancelled when severe resourcing issues are evident and to minimise the impact to patient care. This can be the cause of increased clinical acuity, boarding out or more recently the impact of the introduction of the Women's Service.	• To ensure those staff whose training is cancelled is rearranged at the earliest opportunity.

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance

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

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

	(d) identifies and takes all reasonable steps to mitigate any risks, and (e) having followed the steps described in paragraphs (a) to (d), decides what changes (if any) are needed as a result to its staffing establishment, and to the way in which it provides health care.

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

Please provide information to demonstrate compliance.

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

(**1)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).**

- TSH is currently using SafeCare and the newly named MHLD workload tool alongside Professional Judgement. Since summer 2025 we rolled out SafeCare part 1 to all wards in preparation for the new named tool in October 2025. During November and December 2025, we delivered a soft launch of SafeCare part 2 when we started to enter the patient census using the agreed levels of care descriptors. We have agreed all wards will have their two-week tool run commencing 23rd February 2026. We will require to use both SSTS and SafeCare during this tool run supported by HIS.

Access to resources includes: HIS speciality specific toolboxes, training videos, templates FAQs as well as real time face to face support from the dedicated team within the
(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.

- MHLD & Professional Judgement tool is approved for use however as above; HIS continue to provide support, training, and development updates in conjunction with TSH's Senior Nurse Workforce Lead.

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

(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),

A range of quality measures such as Clinical Quality Indicators, patient safety data, KPIs, risk assessments, physical health steering group, and annual delivery plan etc. are utilised for CSM triangulation and input into workforce. In addition, clinical quality monitor and report on clinical incidents, risk, daytime confinement, complaints/compliment etc. on a monthly basis via various governance routes within TSH.

(c) takes into account—
(i) its current staffing levels and any vacancies,

- Funded establishment, actual staffing (including vacancies/onboarding) is reported via a monthly workforce report. BOXI provides a viable reporting mechanism to monitor the use of additional hours and the PAA absence. With Optima going forward, we will be able to use roster perform to provide this workforce information.

(ii) the different skills and levels of experience of its employees,

- Nursing Ward funded establishments are reviewed regularly to ensure the appropriate gender/skill/experience is in place to support CSM. Ongoing recruitment takes into consideration the age profile and gender/skill requirements and this is reported monthly via the workforce report. TSH aspires to recruit to a 60/40 registered/non-registered split.

(iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care,

- The Charge Nurses and Senior Charge Nurses play an influential role in supporting the triangulation of the CSM. They support evidenced based decision making when considering having the right staff in place to deliver high quality of care. They verify data, consider Clinical Quality Indicators, risk assessments etc and support junior members of staff to feel confident when making staffing resource decisions.

(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,

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

- Reports are submitted to TSH oversight groups for review including Workforce Governance and Clinical Governance. Group members include a wide range of multi professionals who can review patient delivery of care and consider any potential impact of changes to delivery of patient care from an MDT approach.

(v) the local context in which it provides health care,

- The local context for each clinical service is discussed in the daily resource huddles with data captured. Each area is able to input concerns around skill mix, psychological safety results, staff experiences, capacity and demand, and supplementary staffing usage.
- Line management is able to review areas such as missed care results, iMatter scores, staff experiences, age profile of employees, capacity, and demand, PAA v actual, etc.

(vi) patient needs,

- Patient needs are considered at local level by line management and a weekly clinical team meeting. On a daily basis, specific patient needs and activity are considered at the resource huddles to minimise the risk to patient care. This information can be recorded on SafeCare during the 3 census periods.
- In addition, the patient voice is considered and managed via the Person-Centred Improvement Team via the Patient Partnership Group which includes patient representation. This group is externally supported by the Scottish Health Council.

(vii) appropriate clinical advice,

- Clinical advice from involved professionals is sought via the weekly clinical team meetings, service leadership teams, clinical pauses, and the daily resource huddles. Out of hours, clinical advice is provided by the role of Senior Clinical Cover, on call medic, and an on-call director.

(viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides,

- Clinical advice from involved professionals is sought via the weekly clinical team meetings, service leadership teams, clinical pauses, and the daily resource huddles. Out of hours, clinical advice is provided by the role of Senior Clinical Cover, on call medica, and an on-call director.

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

(ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE,

- At present, risk is reported via Datix and via unsafe practice forms.
- Staff can raise red flags via SafeCare, but this practice is in evolution.

(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

- TSH has a robust patient partnership forum which has patients from each hub acting as a voice for the patients within their own areas and ensuring feedback of provided. Person Centred Improvement Team collates and reports on the patient and carer experience and these are used in the triangulation of CSM. The Mental Welfare Commission and the Scottish Health Council provide support to this forum and provides assurance the patient/carer voice is heard.

(xi) comments by its employees which relate to the duty imposed by section 12IA,

- Staff feedback is gathered via a staff survey, 1:1s with line managers, iMatter, PDPs, and business/departmental meetings and will be captured within SafeCare.

(d) identifies and takes all reasonable steps to mitigate any risks

- Risk is reported via Datix, unsafe practice forms and a robust operational support plan as described in 121A. Staff can raise red flags via SafeCare, but this practice is in evolution.

(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.

- Changes to staffing establishments are reviewed in conjunction with service redesign, workforce planning input, clinical/professional advice. These changes are reported and monitored through workforce governance group and if necessary escalated to staff governance, then to the Board.

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. • Significant progress has been made towards compliance, with bespoke training sessions delivered in person and via SOPs, Videos etc. Compliance reports are presented to all SCNs with areas of improvement identified. The Associate Director of Nursing chairs a monthly oversight meeting which focusses on the roll out of Safe Care and the implementation of the MHLD & PJ Tools. Progress is noted and details of actions required. Risks if any are recorded and escalated if necessary. A SLWG has been established to deliver on the actions from the oversight monitoring group lead by a Lead Nurse and supported by representatives from all wards, Learning and Development Centre, Nurse Practice Development, and the Senior Nurse Workforce Planning. • Monthly Finance Meetings take place with SCN, LN and management accountant to determine whether working within the parameters of Funded Establishment.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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.**	**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.**
Nursing	• The Monthly workforce report has evolved to provide us with a range of workforce information including vacancies, hard to fill posts, secondments, fix term, leavers and retire and returns. • SafeCare has been rolled out to all wards, with training being delivered to Band 5, 6, 7 • Training and SOPs have been developed for the Professional judgement version 4 which will be recorded during the 2-week tool run 23rd February 2026. • Awareness sessions have been delivered to one Hub on the Common Staffing Method. Plans to expand this to all other Hubs.	• Workforce report shares data highlighting vacancies across the clinical area looking at skills, gender, experience. This report supports managers to be proactive around recruitment which plans to reduce gaps in vacancies. • HR support planning ahead for any known leaver or planned retirements that can be considered for proactive recruitment. HR have developed a redeployment register for staff who are unfit/not appropriate for substantive role – this allows use of their skills in different areas.

Area of success / achievement / learning	Details	Further action
	• The supplementary staffing register has remained static in the last 3 months. Changes to pension plans has allowed experienced staff to return as full time members of staff whilst partially retiring. This provides a vehicle to ensure experience, skills, and gender are being maximised. • A test of change has been running now for 12 months to resource a post to work alongside the Outings Coordinator. This will minimise the impact on wards to resource planned outings on a daily basis. Initial data is proving positive with a dramatic reduction on the reliance on ward-based staff to fill this activity. • Day time Confinement (DTC) continues to be monitored. • Senior members of nursing are present at all forums across TSH including the daily resource huddles to allow feedback to staff on issues surrounding staffing, gender, skill mix, and DTC. • In addition, charge nurses now attend all daily resource huddles for input and work collaboratively to help manage resources efficiently and to minimise the effect on patient care due to DTC. • The State Hospital was represented in the development of the new MHLD workload which was named in legislation October 2025.	• Further training is required to be delivered to clinical leaders on the use of the common staffing method due to workforce changes in personnel. • Continue to promote positive engagement and feedback to the workforce on areas of staffing levels, risk, and escalation.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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.**
Gender sensitive tool	• The existing Gender sensitive tool used within the hospital has been in place for approximately fifteen years and requires a full review, in line with the principles of the Health and Care Staffing Act. SafeCare will support us with this when fully embedded. Gender has been identified as a skill in Optima, but it is difficult to clearly see where there are gaps.	• Continue to work with Customer Success Manager to identify a solution.

Area of escalation / Challenge / Risk	Details	Further action
Introduction of the Women's Service July 2025	• The workforce assumptions on the Funded Establishment required for this service has not been realised. This service continues to put pressure on all the other wards in the hospital. Recruitment is a constant priority.	• To continue to gather workforce information and recruit to all vacancies to minimise the impact on other patient areas.

COMPLIANCE ASSURANCE LEVEL
Substantial 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.

I**n 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,

- HCSA is incorporated within the corporate training plan 2026-2027. There is a requirement to adapt NES, HIS, and Turas resources to ensure they reflect TSH systems and procedures.

- HIS continue to support the integration of the new MHLD Workload tool on the SafeCare platform as we plan for the scheduled two-week tool run.

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

- CSM awareness sessions are currently being refreshed to include the use of MHLD on SafeCare

- All SCNs and charges nurses have access to a dedicated team of staff as well as access to TURAS resources and HIS learning.

- An online eLearning resource had been developed and tested which will include opportunities to provide feedback. Additionally, the incorporation of a feedback option within iMatter is being explored. Staff surveys allow opportunity for staff to provide feedback alongside business meetings and 1:1 with line manager.
- Daily resource huddles allow full discussion of staffing risks, mitigations, and positive/negative outcomes.

(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,

- Staff involvement and engagement is evidenced via iMatter, PDPs, staff surveys, and training evaluation forms.

- Daily resource huddles provide opportunities for staff to engage in solution-oriented collaborative working. Feedback from these meetings is delivered at hub level by the attending hub coordinator.

- The State Hospital was represented within the SLWG in developing the first new MHLD tool to be uploaded onto SafeCare.

(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

- Face to face and/or teams training sessions have been delivered continuously to staff in areas of SafeCare, Loop, Rostering Skills, and Professional Judgement since Q2 2025 in preparation for the new MHLD Workload Tool.
- Resources have been developed to support staff and are easily accessible within their local drives. An online training module has been developed and tested which will be mandatory for all staff in scope of legislation. Staff are also encouraged to complete HIS TURAS learning resources.

(c) ensure that those employees receive adequate time to use the common staffing method,

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

- Adequate time to undertake CSM duties will be monitored and assured via one-to-one meetings and the PDPs held between manager and clinical leaders. All services/professions are benchmarking the duty to ensure adequate time is given to leaders however this can be challenging due to the small nature of the board and the same people tasked with organisational priorities.

(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.

- TSH is currently using SafeCare and the newly named MHLD workload tool alongside Professional Judgement. Since summer 2025 we rolled out SafeCare part 1 to all wards in preparation for the new named tool in October 2025. During November and December 2025, we delivered a soft launch of SafeCare part 2 when we started to enter the patient census using the agreed levels of care descriptors. We have agreed all wards will have their two-week tool run commencing 23rd February 2026. We will require to use both SSTS and SafeCare during this tool run supported by HIS. All data reported during the tool run will be received from HIS and SSTS and verified by each SCN/LN. This information along with quality information indicators, risk assessments, staff demographics will assist us determine safe staffing from an evidenced based perspective.

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.

- Significant progress has been made towards compliance, with bespoke training sessions delivered in person and via SOPs, Videos etc. Compliance reports are presented to all SCNs with areas of improvement identified. The Associate Director of Nursing chairs a monthly oversight meeting which focusses on the roll out of Safe Care and the implementation of the MHLD & PJ Tools. Progress is noted and details of actions required. Risks if any are recorded and escalated if necessary. A SLWG has been established to deliver on the actions from the oversight monitoring group lead by a Lead Nurse and supported by representatives from all wards, Learning and Development Centre, Nurse Practice Development, and the Senior Nurse Workforce Planning.
- Monthly Finance Meetings take place with SCN, LN and management accountant to determine whether working within the parameters of Funded Establishment.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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.**	**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.**
Learning & Development	• A corporate training programme exists and is reviewed annually by service leads to ensure all statutory and mandatory training is current and relevant. There is input from all Heads of Service. Compliance reporting and monitoring is thereafter embedded within each Directorate Performance framework and monitored through the monthly Workforce Governance meetings. • Optima is now being used across all rosters within TSH. Compliance of using Optima has improved in the last year with all rosters achieving more than 80% compliance. Loop will be the system to manage leave requests and unavailability by all staff by April 2026. Nursing rosters are currently being updated to reflect the newly agreed shift pattern effective April 2026.	• Agreement to include the common staffing method awareness sessions as part of the mandatory training for registered nurses. • Consider the use of SafeCare to be integrated within the nurse induction programme. • Shared training resources to continue to be adapted and refreshed to meet the needs of TSH recording of training compliance. • Explore the evolvement of using red flags in SafeCare as an additional route in escalating risk, not just Datix reporting.

Area of success / achievement / learning	Details	Further action
	Nursing particularly have been fully engaged these last 12 months with Optima, SafeCare and Loop where they are now starting to see the benefits of the system although there is still an added workload related to double keying of data being cited as an area of concern. • Consultation with staff continues to improve with the strengthening of nurse membership engagement at resource forums. This has also enabled a process for hub-based staff to raise staffing concerns/queries and receive feedback either in person or by formal communication. • There has been significant work undertaken to engage with our workforce focusing on staff wellbeing and development. This work has helped to inform our Organisational Development Strategy. • Training and Professional development manager alongside the Senior Nurse – Workforce Planning have developed an online training module which has been tested and will be uploaded on Turas. This will be mandatory for all staff to complete. A flexible approach to delivering awareness training sessions in the use of the CSM is currently underway for all Band 5,6,7. • The SWAY presentation was shared to all service leads as a useful resource and was used as the foundation to build our online module.	• Continue to develop our communication and engagement strategies with ward-based staff to ensure inclusion as the workforce changes with recruitment and leavers. • SWAY presentation has been shared with nursing leaders as a useful resource.

Area of success / achievement / learning	Details	Further action
Nursing	• Optima and SafeCare has been fully implemented across all Nursing, AHP, Medical and Psychology. • Nursing has now established structures and reporting processes in place within their Directorate to ensure escalation of rostering concerns are addressed. • The SCN now manage their rosters to ensure they are accurate, and this continues to be supported with interim Rostering Project Manager support to aid the development of local rostering issues and support with SafeCare. • Significant training was undertaken with all Nursing, AHP and Psychology to ensure their Optima and SafeCare were accurate.	• The Rostering Project Manager and the SafeCare Compliance group meet monthly to review progress of Rostering and SafeCare. A Project plan has been established which is monitored and updated to track completion of target dates in relation to both these products.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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.**
Nursing	• Nursing is testing moving away from a centralised approach to managing resourcing and have SCNs in charge of their wards. Work has been ongoing with the Rostering Project Manager and RLDatix to support the use of SafeCare to manage resources. • This has proved challenging to provide confidence to the Senior Clinical Cover who require to have site wide knowledge of where all staff are as we are a small board and inter dependent in times of crisis. Work has progressed with eHealth to produce a site wide report from Optima to provide this assurance. This is currently being tested out on PreProd.	• The board have supported a dedicated member of staff to work with nursing colleagues and support them progress through these challenges. • A live detailed workplan has been developed and is reported quarterly at Workforce Governance Committee. • Processes in consultation with staff are being tested whilst we make this decentralisation to provide assurance that we are confident we have the right staff arriving for work.

Area of escalation / Challenge / Risk	Details	Further action
	• The eRostering implementation roll out across the hubs has taken longer than predicted due to the significant challenges we have encountered in this process. This continues to be an ongoing challenge particularly with the settings in SafeCare not been fully explained to us as we did not receive in depth training from RL Datix before they moved on. We have been learning from other boards, testing things out on PreProd ourselves and when find something we cannot explain it becomes apparent it has been down to the lack of skills and knowledge we have in the system and how it should be configured.	

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance

Planning and Securing Services

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.** • Guiding principles and staffing arrangements are always considered when planning and securing services. Work continues with procurement colleagues to ensure that these are clearly set out in the processes and can be evidenced to support annual reporting. • In addition, procurement of health care services from another provider falls within the SG guidelines whenever an SLA or other agreements are signed.

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. • As a small Special Health Board, we have a number of long-standing SLAs in place with other local Territorial Boards. These are reviewed approximately every 3 years (or earlier if necessary), and the budget holder/stakeholder will discuss with the provider the staffing levels and skills required. They will then work with Procurement around costs and other considerations such as service providers personnel clauses, scope of service, data protection, confidentiality of Caldicott, compliance with legal obligations etc and a new SLA would then be drafted and signed by both parties. In the rare occasion when more than one Board can provide the service, a non-regulated Tender process would be carried out. The TSH is governed by the National Procurement policies which provides assurance to the process of an SLAs.

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. • All external members of staff who provide a service within the organisation are invested by a security induction to ensure they remain and deliver safe practice in accordance with our policies and procedures. For those delivering a service directly to patients on a regular basis they will also be provided with PMVA or Breakaway training. This has enabled us to provide expert care to patients particularly in areas of Spiritual & Pastoral Care, Patient Advocacy Service, palliative care, Primary Care, Volunteers, and language interpreters when we cannot provide this expertise from within our workforce. The volunteers provide a key role to those patients who have no family or friends in their life. The hospital also supports students in their learning from open universities, other hospitals and across many disciplines. These staff are supported within their specialism and asked to provide feedback on their learning experience. Feedback both formally and informally is positive.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	**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.**	**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.**
Nursing	• The Supplementary Staffing Register has enabled us to support staff work more flexibly. The register is made up of retire and return members of staff at Band 3 and Band 5 grade who are fully aware of their roles and responsibilities. We have also opened up this register to year 3 student nurses who are on placement with the option of remaining on the register after their placement ends. This was an additional support of filling shifts when we were unable to have a 'Bank' facility like other health boards.	• To continue to develop the SSR and to widen the membership.
Patient Engagement	• Robust processes are in place regarding our annual review especially when we hear patients feedback which is included in the Advocacy Annual review.	• Continue to promote patient engagement across various work streams.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	**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.**	**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.**
International Recruitment	• The TSH does not currently have a visa programme in place to allow international recruitment. Potential candidates must be established in the UK to apply for posts.	• Discussions to change/update practice are still in preliminary stages. Overseas applicants are currently being addressed nationally.

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance