THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 27 FEBRUARY 2025
at 9.30am
Hybrid Meeting: in Boardroom and on MS Teams

A G E N D A

9.30am			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 19 December 2024	For Approval	TSH(M)24/12
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 25/01
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**High Secure Forensic Healthcare Services for Women** Report by the Chief Executive Officer	For Noting	Paper No. 25/02
10.10am	**RISK AND RESILIENCE**		
8.	**Corporate Risk Register** Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 25/03
9.	**Finance Report – to 31 January 2025** Report by the Director of Finance & eHealth	For Noting	Paper No. 25/04
10.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 25/05
10.40am	**CLINICAL GOVERNANCE**		
11.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/06
12.	**Clinical Governance Committee:** Approved Minutes of meeting held 14 November 2024	For Noting	CGC(M) 24/04
	Report of meeting held 13 February 2025		Paper No. 25/07
11am	**BREAK**		

11.10am	**STAFF GOVERNANCE**		
13.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 25/08
14.	**14a Whistleblowing Q3 Report** Report by the Director of Workforce	For Noting	Paper No. 25/09
	14b Whistleblowing Champion Annual Update Report by the Director of Workforce	For Noting	Paper No. 25/10
15.	**Equalities Outcomes Report** Report by the Director of Workforce	For Noting	Paper No. 25/11
16.	**Staff Governance Committee:** Approved Minutes of meeting held 21 November 2024	For Noting	SGC(M) 24/04
	Report of meeting held 20 February 2025		Paper No. 25/12
11.40am	**CORPORATE GOVERNANCE**		
17.	**Corporate Objectives 2025/26** Report by the Head of Corporate Governance	For Decision	Paper No. 25/13
18.	**Performance Reporting – Quarter 3** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/14
19.	**Whole System Infrastructure Reporting: Do Minimum Business Continuity Option** Report by the Acting Director of Security, Resilience and Estates	For Noting	Paper No. 25/15
20.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 25/16
21.	**Audit and Risk Committee:** Approved Minutes of meeting held 26 September 2024	For Noting	ARC(M) 24/04
	Report of meeting held 30 January 2025		Paper No. 25/17
22.	**Any Other Business**		Verbal
23.	**Date of next meeting:** 9.30am on 24 April 2025		Verbal
24.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
25.	**Close of Session**		Verbal

Estimated end at 12.20pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 24/12**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 19 December 2024.

This meeting took place in the Boardroom at the State Hospital and also by way of MS Teams, and commenced at 9.30am

Chair:	Brian Moore

Present:

Employee Director	Allan Connor
Non- Executive Director	Stuart Currie
Chief Executive Officer	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Finance and eHealth Director	Robin McNaught
Non-Executive Director	Pam Radage
Non- Executive Director	Shalinay Raghavan
Medical Director	Lindsay Thomson

In attendance:

Head of Estates and Facilities	Kenny Andress [Items 19 & 20]
Head of eHealth	Thomas Best [Item 23]
PAS Manager	Rebecca Carr [Item 8]
Skye Centre Manager	Jacqueline Garrity [Item 7]
Acting Director of Security, Estates & Resilience	Allan Hardy
Head of Communications	Caroline McCarron
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
PAS Chair	Michael Timmons [Item 8]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone, and noted apologies for the meeting from Ms Cathy Fallon, Non-Executive Director.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business on the agenda.

3 MINUTE OF THE PREVIOUS MEETING

The minute of the previous meeting held on 24 October 2024 was noted to be an accurate record of the meeting subject to minor amendment in terms of the record of attendance.

The Board:

1. Approved the minute of the meeting held on 24 October 2024.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted that actions had progressed, or were on the agenda for today's meeting.

The Board:

1. Noted the updated action list, with the updates provided.

5 CHAIR'S REPORT

Mr Moore provided an update on his activities which had included attendance at NHS Board Chairs meetings. Through this mechanism, the Cabinet Secretary for Health and Social Care had met regularly with NHS Chairs to discuss NHS reform, pressures within the system, and winter preparedness.

Mr Moore noted that along with a range of colleagues, he had attended the Annual General Meeting of the Patients' Advisory Service on 11 November 2024. At the end of November, he had also attended the Scottish Prison Advisory Board along with Mr Jenkins, to deliver a presentation on governance arrangements and the operating model at the State Hospital (TSH).

He had attended the Patients Partnership Group (PPG) which had been a positive and motivational meeting especially the discussion on Supporting Healthy Choices. He had also gone to the Patients' Choir Christmas performance, and Ms Radage and Ms Raghavan has also been there. It had been an enjoyable event, well attended by both patients and staff.

The Chair and the Chief Executive had presented at the Staff Long Service Awards which had taken place on 18 December with a range of staff receiving awards. One member of staff had 45 years' service, with no absences which was a remarkable achievement.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins reported on his activities since the last Board meeting, including his involvement with the National Scotland Leadership Group, which had reviewed the recent report from Lord Darzi in respect of NHS England, to help support consideration of how reform could work within NHS Scotland.

As the Chair had mentioned, Mr Jenkins had presented to the SPS Advisory Board, on health provision within secure settings. Further, he had presented on this theme to the Healthcare in Custody Board.

On 6 November, he had participated in a meeting with Minister Todd and with the Lord Advocate in which they confirmed the direction of travel in progressing a high secure female service at TSH. He had received verbal confirmation of the initial funding required to undertake feasibility work (in the sum of £223K) and work had been commended through NHS Assure in respect of the initial framework document and competitive tender.

Mr Jenkins noted that the Annual Review had taken place on 18 November, and had been led by the Minister with very positive engagement from both patients and staff. The outcome letter formed part of today's agenda.

He also noted that he had attended a budget briefing session from Scottish Government, with NHS Chief Executives, and also the publication of the Auditor General's report on NHSScotland at the beginning of December.

There had been a positive feedback session with the Competent Authority Leads on continuing progress within TSH on Network and Information Systems (NIS) at which both Executive and Non-Executive colleagues had attended.

Mr Jenkins noted that the Forensic Governance Advisory Group had been established, and expressed his wish for engagement with TSH Board, as they progressed this workstream. He also commented on the excellent progress being made in respect of the Medium Term and Annual Delivery Plans, and that an update would be presented to the Board later in the private session. He acknowledged the Mental Welfare Commission visit and that their report was expected by 15 January.

He had also taken part in the Mental Health and Wellbeing Strategy Board led by Ministers, which was focused on a refresh of the related Delivery Plan. There had also been engagement with Scottish Government on progress of Serious Adverse Event Reporting, with a view to collaboration within NHSScotland to support quality improvement.

Finally, Mr Jenkins had been pleased to welcome Mr David Mundell MP to the hospital, who was the elected representative for the constituency in which TSH is located, and this had been a constructive visit.

The Board:

1. Noted the update from the Chief Executive.

7 PATIENT STORY: PATIENT PARTNERSHIP GROUP (PPG) REFLECTIONS OF 2024

Ms Garrity joined the meeting, and provided the Board with a presentation which was based on the reflections of the PPG, on a number of different developments throughout 2024. Ms Garrity led the Board through some background relating to the role of the PPG, and the essential function it had in providing a forum for patient voices, and a means through which to develop ideas, contribute to policy development, as well as to raise concerns. This group has reflected on how to build patient involvement further, so that patients could take an active role whenever possible. Ms Garrity described some of the key initiatives the group had been involved in during 2024, and this included helping peers through the TV loan scheme, as well as the Nu2u shop.

The PPG had named some of their highlights of the year, and this had had included the visit by the Minister during the Annual Review in November, as well as enjoying being able to talk directly to the Chief Executive and Non-Executives when they visited the group. The group was considered to be a safe space for patients at which they could have open conversations and develop ideas.

The PPG had reflected on the impact so far of the new clinical model, and had thought that there could have been more information available to patients – there had been lots of information at first when the services were being set up but this had not been sustained since. Patients also felt that there were challenges in being able to move on to the Transitions Service, as well as to progress in security levels for Grounds Access. Generally, there was a feeling among patients that they may feel like the system was not working for them when first admitted to TSH; and then later reflections that they were working with the system as they progressed through services.

Professor Thomson noted the patients' comments around the clinical model in particular, and that this was something that should be followed up and could be reported in more detail through the Clinical Governance Committee, to help inform the evaluation of the new model. Mr Jenkins agreed, and thought there would be a good opportunity to further define potential improvement to the model in the next quarter, linking this to patients' feedback.

Ms Radage commented that she had found that the PPG was evolving well, and was now a group more focused in its remit, with the discussions within the group growing in value. She asked whether there was anything further that Non-Executive Directors could do in respect of their engagement with the group. Ms Garrity said that patients really welcomed this opportunity to talk with the Board, and thought

it might be helpful to provide more background to the role of the Board Members. Mr Currie thought it was useful to have focused topics within the meetings, and that it was good to see the agenda being set in this way. It was agreed that Ms Garrity would link in with Non-Executives for their visits so that the range of topics scheduled to be discussed would be communicated in advance, to aid the discussions.

Action – Ms Garrity/Ms Smith

Mr Moore thanked Ms Garrity for her presentation, and for the work that she and her team had done over the past year. This evidenced a change in approach for the PPG which was much appreciated and demonstrated that patients felt that they could raise issues constructively, and be assured that their suggestions would be listened to and acted upon.

The Board:

1. Noted this update from the PPG.

8 PATIENTS' ADVOCACY SERVICE

The Board received a paper sponsored by the Director of Nursing and Operations, which provided a 12 month update from the Patients' Advisory Service (PAS). Ms Carr and Mr Timmons joined the meeting, to present the main aspects of reporting to the Board which they did by way of a presentation.

Ms Carr provided the background in terms of Key Performance Indicators (KPIs) with 85% of these having been met. She provided some further detail in areas of challenge e.g. patient contact within a given timescale which may due to clinical acuity or service pressures. Overall, it was a positive picture with the level of patient contact and support offered to patients over a range of metrics increasing. There had been focused work in particular around supporting patients in preparing advance statements in the past year. Ms Carr highlighted the feedback from patients themselves, saying that the really valued the support that PAS could provide to them, and the positive relationships built up with advocates over time including when patients moved on from the hospital. Patients highlighted the way in which they valued advocacy support, and being treated with trust and respect because this then helped them to build greater independence themselves.

Ms Carr also underlined the way in which PAS worked closely with colleagues across the hospital, and were playing an active role in ensuring that the patient voice was heard at different levels, and in the development of policies and procedures. At the same time, it was important to ensure the continued independence of PAS within the hospital.

Mr Timmons then talked about future service development – one area of possible improvement would be the provision of a private space within the Skye Centre Atrium for PAS to support drop in sessions for patients. This was something that was being raised regularly by patients, and had been provided in the past. He went on to say that there was growing focus on accessibility, and how to ensure that the support offered through PAS was accessible to all. This may include easy read information as well as use of Makaton and talking mats.

Ms Radage thanked Ms Carr and Mr Timmons for their report and presentation, and commented on the focus on the independence of the service and that this was vital. She asked about the increased volume of enquiries, and how this was being managed within the service. Mr Timmons said that it had been helpful to flag the independence of the service visually e.g. through differentiated lanyards. Ms Carr agreed with this, and provided some further background about the way in which advocates would first make contact with patients and develop a trusted relationship with them. This would start at the point of admission to outline what the advocacy service could do for them, albeit there would be a need to re-visit this regularly with patients who could be too unwell to engage at the time of admission.

Ms Carr also said that in relation to volume of work, the service was probably at its limit, and that there was careful management of individual caseloads. The focus was on trying to link directly with patients as much as possible, and the service was organised in line with the clinical model with two advocates

per hub. Mr Timmons added that efforts were being made in respect of volunteer recruitment, which could be an additional resource.

Mr Jenkins said that he knew how highly valued the service was by patients, and that it was helpful to be able to correlate the information that PAS provided alongside patient engagement though the PPG, and patient feedback and complaints as well. He noted the point about space for a drop in service with the Skye Centre, and would be happy for the possibilities for this to be considered.

Mr Currie considered that establishing of trust with patients, as had been described, was essential and thought that the ability to manage an increased workload against expectations of service users could be difficult. He thought that there was often value for patients to have someone they trusted to talk to, rather than looking for specific actions to be taken forward. He added that it was also important to take account of the wellbeing of staff within PAS as well. Ms Carr thanked Mr Currie for this reflection, and offered assurance that wellbeing was central to the team, who were able to take part in wellbeing initiatives within the hospital. Further, the team were offered reflective sessions when they returned from ward visits, and guided support in how to manage what could be a challenging role, especially supporting patients who may have received disappointing news. She thought it was important to help manage patients' expectations and not to make promises that could not be met later. There was a need to be open and honest with patients, and that could be a challenging role to meet. She added that advocates try to highlight issues that patients raised in a sensitive and constructive way.

Professor Thomson thanked PAS for the work they did in the hospital, which she thought was of enormous value. She thought the work on advance statements was particularly helpful for patients, and noted that the active role played by advocates through the Care Programme Approach (CPAs). There was a new system being piloted in this regard, and it would be helpful for PAS to be included in the development of this. Ms Carr noted this as something she would take forward.

Ms McConnell asked about the increase in patient contacts made, and issues raised and whether this was being initiated through patient approached to PAS, or perhaps as a result of more engagement initiatives. Ms Carr said that there had been an increase in patient approaches and the issues being raised. This covered a number of areas including legal, clinical care as well as general quality of life, like food, grounds access and phone calls. She said that sometimes patients could have unrealistic expectations about the time it could take to resolve what could at times be complex issues.

Mr Moore summed up for the Board who welcomed the continued support that PAS offered to patients. He thanked Ms Carr and Mr Timmons for attending today to provide this overview and to support the resulting discussion. He had also found the presentations at the recent AGM to have been interesting and insightful. The Board was also aware of the very regular involvement that PAS had in supporting patients through the complaints process as well.

<u>The Board:</u>

1. Noted the 12 month report from PAS.

9 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 24/101) from the Acting Director of Security, Resilience and Estates, which provided an overview of the Corporate Risk Register. Mr Hardy provided a summary of the key points of reporting, noting that there were no new risks proposed for addition to the register, and that all of the current risks had been reviewed within the scheduled timescales. He noted the ask of the Board to consider the upcoming completion of the security project works, and how this would be reflected within the register going forward.

Mr Hardy detailed the updates made to the current register as outlined within each directorate area in the report. He also confirmed that there remained four 'High' graded risks as set out, and the work being taken forward to review these and to detail any possible mitigation. Mr Hardy also asked the Board to note the continuing development of the register taken forward in conjunction with each

directorate.

Ms Radage thanked Mr Hardy for the report, and for including the risk assessment on cyber security which had been helpful. She asked for some further background on the slippage experienced in completion of PMVA level 2 training levels. Mr Hardy acknowledged that this had been due to the challenge of making staff available for training in the context of pressures on resourcing. Mr Jenkins added that there was a legacy issue in the timing of training as well, following the Covid-19 pandemic. Training had been paused necessarily and the re-start of it meant that staff were due to undertake refresher courses simultaneously. Ms McCaffrey echoed this point, and the need therefore to stagger training.

Mr Jenkins also noted that in relation to the point made on the security project works, the project had a dedicated Project Risk Register, and that following completion any relevant risk would transfer over to the main Corporate Risk Register.

In response to a question from Mr Moore on the potential for a move to InPhase (from the existing Datix system) Mr Hardy advised that this was being rolled out gradually to NHS Board with the expectation that this would be in 2025 for TSH.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.

10 CLINICAL MODEL – RESOURCING

The Board received a paper (Paper No. 24/102) from the Director of Nursing and Operations, which outlined the work undertaken to review the funded nurse staffing establishment figure, resulting in a proposal to recruit to an additional ten whole time equivalent (WTE) AfC Band 3 Healthcare Support Workers on fixed term contracts, to March 2026.

Ms McCaffrey led the Board through the key factors that had been found during this review, and the principles underpinning the proposal. She emphasised that it was expected that overtime costs would continue to rise, taking into account indications including clinical acuity and the need for patient transfer to acute care. Further that this review had looked in detail at the resourcing model required for the new clinical model, and that this had taken into account the impacts of daytime confinement. Nursing colleagues had worked alongside finance colleagues to deliver this work, which provided a much more informed basis upon which to make staff resourcing decisions. The aim was to reduce organisational reliance on overtime to mitigate shift deficits, and the new posts would support this. The funding was available within the existing nursing budget for 2025/26, but this would add pressure to the ability to make required savings targets in the coming year.

Mr Jenkins added that this proposal had been carefully considered by the Corporate Management Team (CMT) as well as through the Partnership Forum. It provided a solution to the existing resource challenges by redistributing monies within the existing budget rather than additional funding being required. This model would be monitored very closely through the CMT on a monthly basis, to measure the impact. There was a continuing need to address the high levels of sickness absence within the Nursing and Operations Directorate.

Mr Currie thought that the benefit of the proposal lay in the shift away from use of overtime, especially if this had become an expectation or norm for front line staff. He said that it would be useful for the Board to receive updates on the effectiveness of this, as the initiative progressed, to make comparisons to staff wellbeing and also levels of sickness absence. It may be difficult to make these links directly, but this would be a useful measurement to add to help consider this and give assurance to the Board.

In answer to a query from Ms Raghavan about why recruitment would be focused on Band 3 staffing, Ms McCaffrey noted that the review had ascertained where the additional staff resourcing would be required. This showed a need for staffing of 9am to 5pm shifts especially to support clinical outings.

This could be supported by Band 3 staff and did not necessarily require registrant nurses.

Ms Radage said that this was a sensible proposal, especially to move away from the costs of overtime, and welcomed the plan to monitor and report on the impacts. She noted the appreciable superannuation savings that would be made in-year.

Mr Mc Connell asked about recruitment within the current climate, and whether staff would be available. Ms McCaffrey said that TSH had found a good response when advertising Band 3 posts recently, and that she was confident of being able to recruit to these posts.

Mr Jenkins acknowledged that this proposal would add pressure to savings targets in the next financial year, but thought that this should be balanced against the need to meet the cost of overtime. He also noted that this proposal did not cover the costs of the reduced working week. It was a structured means through which to meet service demand, rather than continuing to organise overtime on a week to week basis.

Mr Moore echoed this point, saying that there did need to be a fundamental resolution to this problem. He noted the Board's agreement to the proposal, as well as that there would be regular updates back to the Board about progress in terms of funding within finance reporting. There should also be consideration about how to make additional savings in the coming year. Further that the Board understood that this proposal was necessary, and hoped to see evidence of impact on staffing pressures, and general wellbeing indicators for staff.

The Board:

1. Reviewed the proposal for additional HCSW on fixed term contracts, and agreed to this being taken forward as outlined.
2. Requested regular update reporting on the impacts of this once implemented including budgeting, staffing resourcing and staff wellbeing indicators.

11 FINANCE REPORT TO 31 OCTOBER 2024

The Board received a paper (Paper No. 24/103) from the Finance and eHealth Director, relating to the financial position. Mr McNaught provided an overview of reporting noting that the paper presented the financial position to the end of October 2024. There was a small adverse variance at this date of £0.157m, and it was still anticipated that a year-end break-even position would be achieved. Regular reporting continued to Scottish Government, with the next quarterly meeting scheduled for January 2025 which would cover Quarter 3. He noted that the funding for the AfC pay uplift of 5.5 % for the current year was released in October, and would be phased in over the coming months.

Mr McNaught advised that meetings were being held monthly with each directorate to address plans required to achieve required savings and maintain the breakeven position. An uplift of 3% would be factored into both pay and non-pay aspects for the coming year.

Mr McConnell asked about the ongoing costs of boarding out for patients who required care off-site, as well as in relation to clinical acuity wherein individual patients may been additional resourcing to deliver care, and whether additional funding may be available. Mr McNaught advised that there was no confirmation in this respect and that this may be discussed at the upcoming quarterly review in January.

Mr Currie said that this was a positive position for the Board to be in, especially given the high level of pay related costs for TSH, and that any savings in this respect were assessed as non-recurring.

Mr Moore summed up for the Board, noting the position a outlined, as well as the need for continued focus on achieving a break–even position.

The Board:

1. Noted the content of the report.

12 BED CAPACITY REPORT

The Board received a paper (Paper No. 24/104) from the Medical Director. The report outlined bed capacity within TSH for the period 1 October to 30 November, and added context in terms of the wider issues across the forensic estate.

Professor Thomson asked the Board to note this position, including the flow of patients between services within the hospital. The Intellectual Disability Service continue to have 15 patients, with bed allocation of 12. In relation to the pressures being experienced in the wider estate, Scottish Government had requested that the Forensic Network lead a collaborative approach and progress on this was ongoing. Finally, works continued on refurbishment of the Orchard Clinic and this meant continued closure of seven beds.

Mr Moore thanked Professor Thomson for this update, which helped inform the Board of the wider position.

The Board:

1. Noted the content of report.

13 CARERS STRATEGY

The Board received a report from the Director of Nursing and Operations (Paper No. 24/105) presenting the Carers Strategy. Mr Moore introduced this by noting that this strategy had been considered previously this year through the Board at a development session, and then formally reporting to the Clinical Governance Committee for detailed discussion and oversight.

Ms McCaffrey then provided a summary overview of the aims and content of the strategy, as outlined within the report. This strategy would cover the upcoming three year period of 2025/28, and there was a detailed plan through which the effectiveness of its implementation would be monitored, and reported upon.

Mr Currie welcomed the strategy saying that this was a positive addition for the hospital, and thanked Ms McCaffrey and her team for the work evidenced to bring this together. This was an important areas, and it was essential for this to be monitored closely in terms of the impact of it. In response, Ms McCaffrey said that this strategy had to be bespoke to the need of TSH patients and carers. It would be a standing item for review through the Person Centred Improvement Group, with regular reporting to the Clinical Governance Committee. She also underlined the need to communicate this strategy widely to carers as the strategy was implemented.

Mr Moore agreed with this, saying that whilst there had always been engagement with carers, there had not previously been a dedicated strategy to underpin this. He also thought that the action plan would be helpful in progressing the key priority areas. It was agreed around the table that the Board should also receive periodic updates at the progress being made in this area.

The Board:

1. Approved the Carers Strategy 2025/28.
2. Endorsed the plan for governance and oversight, including that updates should be provided to the Board, adding this to the workplan.

14 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 24/106) which provided an update on the progress made in quality assurance and improvement activities, since the date of the last meeting.

Ms Merson highlighted the key points, including the programme for clinical audit, and the inclusion of a table summarising performance within ward areas as well as any areas for improvement. She also provided an update on the activities of the Quality Forum, as well as the work continuing to be progressed in relation to Realistic Medicine. Lastly, she asked the Board to note the projected completion dates for the three outstanding evaluation matrices as these should all be completed in the next two months.

Mr Moore referred to the administration of medication, asking about the areas for improvement of this. Professor Thomson advised that there were clear processes in place, and that one patient should be administered their medication at a time. The audit had highlighted this, and this was being addressed.

The Board:

1. Noted the content of the report.

15 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 8 August 2024; as well as a summary report (Paper No 24/107) noting the key areas of reporting and discussion at the meeting on 14 November 2024.

The Board:

1. Noted the content of the approved minutes dated 8 August 2024.
2. Noted the update from the meeting held on 14 November 2024.

16 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 24/108) summarising workforce performance since the date of the last Board meeting.

Mr Wallace provided an overview of reporting which was informed by a range of metrics. He highlighted that sickness absence continued to be a crucial element, with the need for improvement. This was a significant challenge, especially within nursing. This was being managed actively, including a review of how absences were being reported. He also offered comparison to other forensic setting, where similar challenges exist.. Mr Wallace noted the positive position on recruitment, and that TSH was able to attract applicants. In relation to employee relation cases, there was focus on improving the timeline in managing cases, The job evaluation process was being progressed timeously, and there had not been any out with TSH to date, following the AfC Band 6 review in nursing. Finally, Mr Wallace noted a small slippage in PDPR performance, but that this remained above the national target.

Ms Radage thanked Mr Wallace for the report, noting the context with other forensic settings in terms of sickness absence. She was pleased to see the progress made in the job evaluation process.

Mr Moore commented on the need to link the impact of sickness absence to the impact on the financial position. Mr Wallace agreed, though also noting that this would require a nuanced approach, and he would take this on board going forward.

The Board:

1. Noted the content of the report.

17 WHISTLEBLOWING QUARTER 2 REPORT

The Board received a paper (Paper No. 24/109) from the Director of Workforce in relation to whistleblowing activity during Quarter 2, and Mr Wallace confirmed that there had been no cases

received during this period.

Mr Moore noted the continuing work to refresh the approach taken with TSH, and that this would be an area of focus in 2025.

The Board:

1. Noted the content of reporting.

18 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 15 August 2024; as well as a summary report (Paper No 24/110) on the key areas of reporting and discussion at the meeting, which had taken place on 21 November 2024.

As Chair of the Committee, Ms Radage advised the Board about the work ongoing to review the way in which the agenda was set and on the quality of reporting, to support discussion. The meeting in November had been very constructive as a result of these improvements.

Mr Currie agreed with this, saying that it had been a productive meeting, and that the approach in streamlining the reporting helped, and shifted the focus to more expansive discussion. Papers had also linked together more cohesively. Mr Moore thought that it would be helpful to look further at the assurance pathways across committees and the Board itself. This should strengthen oversight within the committee structure, and support the role of committees in giving assurance to the Board.

The Board:

1. Noted the content of the approved minutes 15 August 2024.
2. Noted the update from the meeting held on 21 November 2024.
3. Noted good practice in agenda setting and oversight within the committee, and learning that can be taken across the committee structure.

19 CLIMATE EMERGENCY AND SUSTAINABILITY ANNUAL REPORT 2023/24

The Board received a paper from the Acting Director of Security, Resilience and Estates (Paper No. 24/111) which presented the Annual Report on Climate Emergency and Sustainability for 2023/24.

Mr Hardy presented a summary of the report, which was a request from Scottish Government, with prescribed areas of reporting. Mr Andress also joined the meeting for discussion of this item. Overall TSH was performing well in this area, with a massive decrease of 83.7% in carbon emissions compared to the baseline year 1993/94. Reporting outlined the future areas of focus for continued improvement, and which would require funding to take forward.

Mr McConnell asked about the scope of the active travel programme, especially given the geographical location of the hospital. Mr Hardy acknowledged that this did present a challenge, but that there was some opportunity for staff to get involved in cycling to work. Mr Jenkins added that there were wider possibilities especially around the local infrastructure e.g. improvements in verges and cats eyes on the road network. He also noted the need to improve local public transport links, including train stops, and that this had been part of a productive discussion with Mr Mundell MP when he had recently visited the hospital.

Mr Moore referenced the feasibility report in relation to net zero, and if there was an active plan in place. Mr Andress noted the use of Biomass as a heat source on site, and LPG given the lack of connection to natural gas. Progress would need to be made in the next 5/6 years to replace LPG with an alternative like air source or ground pumps. He also advised that the Biomass system was over ten years old, and would need to be upgraded within the next ten years.

The Board:

1, Endorsed the content of report for submission to Scottish Government.

20 WHOLE SYSTEM INFRASTRUCTURE REPORTING: DO MINIMUM BUSINESS CONTINUITY OPTION

Mr Hardy advised the Board that there was a requirement for all NHS Boards to undertake a review of infrastructure, for submission to Scottish Government by the end of January 2025. This was focused upon maintenance of existing infrastructure to future proof it over the course of the next five to ten years. He noted that the Scottish Government had not asked for formal Board approval on the submission. Work was ongoing in this regard, and Mr Andress would provide a presentation on the current position.

Mr Andress led the Board through this presentation, outlining the phased approach required in this regard, and detailed the current status. Reporting would require a description of risk as well as a score for the likelihood of failure. This would generate a priority project list, and this would form the basis of the submission to Scottish Government. There would be ongoing review of this, with the ability to make alterations to it. It would be for Scottish Government to assess and make decisions on how to prioritise between the requirements of NHS Boards across NHSScotland. For the coming year, it was expected that this would be assessed and fed back to Boards by March 2025. Mr Andress also noted that the timescale for annual reporting in this regard would change, with reporting due by November each year going forward.

Mr Jenkins noted the position on availability of capital funds, and the pressures across NHSScotland, and suggested that reporting was submitted to Scottish Government by 31 January, and then submitted to the Board at its next meeting. This approach was agreed around the table.

Action – Mr Hardy

The Board:

1. Noted the update and that the finalised report would be included in the next Board meeting.

21 BOARD WORKPLAN

The Board received a paper from the Head of corporate Governance (Paper No 24/112) which provided a review of the Board's workplan for the coming year. Ms Smith presented a summary of the plan, underlining that it should support the Board's priorities, as well as being flexible to change within this period.

There was agreement around the table on the appropriateness of the workplan. There was a suggested change so that final reporting of the security project was phased to June 2025, allowing review of completion. There was also a suggestion to add in the planned feedback with the PPG, as discussed earlier in the meeting.

The Board:

1. Approved the workplan for 2025, subject to amendments.

22 PERFORMANCE REPORTING – QUARTER 2

The Board received a paper from the head of Corporate Planning, Performance and Quality (Paper No. 24/113) providing a high-level summary of performance throughout Quarter 2.

Ms Merson presented the paper, noting the five KPIs which were off target for this quarter, as well as work progressing in each area to seek improvement.

Mr Moore noted that the standing committee took detailed oversight of each of these performance areas. He thanked Ms Merson for the paper, which helped to focus attention on any area of underperformance.

The Board:

1. Noted the content of report.

23 eHEALTH ANNUAL REPORT

The Board received a paper (Paper No. 24/92) from the Finance and eHealth Director, and it was noted that this paper had been deferred from the previous Board meeting. Mr Best joined the meeting to summarise the report, which included details across a number of workstreams. In particular, he emphasised the work completed on the upgrade of the patient call system, as well as the NIS submission, business tableau and RiO upgrades. Overall, the team was working well. It had been a busy period but there had been the ability to manage and develop key projects.

Mr Moore noted the examples of use of AI and welcomed this development, and asked whether the RiO system would reach a point of optimisation or if it would be capable of continued development. Mr Best advised that there would continue to be opportunity to develop the system, tailoring this to TSH needs. It was noted that no other Boards used this system, although the Mental Welfare Commission did so, and there was discussion as to whether this would raise a risk for TSH. Mr Best provided the background to the adoption of RiO within TSH, and offered the view that it should offer the flexibility required within the hospital, and that it should be able to link to other NHS Systems. He offered assurance that there were no additional risks for TSH in this respect. Mr Moore also noted the ambition to create a Once for Scotland approach for patient records systems for the future.

In response it a query on the increased uptake of Near Me consultations, Mr Best confirmed that this was the case and that there was an intention to assess how this could support CPAs as well. Professor Thomson said that there was increased focus at using this clinically, especially for meetings with carers. The Heath Centre will consider whether a consultation could be through Near Me provided that there was no need for diagnostic testing like scans that could not be completed within the hospital. She added that for clinical use, RiO continued to be helpful.

Mr McNaught asked the Board to note the amount of input by the eHealth team, who made fixes directly to RiO, especially as mush of this work was completed in the background to ensure smooth running of systems.

The Board welcomed the annual report, and thanked Mr Best and his team for their contribution.

The Board:

1. Noted the content of report.

24 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Acting Director of Security, Resilience and Estates (Paper No.

24/114) to confirm the updated position. Mr Hardy noted the key highlights of the report, focused on the projected completion date in February 2025. The next Project Oversight Board was scheduled for 16 January 2025.

Board Members noted this position, and the continuing efforts being made to bring the final stages of the project to completion.

The Board:

1. Noted this update in relation to the Perimeter Security and Enhanced Internal Security Systems Project and recognised that this was a feature within the Private Session of the Board Meeting.

25 ANNUAL REVIEW 2023/24

The Board received a paper from the Head of Corporate Governance (Paper No. 24/115) which provided details of the Annual Review which had taken place on 18 November 2024. Since then, a letter had been received from the Minister for Social Care, Mental Wellbeing and Sport, which provided a positive overview of the event. The Board noted outcome letter and the future updates requested by Scottish Government in specific areas.

The Board:

1. Noted the content of reporting.

26 ANY OTHER BUSINESS

Ms Radage advised the Board that the first of the informal Board walkrounds had taken place to a hub, and that this had been very productive and helpful. The Board were pleased to note that these walkrounds had been re-established.

There were no other additional items of competent business for consideration at this meeting.

27 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 27 February 2025.

28 PROPOSAL TO MOVE TO PRIVATE SESSION

The Board then considered and approved a motion to exclude the public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

29 CLOSE OF MEETING

Mr Moore brought the session to a close by noting the strong focus on the patient and carers especially though the item focused on the PPG, PAS and the Carers Strategy. He thanked everyone involved in the Board for all of their work and contributions throughout the year.

The meeting ended at 12.45pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	April 24	A.O.B	Reporting template review around the monitoring report, and how to re-frame report template	M Smith	May 2025	**October Update:** Review and align to governance arrangements for committees, and bring back to the Board. **February:** Scheduled for Board Development Session, alongside wider review of governance.
2	June 24	Workforce Plan – Annual Review	Update requested on gender balance workstream	K McCaffrey	December 24	**December Update:** CMT reviewed, and agreed that extant position to remain for 12 months pending review of Risk Assessment Workstream led by the Head of Psychology. **CLOSED** – added to workplan for update December 2025
4	August 24	Carers Story	Travel scheme to TSH – for carers and to come back along with Carers Strategy (note link to staff transport)	K McCaffrey/ A Hardy	April 25	**December Update:** CMT requested further work in this respect to consider how best to support travel scheme, and to link this to the Carers' Strategy, to be further developed and return to CMT for consideration. **February Update:** Update provided to February meeting of CMT, there is a review underway which includes gathering data on carer needs, which will help form the recommended way forward – further update to follow.

6 (a)	August 24	Quality of Care	- Quality of Care Reviews implementation	K McCaffrey	December 24	**December Update:** Associate Nurse Director progressed through Patient Safety Forum, and first QoC walkround to commence in January 24. **February Update:** Visit by Excellence in Care colleagues from NHS Forth Valley and took forward first informal walkround with NPD on 17 February. Further work linking to SPS with visit to HMP Polmont on 5 March, and will confirm date of first formal walkround. Plan to have four walkrounds a year.
7	August 24	Whistleblowing	Agree new Exec Lead & re- launch Non Exec Champion role	S Wallace	April 25	**October Update -** Refreshed approach re Speak Up Week progressed to raise awareness across organisation. Update on agenda as part of Board Improvement Plan. Establish change of Exec Leadership/ re launch Non-Exec role as next steps. **February Update:** Work progressing, and reporting on agenda
8	October 24	Corporate Risk Register	-Consider Risk SD51 in context of project finalisation – and post completion period and how to re-frame risk -Circulate FD96 full risk assessment – cyber security for consideration -Review Workforce Risks and potential to add to CRR – absence/ WTD etc. - Update on progress of improvement work on	A Hardy	April 25	**December Update:** This will be reviewed fully on completion of the project to understand risk the requirements to mitigate system failure. **December Update**: Risk Assessment included with reporting on agend**a. CLOSED** **December Update:** This is under review and will return to the Board. Reviewed at Staff Governance Committee in February 25. **December Update:** Work remains ongoing to improve SAER process. Risk team will complete

			management of SAERs			this work in the fourth quarter, once all outstanding SAER's are complete
9	October 24	Finance	Updates requested on position on additional allocation, and also info re Distinction Awards	R McNaught	December 24	**December Update:** Updates will be provided in reporting as item on agenda – reviewed at meeting. **CLOSED**
10	October 24	QI and QA	Further info re timing of progress notes compared to incident – as part of clinical audit reporting – Post Physical Intervention Audit	M Merson	December 24	**December Update:** Clinical Quality reviewed position and this was found to be administrative system error. Patient Safety Forum is taking this forward as part of their improvement plan, in liaison with Practice Development. Posters are been circulated to all wards to remind staff of the importance of accurate record keeping. **CLOSED**
	December 2024	Patient Story PPG	To advise the attending Non-Execs of the topic at each meeting in advance – to aid discussions	M Smith/ J Garrity	February 2025	**February Update:** Linked with Skye Lead PCIT and have set up plan whereby all planned upcoming events will be flagged to ensure awareness and potential for involvement for Non Executive Directors. **CLOSED**
	December 2024	Business Continuity Plan – infrastructure	To submit report, and then bring to next meeting of Board in Feb	A Hardy	February 2025	**February Update:** Reporting on agenda

Last updated 21 Feb 25 M Smith

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 7
Sponsoring Director:	Chief Executive Officer
Author(s):	Chief Executive Officer
Title of Report:	High Secure Forensic Healthcare Services for Women
Purpose of Report:	For Noting

1. SITUATION

This paper provides a status update on the provision of high security forensic mental healthcare provision in Scotland. The concept was endorsed by the Women's Forensic Service Planning Group (WFSPG) in earlier debate and presentations.

The State Hospital has been asked by Scottish Government to implement a proposal to deliver High Secure Services for Women in Scotland at The State Hospital.

Strategically, this development supports 'The Independent Review into the Delivery of Forensic Mental Health Services in Scotland' published in 2021 (Recommendation 3); and 'The Mental Health and Wellbeing Delivery Plan 2023-25' published in November 2023 (Priority 8.1.2). This states 'During the lifespan of this Delivery Plan, develop a plan with stakeholders to deliver services in Scotland for women who need high secure care and treatment in the short and longer-term'.

Following discussion and agreement with the Mental Health Directorate, the proposal is as follows:

i. develop and implement an **interim women's service model**, to receive pre-trial and pre-sentence patients, who have been clinically assessed as requiring high security care and treatment. In the context of the TSH Clinical Care Model, this will be an admissions ward, with equivalence of service provision to that of male patients in the existing admissions service.
ii. develop and implement an **outreach service model** from high security to medium security providers and the Scottish Prison Service.

Points i and ii above will be referred to as Phase 1, The Interim and Outreach Service Model. The timeline for completion and go live is **July 2025**.

iii. oversee the development and implementation of a capital development of the 'Harris Option*', following the outcome, and preferred option, from a professional design team

feasibility report. (*Members of the WFSPG received a presentation on the 'Harris Option' at an earlier meeting)

Point iii above will be referred to as Phase 2, **The Medium- Longer Term Service Model**.

It is the intention that Phase 1 will integrate and co-locate with Phase 2 on its completion, therefore co-locating the three aspects of the patient's treatment journey into a central 'treatment hub' at The State Hospital.

2. BACKGROUND

In November 2023, a meeting was held with the Minister for Mental Health and Wellbeing and a representative group of NHS Chief Executive Officers. A discussion paper was presented and debated, looking at three options utilising TSH, plus a fourth option of the status quo. Indicative revenue and capital costs were detailed for each option.

Consultation occurred throughout 2024 to seek support for the model whilst funding was being sourced. Endorsement was received from NHS Chief Executive Officers, The Woman Forensic Services Planning Group, The Mental Welfare Commission, The Scottish Prison Service, and other key service stakeholders.

A meeting was held in November 2024, led by the Minister for Mental Health and Wellbeing, supported by The Lord Advocate and Solicitor General for Scotland alongside civil service colleagues. The State Hospital Chief Executive Officer, Board Chair and Medical Director attended this meeting with colleagues from Central Legal Office. The outcome of this meeting resulted in agreement that an interim service model be developed at The State Hospital.

On 06 January 2025, funding was confirmed to support a project team to take forward planning and a feasibility study on Phase 2. On 13 January 2025, revenue funding was confirmed by the Mental Health Directorate to progress with the Phase 1 aspect.

3. ASSESSMENT

Phase 1: Interim and outreach service model

A Project Team has been set up and work is underway to develop this service in Mull 3 ward. This involves a number of separate work streams looking at:

- clinical operating model (including Intellectual Disabilities and under 18's)
- ward modifications
- admission criteria
- recruitment
- training packages

Priorities for the forthcoming period are:

- Finalise recruitment timeline
- Staff Training Plan
- Agree referral criteria

- Ward adaptations in Mull 3

Work is also taking place with colleagues at Rampton Hospital in England to scope and develop an outreach service. The aim of the outreach service is to work support Medium Secure units and the Scottish Prison Service and assist in managing patients who may require admission, or who are displaying behaviours that could necessitate a high security referral.

Phase 2: Medium to Longer Term service model

This development will create a dedicated care and treatment centre for women with tailored person-centred care packages aligned to the three phases of the Clinical Care Model: Admissions, Treatment & Recovery, and Transitions.

The timeline for completion and go live is dependent on the outcome of a design team feasibility study, and agreement from NHS Assure. This element of work is underway and will be completed by April 2025.

Thereafter the project plan, capital plan and key milestones will be agreed and an implementation timeline developed. It is anticipated at this stage that the duration will be circa 36 months.

Recruitment

A recruitment campaign for Phase 1 will shortly be commencing, the initial component of this will be seeking interest from staff internally who may wish to be part of this element of the clinical service delivery model.

Following assessment of interest, an external recruitment campaign will commence and is anticipated at this point to run through March and April with staff onboarding from June onwards. Thereafter, they will undertake a four-week induction programme which includes core training and PMVA.

Governance

A Project Oversight Board has been established to oversee the work programme. The Oversight Board will be chaired by Mr Stuart Currie, Non-Executive Director. Membership of the group will be drawn from relevant departments and external stakeholders. Staff side will be represented by the Employee Director.

The Project Team will be in contact with external stakeholders shortly to seek nominations to join the Board. The Project Oversight Board will report to the State Hospitals Board directly in terms of all aspect of governance, and a terms of reference will return for formal approval.

Stakeholder Engagement / EQIA

A Stakeholder engagement plan is being developed by the project team for endorsement by the Project Oversight Board.

An Equality Impact Assessments in place for both phases of the project. A further meeting is planned with NHS Central Legal Office to ensure compliance with Human Rights and Equality legislation.

4. RECOMMENDATION

The Board are asked to note the progress of this development to date, and that further reporting will be provided at each meeting of the Board going forward.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	This paper outlines the strategic direction, as led through Scottish Government and being taken forward by the State Hospitals Board. The Corproate Objectives 2025/26 proposed include this as a key focus of work.
Workforce Implications	There are considerable implications as set out in the paper, as this service requires staff with specific skills required for this service, and also to consider any impact on existing staff.
Financial Implications	The funding is outlined in details within the paper, representing additional revenue and capital outwith existing budget.
Route to Board Which groups were involved in contributing to the paper and recommendations.	The Board has requested that this reporting comes in light of the development of this service, and the need for this to be progressed immediately, and to outline the oversight and assurance structure.
Risk Assessment (Outline any significant risks and associated mitigation)	The report sets out the initiation of work to develop this service, and the risk framework for the project will be reported through the Project Oversight Board, and to the State Hospitals Board.
Assessment of Impact on Stakeholder Experience	Reporting confirmed that a Stakeholder engagement plan is being developed by the Project Team for endorsement by the Project Oversight Board. The POB will be responsible for reporting in detail on impacts for all stakeholders, as the project develops.
Equality Impact Assessment	An Equality Impact Assessments in place for both phases of the project. There is panned linkage with NHS Central Legal Office to ensure compliance with Human Rights and Equality legislation.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This is not a relevant requirement.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	February 2025
Agenda Reference:	Item No: 8
Sponsoring Director:	Acting Director of Security, Estates and Resilience
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

- Has potential to interfere with achievement of a corporate objective / target; or
- If effective controls were not in place, would have extreme impact; or
- Is operational in nature but cannot be mitigated to the residual risk level of Medium (i.e. awareness needs to be escalated from an operational group)

This report provides the Board with an update on the current Corporate Risk Register (CRR).

2 BACKGROUND

Each corporate risk has a nominated executive director who is accountable for that risk, as well as a nominated manager who is responsible for ensuring adequate control measures are implemented.

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

All risks are in date.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register (CRR)

N/A

3.4 Corporate Risk Register Development

The Risk Management Team are continuing to review and refresh the risk management process working closely with directors across the services to refresh the Corporate Risk Register.

The following update informs the Board of the current ongoing development work with each Directorate and any changes made to the agreed level of risk over the last quarter.

Current Progress:

Nursing Directorate

Review is almost complete with ND71 and ND73 (Now moved to Local Risk Register) having been fully reviewed, and positive feedback received about new format. ND70 is current being redeveloped, expected completion date is March 2025 following Tableau staffing resource data going live.

Workforce.

Workforce Directorate Review is underway. All risks remain on the CRR although some updates made to grading as detailed in Section 3.4. Consideration is being given to adding Corporate Risks relating to Staff Absence, Breaching the Working Time Directive and Reduction in hours over 2025 and 2026.

HRD112- Failure to Comply with Level 2 Refresher Training – A reduction in PMVA Level 2 refresher training compliance was highlighted to Operational Management Team (OMT) in October 2024, and to reflect the reduction in training compliance the risk rating on the corporate risk register was subsequently increased from low to medium. This will remain under review returning to low once compliance is achieved.

Medical

Work is ongoing to review the risks aligned to the Medical Director and is 75% complete In light of the review one risk has been removed and the risk recognised within the Security Directorate and two risks have subsequently been reduced to the Local Risk Register.

MD30 Failure to Prevent or Mitigate Obesity – This risk is under review following the relaunch of “Moving towards a Healthier State Hospital: A whole system approach”. Risk of Obesity will be redeveloped with Lead Dietitian in March 2025. An update will be available to the board in March on progress.

Corporate

All Corporate Risks aligned to the Chief Executive Officer (CEO) are still under review. During this quarter two risk have been combined **CE10** and **CE13**. **CE10** remaining as the overarching risk assessment noting similarities in the hazards and control measures and by combining will allow a more streamlined approach to managing the risk.

CE14 – Impact of Covid-19 has been moved to the Local Risk Register and combined with the Infection Control – Risk of Outbreak local risk

CE15 Impact of Covid Statutory Inquiry – Consideration is being given to reduce the risk to low following a review of the impact the inquiry has had so far. Full review will take place at meeting with CEO in March.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has 4 'High' graded risks:

Medical Director: MD30- Failure to prevent/mitigate obesity.

Monthly Update:

Obesity remains a challenge across the hospital and work is progressing to better measure the impact. Supporting Healthy Choices are the main driver for progressing and monitoring, with performance data now available that will assist in our measures.
Focus still remains on physical activity for our patients, and new medication is also in use to try to assist in weight loss

Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.

Monthly Update:

This Risk still remains as High. We are awaiting the finalisation of a Staff Resource Dashboard is in development and due to go live mid-March, the data will allow identification of impacted areas and help inform the risk rating.

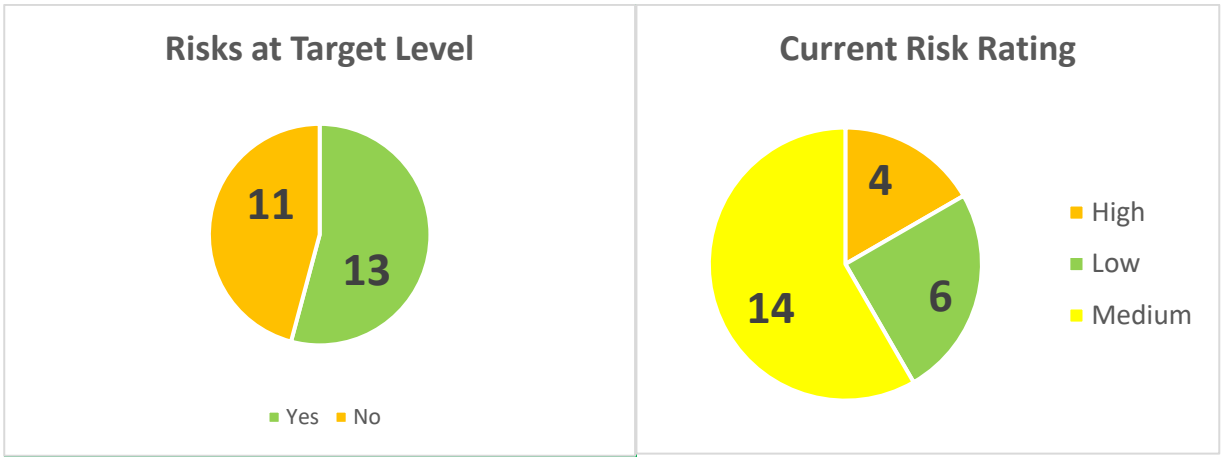
Finance Director: FD90: Failure to implement a sustainable long-term model

Risk was revised to reflect the national financial pressures as highlighted by SG communications in January and February 2024. A further review of this risk will take place following the outlined Scottish Budget.

Security Director: SD57: Adverse Event Review and Action Completion

Increased to 'High' following a review in October 2024. The Risk and Resilience Team have identified the risk of adverse event reviews and resultant actions not being completed on time has increased following recent pressures within the team. The team will continue to review the risk and share the next steps that will reduce the risk to target level.

3.6 Risk Distribution



Currently 13 Corporate Risks have achieved their target grading, with 11 currently not at target level.

Risk Grading – 12 Month Movement
Graphs are available in Appendix 2 for each Directorate which show the movement of the grading of each risk over the last 12 months.

As per the TSH Risk Management Strategy, Low and Medium risks are tolerated within the organisation's risk appetite. While some of the Corporate Risks have not met their target level, they still remain within the agreed risk parameters. Ongoing focus remains to reduce risks to target level by the Risk Manager by ensuring risks are reviewed continuously and updated where required.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70, SD57	MD30	
Possible	FD91		CE12, HRD113, ND71, SD54, HRD112	FD90	
Unlikely			FD96, FD98, SD52	MD34, SD51, HRD111	
Rare			FD97, SD56, FD99,HRD110, SD50		CE10, CE11, CE15

Review Periods:

Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly
Very High	Monthly (or more frequent if required)

4 RECOMMENDATION

The Board is invited to endorse the current Corporate Risk Register as an accurate statement of risk.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report provides an update of the Corporate Risk Register.
Workforce Implications	There are no workforce implications related to the publication of this report.
Financial Implications	There are no financial implications related to the publication of this report.
Route To Board Which groups were involved in contributing to the paper and recommendations	CMT and Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No. 25/03

High Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	Mar 25	Clinical Governance Committee	Monthly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Major x Likely	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Mar 25	Clinical Governance Committee	Monthly	-
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Major x Almost Certain	Major x Possible	Moderate x Rare	Finance & Performance Director	Finance & Performan ce Director	Mar 25	Finance and Performance Group	Monthly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Likely	Moderate x Likely	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	Mar 25	Security, Risk and Resilience Oversight Group	Monthly	-

Medium Risks

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	May 25	Corporate Governance Group	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Head of Risk and Resilience	May 25	Clinical Governance Committee	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Negligible x Unlikely	Chief Executive	Head of Risk and Resilience	May 25	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	May 25	Covid Inquiry SLWG	Quarterly	-

Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Likely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	May 25	Clinical Governance Committee	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	May 25	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	May 25	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Moderate x Possible	Moderate x Rare	Security Director	Head of Estates and Facilities	May 25	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	May 25	Clinical Governance Committee	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	May 25	Information Governance Committee	Quarterly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth/ Info Gov Officer	May 25	Information Governance Committee	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x unlikely	Major x unlikely	HR Director	HR Director	May 25	HR and Wellbeing Group	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Possible	Moderate x Rare	HR Director	Training & Professional Development Manager	May 25	Clinical Governance Group	6 Monthly	-
Corporate HRD 113	Service/Business Interruption	Job Evaluation and impact on services in TSH	Major x Possible	Moderate x Possible	Negligible x Unlikely	HR Director	HR Director	May 25	HR and Wellbeing Group	Quarterly	-

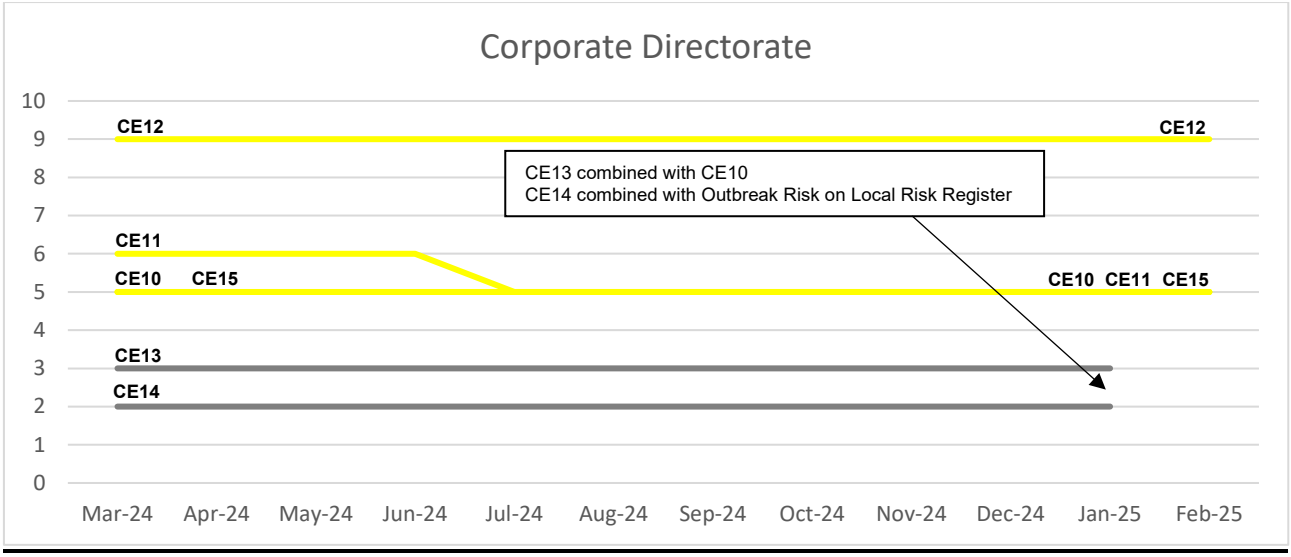
Low Risks

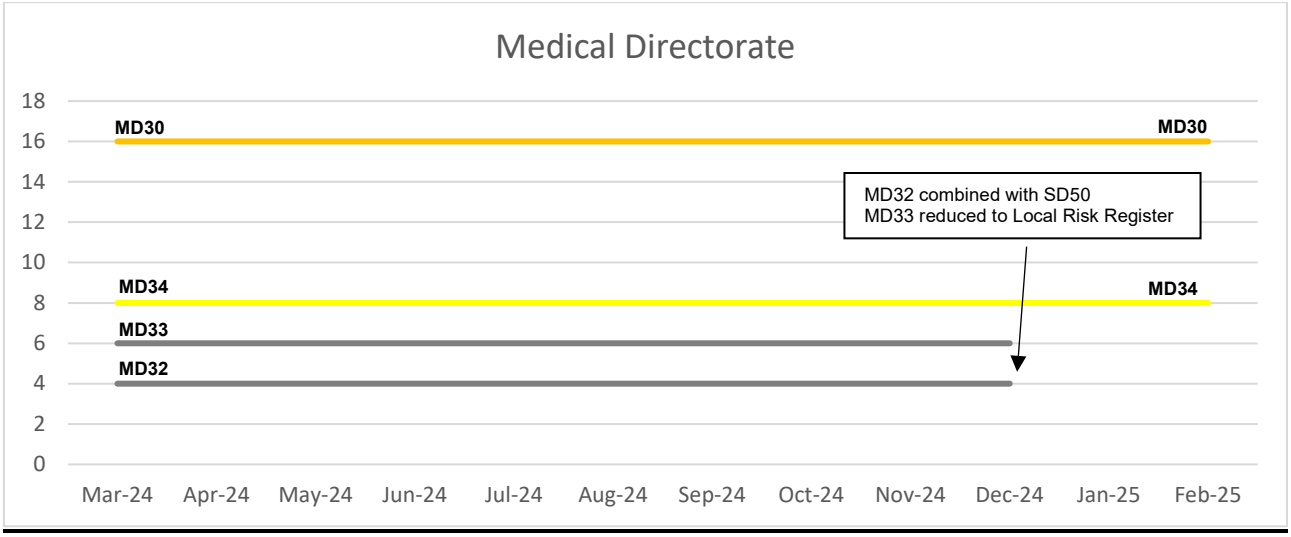
Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Monitoring Frequency	Movement Since Last Report
Corporate SD 50	Service/Business Disruption	Serious Security Incident or Breach	Extreme x Likely	Moderate x Rare	Moderate x Rare	Security Director	Security Director	Aug 25	Security, Risk and Resilience Oversight Group	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Aug 25	Security, Risk and Resilience Oversight Group	6 monthly	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Negligible x Possible	Negligible x Possible	Finance & Performance Director	Head of eHealth	April 25	Finance and Performance Group	6 Monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	Aug 25	Information Governance Committee	6 Monthly	-
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	April 25	Information Governance Committee	6 Monthly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Rare	Moderate x Rare	HR Director	HR Director	April 25	HR and Wellbeing Group	6 Monthly	-

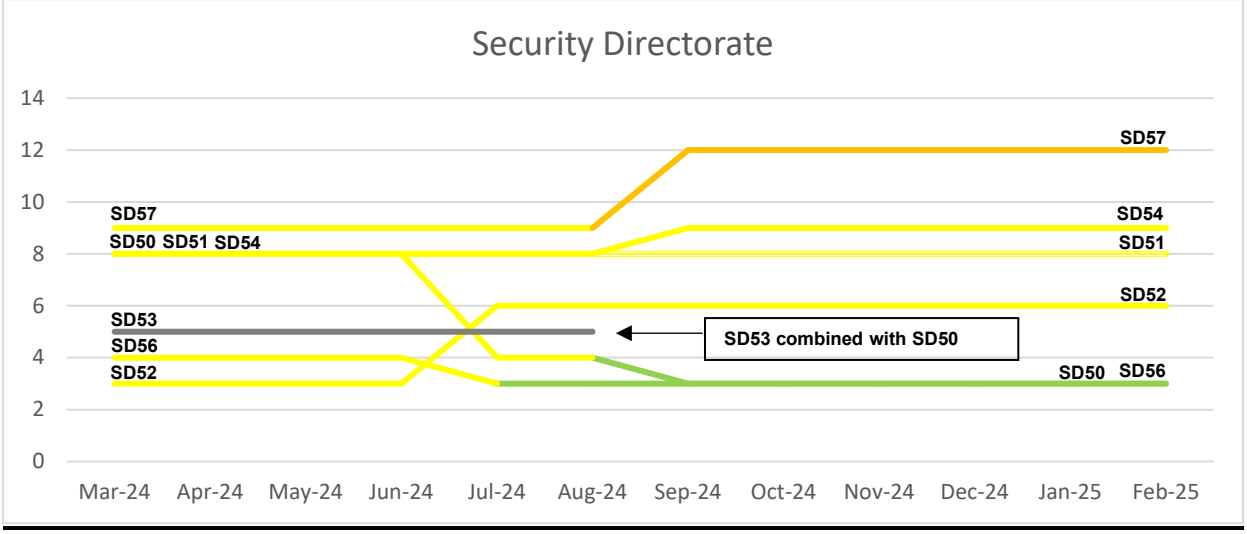
Appendix 2 – Corporate Risks 12 Month Movement

Likelihood	Impact/Consequences				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	Medium (5)	High (10)	High (15)	V High (20)	V High (25)
Likely (4)	Medium (4)	Medium (8)	High (12)	High (16)	V High (20)
Possible (3)	Low (3)	Medium (6)	Medium (9)	High (12)	High (15)
Unlikely (2)	Low (2)	Medium (4)	Medium (6)	Medium (8)	High (10)
Rare (1)	Low (1)	Low (2)	Low (3)	Medium (4)	Medium (5)

- Very High **17 -25**
- High **10 - 16**
- Medium **4 - 9**
- Low **1 - 3**



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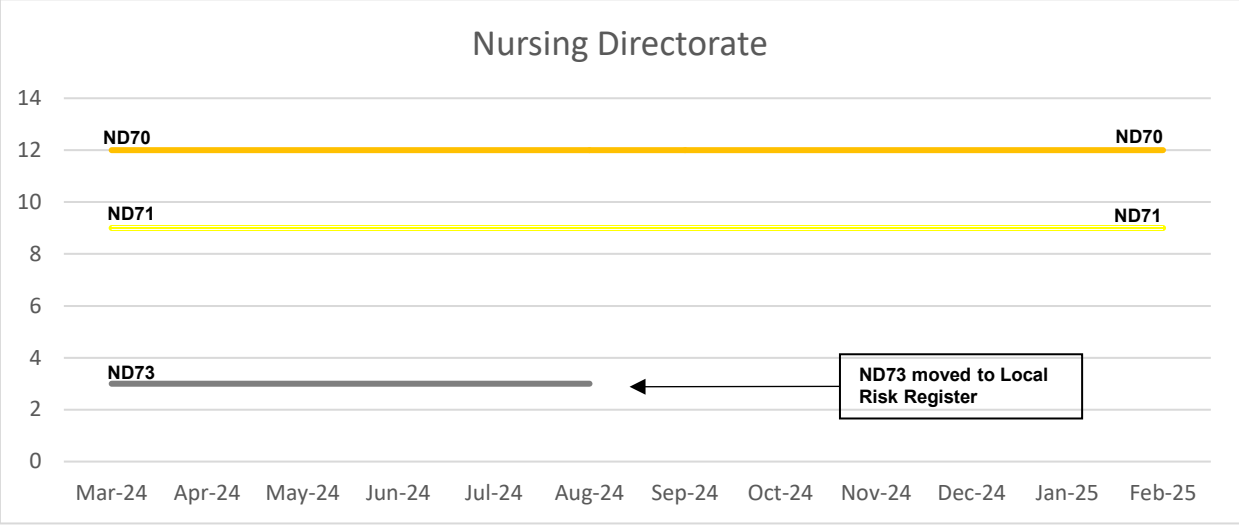
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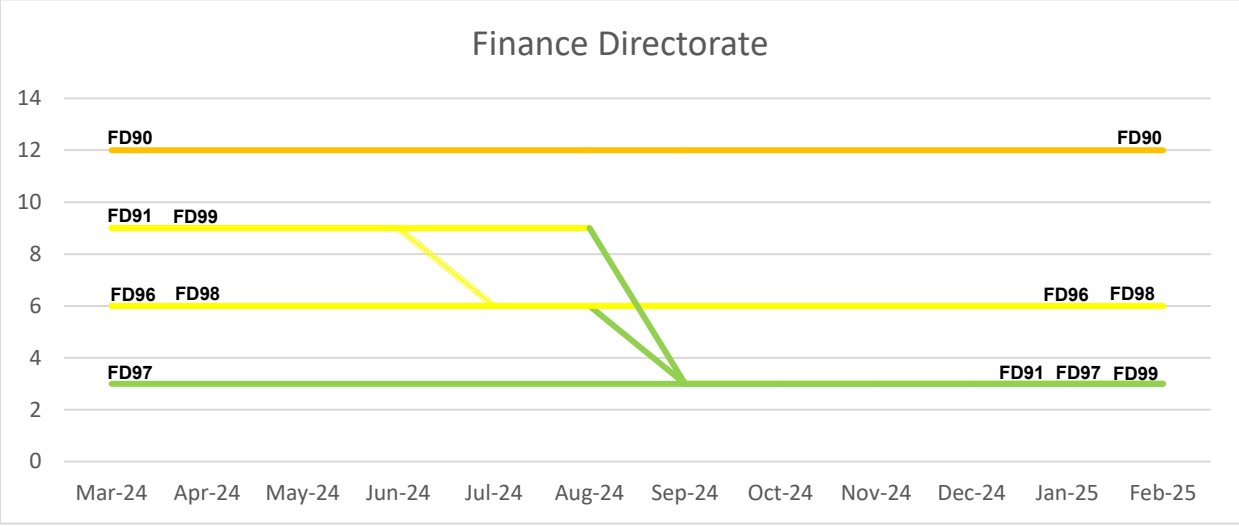
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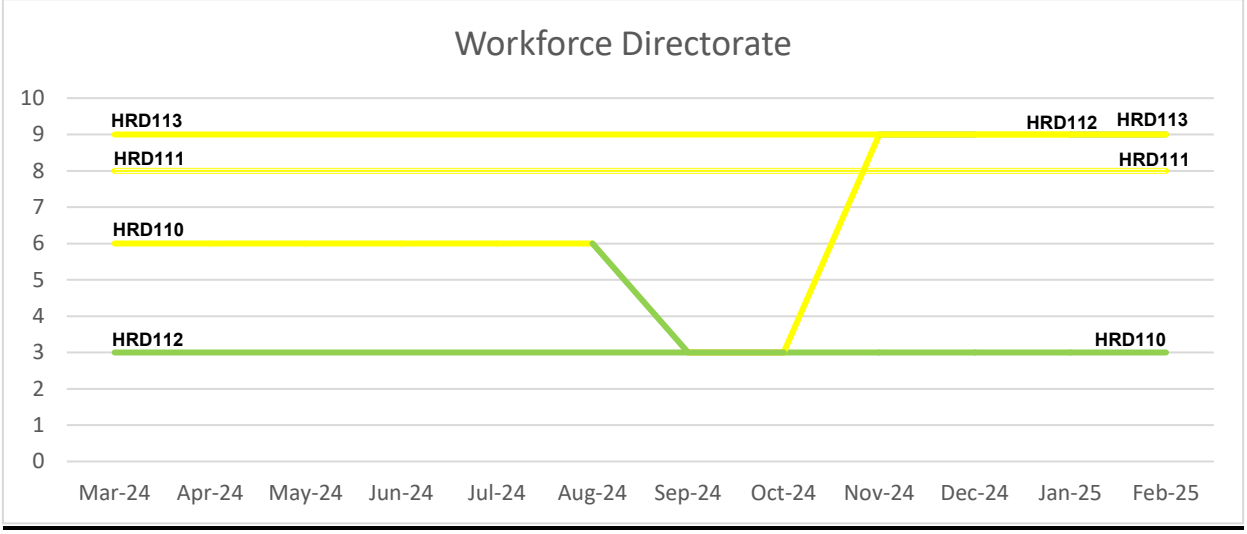
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THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 9
Sponsoring Director:	Finance and eHealth Director
Author(s):	Senior Management Accountant, Finance and eHealth Director
Title of Report:	Financial Position as at 31st January 2025
Purpose of Report:	For Noting

1 SITUATION

This report provides information on the financial performance, which is also issued monthly to Scottish Government (SG) along with the statutory financial reporting template.

The Board is asked to note the Revenue and Capital Resource outturn and spending plans.

2 BACKGROUND

The approved annual operating plan for 2024/25 was submitted to SG and signed off, with a projected breakeven forecast, regular meetings between TSH and SG monitor progress against targets.

With regard to the capital spend programme, the Perimeter Project is noted to have a delayed end date, as reported directly to the Board and notifed to SG finance through the regular liaison meetings and capital updates.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £49.379m is primarily the Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated (increased capital charges for Perimeter project £0.445m).

The State Hospital Annual Budget	£'000
Total Budget	49,379
Plus Perimeter project capital charges (to be finalised)	445
Revised budget for FPR £'000	**49,824**

In addition, there is further anticipated allocation not yet input to budgets as awaiting confirmation, as follows – Distinction Awards £36k

The January accounts show an over spend to date of (£147k), driven mainly by Ward Nursing pressures, and capital charges for depreciation of buildings that have been backdated - these pressures partly offset by a number of staffing vacancies and a benefit of income from exceptional circumstances patients.

3.2 Female service provision

An additional allocation has been agreed with regard to the initial stages of evaluation now underway of options for the provision of female services – to cover TSH staffing costs for this work, together with the costs of external advisers looking specifically at the options regarding provison of specific accommodation and capital requirements.

This will be controlled and monitored distinctly from the main TSH SG allocation.

3.3 2024/25 Budget

The 2024/25 budget template required by SG includes savings requirements of £1.3m (approx.3%), and it is forecast that the savings target will be achieved.

Individual directorate budget reviews established detailed plans for the achievement of a satisfactory level of savings being identified for the start of the year, achieved savings being reported monthly (section 4. below).

The Capital budget for 2024/25 remains at a recurring level of £269k, with additional £325k non-reccuring capital budget granted this year for case conference IT equipment and replacement x-ray machines – the procurement of these items now underway.

3.4 Year-to-date position 2024/25 – allocated by Board Function / Directorate

Directorate	Annual Budget £'k	YTD Budget £'k	YTD Actuals £'k	YTD Variance £'k	Budget WTE	Actual WTE	Comments on Variance
Cap Charges	3,112	2,593	2,678	(84)	0.00		RRL has been anticipated for phase 1 perimeter project capitalisation (£244k already "released" to capital charges). Phase 2 perimeter (£445k)will hit later in the year so while not yet reflected in the budget, has been notified to and confirmed by SG
Central Reserves	731	0	43	(43)	0.00	0.00	Phased to period 12 and released as required, includes apprenticeship levy, paiaw, oncall, SLA's, utilities and any new RRL (eg RWW)
Chief Exec	2,538	2,122	2,113	8	26.17	23.98	SW SLA has been uplifted to reflect anticipated costs
Finance	3,316	2,778	2,794	(16)	29.18	32.47	ehealth strategic allocation was used in full to fund 4 posts, a pressure has started to emerge as the allocation is insufficient to fund pay uplift
Human Resources Directorate	1,161	971	937	34	16.30	16.70	This is resulting from an underspend in training and vacancies across the directorate
Medical	3,674	2,920	2,826	94	23.95	19.59	Driven by an underpend in pharmacy drugs and vacancy in pharmacy SLA
Misc Income	(100)	(83)	(68)	(15)	0.00	0.00	Timing of income (mainly VAT, CNORIS) is slightly at variance from budget phasing
Nursing And Ahp's	26,701	22,391	22,659	(268)	405.27	418.56	see below for detailed narrative from nursing directorate
Security And Facilities	8,246	6,935	6,792	143	123.63	115.09	Vacancies in housekeeping, risk and security are contributing to underspend
	49,379	**40,627**	**40,774**	**(147)**	**624.50**	**626.39**	

Nursing & AHPs (as provided from Nursing Directorate Jan '25)

In keeping with previous submission reports, the main contributors to nursing overtime costs continue to be fluctuations in clinical acuity (including boarding patients), vacancies and sickness absence. Routine external outings (e.g. court and pre-transfer/transfer) continue to take place and are monitored on a case-by-case basis to ensure balance between onsite and offsite activity.

The additional ward which was opened in July 2024 continues to operate and provide care for a patient with specific clinical and risk needs.

Pro-active-recruit campaigns to close the Band 5 nursing vacancy gap have demonstrated success and work was undertaken in January to employ an additional ten Healthcare Assistants. Over the coming weeks and months there will be focus on recruitment to support the opening of an interim women's service at the hospital.

Robust attendance management processes and regular reviews of employee relation cases remain ongoing. Likewise, monthly Senior Charge Nurse (SCN) performance reviews continue to be in place. These finance meetings enable supportive discussions with SCNs around effective roster management, effective use of allocated funding, and robust oversight of non-pay related spending.

Across the Nursing Directorate all Heads of Service continue to meet the savings targets set.

3.5 Financial pressures / potential benefits.

Pressures:

Ward Nursing (has been raised with SG for consideration – to be reviewed depending on February / March outtrun)

- Boarding out costs – patients being treated at acute hospitals with staff in attendance (to date £483k)
- High risk patient on enhanced care requiring 4 staff members for both day shift and back shift and 2 staff members on night duty. 6th July to 31st January - £954k
- Escorted transfer of female patient to Wales – cost of staff in attendance £1.7k

M365

- Q1 and Q2 have been recharged by NSS and are included in the position. It is envisaged this cost will be met from reserves (approx. £35k per quarter). The cost of Q3 and Q4 are potentially a pressure.

Energy and Inflation Increases

- The unused prior year accrual has been carried forward to provide against anticipated pressure in 2024/25, with a reserve in place as well. This has been highlighted as a risk to SG, £332k additional budget allocated to cover to 31 January '25

AFC Reform

- Reduction in 37.5 hour working week underway by 1/2hr for full time and (pro rata for part time staff), this has been funded in 24/25. Further reductions will be made over the next two year to reduce the working week down to 36 hours by the year 26/27.
- Adjustment to certain posts – to be determined – from band 5 – band 6 (funding awaited)
- Also yet to be determined is any costs re protection of training time.

PAIAW – (payment as if at work)

- Funding continues to be held as a reserve for the current year and released monthly to cover the costs incurred. The majority of the prior years PAIAW arrears have now been paid, there are a few outstanding and due to be paid in the coming months. These costs have been covered by an accrual from previous financial years.

Benefits:

Travel & Training

- Less spend following covid, meetings and some training online.

4 ASSESSMENT – SAVINGS

Savings targets are generally phased evenly over the year (twelfths) – and equate to £1.3m (3%). – with adjustment re nursing for accuracy of tracking (phased July to March).
As shown in the table below savings are slightly over achieved to date.

Directorate	Annual Target £'000	YTD Target £'000	Amount Achieved £'000	Surplus/ (Shortfall) ytd £'000	Still to Achieve £'000
Chief Executive	74	62	10	(52)	64
Finance	101	84	78	(6)	23
Human Resources	25	20	10	(10)	15
Medical	74	62	17	(45)	57
Nursing & AHP	828	666	916	250	(88)
Security & Estates	233	194	70	(124)	163
Total Savings	**1,335**	**1,088**	**1,101**	**13**	**234**

It should be noted that of the Hospital's budget only 14% of costs are non-pay related, certain boards also treat vacancy savings, as recurring savings, we class ours as non-recurring.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation is £269k, with capital projects planned and agreed through the Capital Group. Additional funding has been granted by SG for 24/25. Additional non-recurring capital budget has been granted of £325k – for which work is now underway, as noted above.

With regard to the Perimeter Security Project allocation, there are elements of delays in the Project – now expected to be completing shortly, with first lot of retention spend now delayed until following year rather than current year, with final retention two years later.

SG return Jan '25	Annual	YTD
Capital CRL 2024/2025	Plan	Spend
	£'k	£'k
Perimeter Security		
Securitas (previously Stanley Security Solutions LTD)		7
SECURITY CONTRACTING SERVICES LTD		0
DOIG & SMITH		0
Thomson Gray LTD		188
TSH Staffing		150
SENSTAR CORP		0
Income re Covid recharges, sale of radios etc.		-63
Perimeter Security Total	**372**	**281**
Capital		
IM&T		50
Other		47
Capital	**269**	**97**
Additional Capital granted Dec 24		
IT/AV equipment for case conference rooms	**82**	
replacement x-ray machine	**243**	
Additional Capital	**325**	
Total CRL	**966**	**378**

6 RECOMMENDATION

The Board is asked to note the following position and forecast –

Revenue
The year to date position is an over spend of (£147k), with ward nursing costs remaining the key pressure.
Forecast for the year remains for a breakeven position to be achieved, with savings target on track.

Capital
The budget is fully committed with a breakeven position forecast for the year.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of financial position
Workforce Implications	No workforce implications – for information only
Financial Implications	No workforce implications – for information only
Route to SG/Board/CMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Deputy Director of Finance CMT Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed. □ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 10a
Sponsoring Director:	Medical Director
Author(s):	Associate Medical Director PA to Medical Director
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

Capacity within the State Hospital (TSH) and across the Forensic Network has been problematic and requires monitoring.

2 BACKGROUND

a) TSH

The following table outlines the high level position from the 1 December 2024 until 21 January 2025.

Table 1

	Admissions & Acute	**Treatment & Recovery**	**Transitions**	**ID**	**Total**
Bed complement	24	48	24	12 ID beds (and 12 contingency beds) Total 24	120 (+ 20 additional unstaffed beds)
Beds in use	19	48	20	12 + 3 ID surge	102
Admissions	2 (external) 0 (internal)	0 (external) 2 (internal)	0 (external) 1 (internal)	0 (external) 0 (internal)	2 (external) 3 (internal)
Discharges/Transfers	1 (external) 2 (internal)	1 (external) 1 (internal)	2 (external) 0 (internal)	0 (external) 0 (internal)	4 (external) 3 (internal)
Bed occupancy as at 21/01/2025	79.2%	100%	87.5%	125% (ID beds)	83.3% (available beds) 72.9% (all beds)

Please note that in total there were 102 patients as of 21 January 2025. Within this number, 15 patients are under the care of the Intellectual Disability Service (the service is currently 3 patients in excess of their 12 patient allocation).

Table 2 – Time between admission and referral

Date	6 weeks or less	More than 6 weeks	Total Number
21/01/2025	2	0	**2**

Both patients were admitted within 6 weeks of referral.

There are 7 patients identified for transfer (6 MMI and 1 ID), 3 of whom have been fully accepted. One patient has been waiting longer than 12 months. There have been two excess appeals won. Full details are available but not included for reasons of patient confidentiality.

There is one patient currently in TSH under the Exceptional Circumstances clause; he was admitted on 26/07/24.

b) Bed Occupancy since start of new Clinical Model

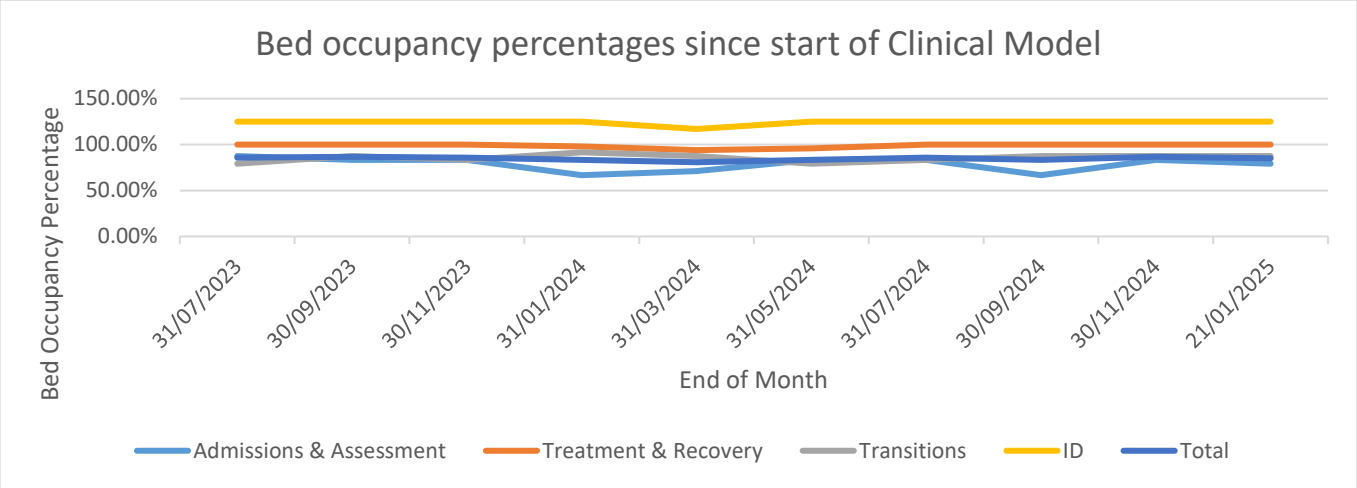


Table 2 Bed Occupancy by Service and in Total

Service	31/07/23	30/09/23	30/11/23	31/01/24	31/03/24	31/05/24	31/07/24	30/09/24	30/11/24	21/01/25
Admissions & Assessment	87.50%	83.30%	83.30%	66.70%	71%	83.30%	83.30%	66.7%	83.3%	79.2%
Treatment & Recovery	100%	100%	100%	97.90%	94%	95.80%	100%	100%	100%	100%
Transitions	79.20%	87.50%	83.30%	91.60%	87.50%	79.20%	83.30%	87.5%	87.5%	87.5%
ID	125%	125%	125%	125%	117%	125%	125%	125%	125%	125%
Total	**85.8%**	**86.7%**	**85.8%**	**83.3%**	**80.8%**	**83.30%**	**85.8%**	**83.3%**	**86.7%**	**85%**

Table 2 shows more patients in the admissions service, which reflects the greater number of admissions as outlined in table 1.

c) TSH Contingency Plan

Following the new Clinical Model being implemented, SOPs for surge bed contingency planning has been agreed through the Clinical Model Oversight Group. There exists 2 agreed SOPs. One allows for use of surge beds within the Intellectual Disability Service solely at night/when patients have defined time in the rooms. The other for patients who would remain in the surge bed within the Intellectual Disability Service day and night. No patients are currently identified given current bed availability and recent patient flow, it would be possible though to identify patients with clinical teams rapidly should this be required. These arrangements have never been used.

d) Forensic Network Capacity

We receive a weekly forensic estate update report from the Forensic Network to aid patient flow (Appendix 1). As of the 13th of January there were 13 empty beds (Male Mental Illness and Male Intellectual Disability) and 5 available beds within the medium secure estate. The Orchard Clinic has temporarily reduced its capacity for over one year by 7 beds for urgent repairs.

On 26/9/24 the Scottish Government requested that the Forensic Network carry out further work on capacity across the estate. The Network have been asked to take a collaborative, all-inclusive, and whole-systems approach that focuses on patients' interests. The Forensic Network have submitted their Capacity and Patient Flow report, setting out a plan of action with approximate timescales for delivery. A copy of this report dated December 2024 to the Scottish Government is attached to the end of this report (Appendix 2).

3 ASSESSMENT

The current bed situation within TSH is manageable. We continue to have surge beds available should we need to move to our bed contingency plan. It is recognised that there is a natural variation in the number of referrals and admissions and we are impacted by capacity in lower levels of security.

The Orchard Clinic's temporary closure of 7 beds for urgent work is causing further pressure across the forensic estate.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP / Corporate Objectives	The report supports strategy within the hospital, and all associated assurance reporting.
Workforce Implications	N / A
Financial Implications	N / A
Route To Board Which groups were involved in contributing to the paper and recommendations	Board requested as part of workplan
Risk Assessment (Outline any significant risks and associated mitigation)	The various reports throughout the year would include any issues
Assessment of Impact on Stakeholder Experience	All the reports are assessed as appropriate
Equality Impact Assessment	All the reports are assessed as appropriate
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	All the reports are assessed as appropriate
Data Protection Impact Assessment (DPIA) See IG 16	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included

APPENDIX 2

Capacity and Patient Flow

Response to letter from Director of Mental Health (Scottish Government) dated 17 September 2024

Date of Report: 16 December 2024

Contents

1. Introduction

The Forensic Network acknowledges the receipt of the letter dated 17 September 2024, and the urgency conveyed regarding addressing capacity issues within the forensic mental health estate. These issues, particularly those related to access to medium-secure services, represent critical challenges that directly impact patient care and service efficiency.

This request follows a similar initiative in September 2021, during which the Forensic Network engaged extensively with stakeholders to develop and implement a 16-point short-term plan, complemented by medium- and long-term strategies. These efforts successfully alleviated some immediate pressures on bed capacity through collaborative actions across secure settings, such as optimising patient transfers and utilising available resources more effectively.

The current landscape underscores the persistent nature of these challenges, necessitating renewed focus on streamlining processes, minimising delays, and enhancing co-ordination across services. On 5 September 2024, a meeting convened by the Scottish Government identified several priority areas for short-term improvement, including clarity on referral criteria and pathways, reduction in multiple assessments, and development of robust mechanisms for escalation and conflict resolution.

This paper provides an update on the actions taken to address the issues highlighted in the letter. The report was requested by 16 December 2024, as was significant collaboration across the Network. Therefore, it reflects ongoing work and emphasises the continued collaborative efforts necessary to achieve meaningful change. In light of the proposed move towards a unified governance system for forensic mental health services in Scotland, the paper also underscores the need for sustained, long-term action to effectively address these issues over time.

2. Methodology

Aims

The primary objective of this work was to identify and address short-term issues that will streamline, simplify, and expedite processes related to accessing services, with a particular focus on medium-secure settings.

Method of Engagement

In preparing this document, we adopted a methodology similar to that used in 2021, ensuring a comprehensive and inclusive approach. This involved consultation and collaboration with a diverse range of stakeholders. Specifically, two Advisory Group meetings were held on 5 November 2024 and 3 December 2024. The Advisory Group included a broad spectrum of clinical and managerial representatives from NHS and independent sector forensic mental health services (spanning high, medium, and low security), as well as the Mental Welfare Commission and the Scottish Government. A complete list of stakeholders involved in these meetings is provided in Appendix 1.

Given the importance of support from individual Health Boards in implementing any recommendations from this work, the NHS Scotland Board Chief Executive Group were also made aware of the request.

Use of Data

At the outset of this work, we analysed data collated by the Forensic Network to monitor patient flow and bed usage across the forensic estate. This analysis included comparisons with bed capacity data from 2021, providing context and highlighting changes since that time.

3. Analysis of Current Bed Use and Capacity Trends

Data sources

The Forensic Network produces a weekly bed position paper which seeks to provide an overview of bed availability across forensic mental health services. Initially focused on high and medium secure services, the report was extended in 2021 to include low secure services, offering a comprehensive overview of the entire forensic inpatient estate. Over time, refinements have been introduced, such as recording the number of delayed discharges within each service. The report is shared widely with stakeholders, and clinicians involved in bed management are encouraged to use it to inform their decision-making.

The data gathered through the weekly bed position paper also informs the longitudinal bed papers provided quarterly to the Inter Regional Group. These reports consistently highlight bed pressures across the forensic estate and identify blockages to patient flow, particularly within low secure services. Versions of these papers have been shared with the Forensic Mental Health Policy Team to support discussions with the Minister for Social Care, Mental Wellbeing and Sport.

Since 2018 the Forensic Network has also tracked the volume of prison to forensic mental health hospital transfers. In 2023, a process improvement initiative strengthened this system, introducing a revised procedure in December 2023. This enhanced process captures comprehensive information on all referrals to forensic services, including outcomes and delays, enabling better monitoring and resolution of transfer delays.

Finally, the Forensic Network conducts an annual forensic inpatient census in November each year, involving all high, medium and low secure sites, as well as some locked wards and IPCUs. The census completed in November 2023 recorded 461 patients across the forensic inpatient estate.

2024 Analysis

At the outset of this work, the Forensic Network sought to examine national data and compare this to the position in 2021. A 'Capacity Paper' was produced providing information on longitudinal bed data and prison monitoring information. This paper served as a foundation for discussions at the initial Advisory Group meeting in November 2024. Key highlights from the paper are summarised below, with the full document available upon request.

- Bed Capacity

Since 2021, there has been a documented reduction in bed capacity across the forensic estate. In October 2021, the Orchard Clinic reported a capacity of 33 male and 7 female beds. However, in autumn 2022, the clinic reduced its capacity by seven beds to facilitate a phased refurbishment programme. Although this refurbishment was initially projected to take 18 months, delays have extended the timeline, resulting in an ongoing reduction in available beds that is likely to persist until at least 2026.

Similarly, Bellsdyke Hospital has reduced bed capacity in recent years. In October 2021, it reported 18 male low secure beds but formally closed six beds shortly thereafter. As the service had been operating below capacity for some time before the closure, this reduction did not have a significant impact on patient care at the site.

- Bed Availability

In 2021, Rohallion Clinic consistently reported 7–10 available beds. By 2024, however, this availability had declined, attributed to increased bed usage, as well as staffing and operational challenges. In contrast, Rowanbank Clinic, which reported no available beds for much of 2021, showed some of the highest levels of bed availability in 2024.

At the low secure level, bed availability remained persistently limited in 2024 across most services. Several units, including Ayr Clinic, Surehaven, and Leverndale, consistently reported no available beds over the past year, reflecting ongoing pressures and constraints within the low secure estate.

- Waiting Lists

At medium security, both the Orchard Clinic and Rohallion maintained relatively stable waiting lists for mental health services from 2021 to 2024. During the same period, Rowanbank Clinic significantly reduced its male mental health waiting list, decreasing from 22 patients in 2021 to an average of 5.2 patients in 2024.

At low security, Leverndale Hospital also achieved a reduction in its waiting list, dropping from 33 patients in October 2021 to 23 patients in October 2024, with an average of 24 patients over the past 12 months. Whilst a reduction, this remains a lengthy waiting list. Most other low secure services outside NHS Greater Glasgow and Clyde reported waiting lists of eight or fewer patients. For the female low secure estate, the Ayr Clinic maintained a steady average waiting list of six patients over the last 12 months.

- Transfer Delays

At medium security, Rowanbank Clinic had an average of 9.4 patients waiting for conditions of lower security throughout 2024, with a peak of 13 patients. Orchard Clinic and Rohallion Clinic reported lower averages of 5.2 and 4.8 respectively. Notably, these averages have nearly doubled compared to the same period in 2021 for both Orchard and Rohallion Clinics, whilst Rowanbank Clinic's average has declined.

Reflecting the demand for services in the West of Scotland, Leverndale Hospital has consistently maintained a community transfer list for MMI services, averaging 11.6 patients and ranging between 11 and 14 at any one time in 2024. The hospital's female mental illness (FMI) service only had one patient listed as awaiting transfer to community settings during this time.

- Forensic Intellectual Disability (ID) Estate

The data demonstrate that The State Hospital ID service consistently exceeded its capacity throughout 2024. The service accommodates 15 patients, exceeding its designated capacity of 12 beds by three. This has been the case since 2021.

At medium security, the National ID service at Rowanbank Clinic has also been operating at full capacity over the last 12 months and there remains very limited flexibility in capacity across low secure forensic ID services, particularly for male patients.

4. Issues to be considered

The letter of 17 September outlined eight key issues to be considered as part of this work

- Referrals
- Waiting Lists
- Multiple Assessments
- Regional Agreements
- Conflict Resolution
- Escalation Processes
- Prison to Hospital Transfers
- Inter Regional Group (IRG) Representation

4.1 Referrals

The Forensic Network acknowledge the need to clarify referral pathways and processes and to minimise variation in referral criteria. In 2019, we published *Guidance on Patient Referral to or within Scottish High and Medium Secure Services.*[1] This document aimed to offer a supporting framework to assist clinical teams and provide increased clarity in relating the nature of the level of risk posed, to the level of security required. In May 2024, the Forensic Network IRG recommended that this guidance be reviewed and updated.

A short-life working group was established, chaired by Dr Daniel Bennett (Consultant Forensic Psychiatrist, NHS Grampian). The first meeting was held on October 2024, with the intention to complete the work by March 2025. The Terms of Reference for the group outline the aims to review the existing referral criteria for medium and high secure services, reduce variation in referral criteria, clarify pathways and support appropriate referral decisions (see Appendix 2).

Response

As the short-life working group was established prior to the current request, the Network has not focused extensively on this area, opting instead to allow the referral group to proceed as planned. During Advisory Group discussions, the importance of developing consistent referral criteria for low-secure services was highlighted. It was agreed that low secure services would share their existing policies with the Network for review. Responses were received from the majority of low secure services, with many adopting broad referral criteria for their services, while others, such as Trystpark (NHS Forth Valley), confirmed the absence of specific criteria. A summary of responses and practice across all services will be compiled and shared with the Referral short-life working group.

The Referral short-life working group will then consider broadening the scope of its work to develop referral criteria applicable to all three levels of security. If this adjustment is made, the group's projected completion date is likely to extend beyond March 2025.

[1] Forensic Network (2019) Guidance on Patient Referral to or within Scottish High and Medium Secure Services

4.2 Waiting Lists

As with Referral Criteria, we acknowledge the importance of minimising variation in the management of waiting lists across services. In May 2024, whilst reviewing the need to update Referral Guidance, the IRG noted that some services make use of tools to support their decision-making and waiting list management. For example, the Orchard Clinic have formalised the use of the DUNDRUM Triage Urgency Manual[2] within their bed management meetings. IRG members recommended that the use of such tools be considered as part of the short-life working group to update the 2019 Guidance.

Another factor influencing waiting list prioritisation is the impact of existing Regional Agreements, particularly when considering out-of-area patients. These agreements often dictate the level of priority assigned to individuals based on their geographic location relative to the service. This issue is examined in greater detail in Section 4.4.

Response

The Referral Guidance short-life working group will formally consider and reach a view on the use of Structured Professional Judgement tools to support admission and waiting list decisions (e.g. DUNDRUM Quartet). This is explicitly outlined within the agreed Terms of Reference for the group. This approach will support a consistent and agreed upon way forward for services in the longer term.

The Forensic Network weekly bed position provides an overview of number of patients on the waiting list for access to each inpatient service, and which of these are considered out-of-area. As an interim measure, we propose an amendment to the weekly bed position to more accurately capture the location of those on waiting lists e.g. high, medium, low, community or prison. This would allow for a greater understanding of those awaiting access to services.

4.3 Multiple Assessments

The Independent Review into the Delivery of Forensic Mental Health Services (2021)[3] highlighted that repeat assessments in forensic mental health, especially for patients transferring from prison settings, often create delays, foster frustration amongst both patients and providers and impact on continuity of care. The Review included a recommendation that the system of multiple assessments to facilitate transfers from prison should be reviewed with the aim of streamlining the process to the benefit of the person in need of services (Recommendation 21).

In advance of the November Advisory Group meeting, a survey was shared with clinicians across all forensic inpatient services to ascertain current practice with regard to multiple assessments. The responses indicated

[2] Kennedy et al. Dangerousness Understanding, Recovery and Urgency Manual (The DUNDRUM Quartet): Four Structured Professional Judgement Instruments for Admission Triage, Urgency, Treatment Completion and Recovery Assessments. Trinity College, Dublin: Dundrum; 2013

[3] Scottish Government (2021) Independent Review into the Delivery of Forensic Mental Health Services

that services generally conduct their own assessments, particularly for patients referred from prison settings. While medium and low secure settings may occasionally accept assessments from other services in emergencies, or for patients well-known to them, this is usually limited to services within the same region. A clinician familiar with the receiving service was emphasised as essential to ensure safe planning, manage relational security, and address gaps in referral information. Without direct assessments, critical intelligence could be lost, making it harder to plan for a successful admission.

Health Boards were noted to have a duty to allocate resources effectively, often necessitating assessments by the receiving service's clinicians. Joint assessments with other services were considered resource-inefficient and impractical for urgent referrals. The need for direct assessments to confirm lawful detention and appropriate security levels was also highlighted. The risks of admitting unsuitable patients were underscored, particularly given challenges in returning them to distant Health Boards.

Response

Several potential solutions were proposed through the survey, and after deliberation at the November Advisory Group meeting, it was agreed to convene a sub-group to explore these options in greater detail. The sub-group was established with representatives from high and medium secure services, the Principal Medical Officer (Forensic Psychiatry), and a low-secure service representative.

The sub-group met on 28 November and agreed on the following proposals as mechanisms to minimise the practice of multiple assessments:

- Strengthen the link clinician role to enhance communication and information sharing.
- Develop a draft standardised referral template for use across the Network.
- Encourage the development of exit strategies and promote flexibility in discussions regarding referrals.
- Leverage virtual technology to support assessments where available and clinically appropriate (e.g., NearMe).

The Link Clinician (LC), typically a consultant psychiatrist, is appointed to patients placed in hospitals outside the local health board to ensure continuity of care and facilitate their return. The LC communicates with the patient's current clinical team, attends or prepares for key meetings (e.g., CPA or MHTS), and ensures the patient receives appropriate care tailored to eventual transfer back to the home area. They monitor the progress of out-of-area patients, maintain contact with the local forensic services, and provide necessary clinical information to ensure seamless transitions. This process includes tracking timelines, preparing local services, and avoiding redundant assessments, ensuring efficient and patient-centred care co-ordination.

The sub-group reviewed the suggestion from the Independent Review regarding a single point of referral for medium secure services. While this approach may appear appealing, it was acknowledged that implementing such a system would require complex governance structures and could have significant implications for services and patient care. Consequently, it was agreed to prioritise other strategies aimed at minimising out-of-area referrals and assessments.

Over the coming weeks, the Network will look to formalise the link clinician role and agree a standardised referral template for use.

4.4 Regional Agreements

Medium secure care in Scotland is organised on a regional basis, with funding allocation and prioritisation of forensic beds varying across regions. While formal Service Level Agreements (SLAs) are not universally in place, regional arrangements and collaborative frameworks are used to address the specific demands and resources of each area, tailoring services to meet local needs. The primary facilities delivering medium secure care in Scotland are:

- NHS Greater Glasgow and Clyde: operating Rowanbank Clinic, which serves Health Boards in the West of Scotland.
- NHS Lothian: operating the Orchard Clinic, which serves Health Boards in the South and East of Scotland.
- NHS Tayside: operating Rohallion Clinic, which serves Health Boards in the North of Scotland.

Response

To gain a comprehensive understanding of existing regional agreements, each region's medium secure service was requested to provide information on their Service Level Agreements (SLAs). At the Advisory Group meeting in November, Rowanbank Clinic confirmed that they have several SLAs in place covering the West of Scotland. In contrast, Rohallion Clinic and Orchard Clinic reported having no formal arrangements.

Following this, additional information was requested from each medium secure service regarding their funding streams and the resultant impact on bed management and allocation within their services. Table 1 provides a summary of responses.

Table 1: Overview of Regional Agreements

Service	Health Boards/HSCP included	Funding Model
Rowanbank Clinic (Male Mental Illness)	NHS GGC NHS Lanarkshire NHS D&G NHS A&A Argyll and Bute HSCP	Based on a Risk Share Agreement with a three-year rolling average. Costs are based on fixed 10% NRAC share which the Boards pay each year, and 90% activity if they have patients within the service.
Rowanbank Clinic (National LD Service)	National Service	Based on a Risk Share Agreement with National Services Scotland. Provision for additional four beds in England which have not been used in recent years.

Rowanbank Clinic (Female Beds)		NHSGGC funded service. Out of area placements charged on a cost per case basis.
Orchard Clinic	NHS Lothian NHS Fife NHS Forth Valley NHS Borders	Previously charged on a cost per case basis, but moved to a 3-year average model as of 2023/24.
Rohallion Clinic	NHS Tayside NHS Highland NHS Grampian NHS Orkney NHS Shetland NHS Western Isles	Cost-share arrangement in place, based on historically agreed percentages. No formal Service Level Agreement in place.

During discussions, clinicians were clear during advisory group meetings that whilst many have a requirement to support beds for their regional partners, it is unlikely that regional agreements are the basis for any significant variation in referral and assessment processes and waiting list management. However, it should be noted that this model results in neither North of Scotland, nor most West of Scotland Health Boards (outwith NHSGGC) having no direct access to medium secure services for women.

As the aim of this work is to explore how we move towards greater cohesion in the delivery of secure inpatient services, it would seem appropriate to consider the broader strategic context. In May 2024, the Minister for Social Care, Mental Wellbeing, and Sport proposed establishing a *Forensic Mental Health Board for Scotland* to create a unified national approach to planning and governance. A Forensic Governance Advisory Group was formed in November 2024 to explore practical and legal pathways and engage stakeholders in developing the Board[4]. Given the potential for significant change, we propose that the issue of Regional Agreements should either be examined further by the Forensic Governance Advisory Group, or revisited after the group reports and service arrangements under the new Board are clarified.

4.5 Conflict Resolution

The letter from the Director of Mental Health indicated that feedback had been provided that not all services are content with the current conflict resolution process, suggesting that it is not quick enough and cumbersome when a service must manage increased risk.

The existing Conflict Resolution process[5] was developed in 2005 and became Scottish Government Policy in HDL(2006) 48, Annex C[6]. The process provides a mechanism for resolving clinical conflicts between forensic mental health services, aiming to assist in finding a suitable resolution within a reasonable timeframe. Over the years, refinements have been made to the process based on learning from individual cases. One example is the development of an expedited process. This differs from the full conflict resolution process as it involves only one appointed clinician (a Consultant Forensic Psychiatrist) reviewing the case and providing a recommendation. The expedited process has proven particularly beneficial when urgent decisions are required regarding patient care, though it may not be suitable for especially complex cases.

[4] Scottish Government, DL(2024)26, 4 November 2024
[5] Forensic Network, Conflict Resolution Process
[6] Scottish Executive, Health Department, HDL (2006) 48

Since the implementation of the process in 2005, there have been twelve referrals. Of these, only five progressed to Stage 3 where a decision was reached; the others were resolved at Stage 1 or withdrawn after a suitable resolution was found. Three cases utilised the full process, whilst two went through the expedited process.

In the most recent case (July 2024), the Network Office was notified on 17 July, agreement to use the expedited process was reached on 22 July, and the assessment was completed by 25 July, totalling eight days from initial contact and three days from the time the process was agreed and enacted. Timescales for cases going through the full conflict resolution process are typically longer, many taking between four and eight weeks to complete.

Response

Given the two approaches within the current Conflict Resolution process, the Forensic Network believes that existing processes are appropriate to support resolution in both urgent and non-urgent cases. However, we recognise the need to enhance awareness of the process among colleagues across all levels of security about the process and how to make a referral. Additionally, that there is an opportunity to gather more feedback and perspectives from services regarding the process. With this in mind, the Network plans to undertake a promotional effort to raise awareness of the Conflict Resolution process and establish an ongoing mechanism for services to provide feedback and share their views.

4.6 Escalation Processes

The Forensic Network was asked to specifically consider developing an escalation process that could be swiftly activated when there is agreement on the required level of security but difficulties arise in securing a bed. The Advisory Group considered the potential benefits of outlining such a process and proposed that it be based on the recently developed escalation framework designed to support timely transfers in prison-to-hospital cases.

Response

The proposed escalation process is as follows:

Step 1: Identify Concerns

- Concerns about delays in transfer due to bed availability can be identified by any individual involved in the case, but particularly referring clinicians.
- A meeting should be held amongst referring clinicians, the receiving service and representatives from others at the same level of security (e.g. medium security). Discussions should be informed by the current weekly bed position report which can be accessed via the Forensic Network office.
- The Referring Service has responsibility for leading discussions to find an appropriate bed for the patient.

Step 2: Report the Concern

- Cases of ongoing concern should be reported to the Forensic Network via:
  - Telephone: 01555 842 018
  - Email: TSH.forensicnetwork@nhs.scot

- Concerns may involve:
  - Delays in transfer due to bed availability issues
  - Complexities in individual cases

Step 3: Case Registration

- Once reported, the Forensic Network Administrator will:
  - Add the case to the Complex Case Register.
  - Escalate concerns to the Forensic Network Director through the Forensic Network Manager

Step 4: Case Management

- Cases on the Complex Case Register will be systematically managed to ensure:
  - Timely responses and advice are provided
  - Escalation to the relevant Health Board is undertaken if necessary.

Step 5: Escalation to Key Decision Maker

- If other alternatives do not resolve the case, the Key Decision Maker in the relevant Health Board area will be contacted to:
  - Explore potential solutions
  - Collaborate with stakeholders to address the delay

Step 6: Monitoring and Communication

- All complex cases and escalations will:
  - Be monitored by the Forensic Network
  - Be reviewed upon closure for any learning that can be taken forward
  - Have advice and outcomes shared with the Forensic Network Inter-Regional Group

To implement this process, confirmation and support from the Scottish Association of Medical Directors (SAMD) would be required, along with the identification of Key Decision Makers. We would also highlight that whilst the Forensic Network can facilitate and support this process, the responsibility for decisions and actions ultimately rests with individual Health Boards.

The Advisory Group strongly endorsed an "informal first" approach, emphasising improved communication between services to prevent unnecessary formal escalations. It was also noted that the existence of an escalation process does not imply all cases should automatically be referred to it. The process intentionally avoids strict timescales for determining when a case is considered “delayed,” recognising that certain referrals, such as those involving women referred to Rampton Hospital, may be inherently lengthy. In such instances, clinical judgment should guide whether concerns warrant escalation.

While urgency is acknowledged in cases requiring transfer to a higher level of security, it is anticipated that services will, in most circumstances, temporarily maintain patients to facilitate the transfer process. This approach is contingent on sufficient capacity within services, highlighting the need for long-term measures to expand and enhance the overall capacity of the forensic estate.

4.7 Prison to Hospital Transfers

Scottish Government highlighted that the routine sharing of information when an individual is awaiting admission to hospital is a critical aspect that needs to be addressed across all medium secure services. A specific case was highlighted in which a medium secure unit was unaware that there were individuals awaiting assessment in prison. The Network were asked to consider how services know about referrals within the prison system and whether communication needs to be improved.

In 2023, issues with delays in transferring individuals from prison to forensic mental health services in Scotland were highlighted by both the Minister for Social Care, Mental Wellbeing and Sport and the HM Chief Inspector of Prisons for Scotland. It was considered that these delays affect not only the individuals awaiting transfer but also place additional strain on prison staff. In response, the Forensic Network initiated a series of actions, including improved data collection, mapping the referral process, establishing a 'Problematic Case Register' to log and track cases experiencing delays, and implementing a formal escalation protocol.

A key component of the response was the structured escalation pathway. Each NHS Health Board has designated a 'Key Decision Maker' (KDM) responsible for addressing and resolving significant delays or obstacles within their area. Key Decision Makers are only involved after all standard avenues for resolution have been exhausted. A formal guidance document detailing the improvements has been drafted and is pending final approval from the Scottish Government.

In addition to this work, in October 2024, the Forensic Network introduced a summary of the number of cases in prison awaiting assessment or admission to forensic inpatient services as part of the weekly bed position report. This report, shared with representatives from all services, offers a regular snapshot of the volume of known referrals from prisons to forensic services and the specific services they are intended for.

Response

The Advisory Group agreed that access to data on current prison referrals is a valuable tool for improving communication. In relation to the escalation process (see section 4.6), the group recommended regular informal meetings between services when bed availability becomes an issue. These meetings would serve to ensure services remain informed about individuals awaiting transfer from prison and to collaboratively identify solutions. Discussions would include a review of bed availability and individuals on each service's waiting list.

The group anticipated that this approach, alongside the publication of the *Guidance for Transfers from Custodial Settings to Mental Health Services*, would effectively address communication challenges.

Additionally, the Forensic Network's oversight of Complex Case and Problematic Case Registers would support learning, enable evaluation of communication practices, and help identify potential issues early should the proposed measures prove insufficient.

4.8 Inter Regional Group (IRG) Representation

The Forensic Network Inter Regional Group (IRG) is an operational group which was established to foster collaboration across the Network, serving as a bridge between the strategic and policy direction set by the Forensic Network Advisory Board and the practical, clinical operations within forensic services.

The IRG is responsible for overseeing patient flow across the forensic estate and guiding national developments within services. It provides an opportunity for developing a joined-up approach to operational issues and addressing emerging challenges in forensic mental health services in Scotland. The group actively monitor transfer lists from high and medium secure services through the Forensic Way Forward process and review complex cases, ensuring referral to the Conflict Resolution process, where appropriate.

Membership of the IRG was structured to align with the regional framework of territorial Health Boards (West, North, and South & East Regions). Each region is represented by a Regional Clinical Lead, typically drawn from the region's medium secure unit, alongside a general manager (or equivalent). Additionally, representation is included from The State Hospital, which serves as the national high-secure service. In 2024, membership was expanded to include representatives from Foxgrove, the National Secure Adolescent Inpatient Service.

At its August 2024 meeting, the IRG recognised the need to enhance communication with colleagues working in low secure services across Scotland. While two of the medium secure services operate low secure facilities within their respective Health Board areas, there remains a risk that the unique challenges faced by low secure services in specific geographic regions are not adequately represented. These facilities often face issues such as bed availability, delays in patient transfers, and resource allocation, which can be difficult to communicate effectively without a voice in the meeting. This concern aligns with the request outlined in the letter from the Director of Mental Health, urging the Network and IRG to explore ways to provide low secure and community services with a stronger voice within the group.

There is broad agreement from stakeholders that given the changes to the configuration of the forensic estate over the past 15 years, it would be beneficial to extend membership of the IRG to reflect services at all levels of secure care.

Response

In November 2024, the advisory group and the IRG considered several options regarding membership restructuring. It was deemed essential to balance the need for representation from all levels of security with maintaining a concise and focused membership to ensure the group remains agile and operationally effective. Ultimately, the decision was made to restructure IRG membership to include both a clinical and a managerial representative from each Health Board and national service (e.g., The State Hospital and Foxgrove). These

representatives will be responsible for representing all levels of secure forensic services within their respective areas, not solely the services in which they are directly involved.

The Forensic Network will compile a list of services within each Health Board and send invitations to prospective representatives in early 2025. Alongside these invitations, a clear outline of the remit and responsibilities associated with representing the Health Board at the IRG will be provided.

The IRG is scheduled to review its Terms of Reference in May 2025. This review will be particularly significant in light of the changes to membership structures.

5. Plan – Summary of Actions and Timescales

Action	Owner	Proposed Timescale
Referral Guidance – Referral short-life working group to review and update 2019 Guidance on Patient Referral to or within Scottish High and Medium Secure Services. Consideration to be given to inclusion of low secure services within guidance.	Forensic Network / SLWG Members	Oct – March 2025 (subject to amendment)
Waiting Lists – Referral short-life working group to consider use of SPJ tools to support admission decisions and promote consistency in waiting list management practices.	Forensic Network / SLWG Members	Oct – March 2025 (subject to amendment)
Waiting Lists – Amendment to be made to the Weekly Bed Position to more accurately capture current location of individuals on waiting lists.	Forensic Network	w/c 16th December 2024
Multiple Assessments – Agreement on strengthening of Link Clinician role.	Forensic Network / Multiple Assessments Subgroup	End January 2025
Multiple Assessments – Development of referral template for use across services.	Forensic Network / Multiple Assessments Subgroup	End January 2025
Conflict Resolution – Conflict Resolution processes to be widely promoted across clinicians at all levels of security. Feedback mechanism to be provided to ensure clinicians can share views on the existing process.	Forensic Network	January 2025
Escalation Process - Proposed escalation process to be discussed with the Scottish Association of Medical Directors (SAMD) and agreement reached for a Key Decision Maker for each Health Board.	Forensic Network / NHS Health Boards	February 2025
Inter Regional Group Representation – Health Board representatives to be identified and invited to join IRG to represent forensic services in their area. Outline of remit and responsibilities to be provided.	Forensic Network / NHS Health Boards	February 2025

6. Conclusion

This report provides a work-in-progress update on efforts to address capacity and patient flow challenges within Scotland's forensic mental health services, following the Director of Mental Health's request in September 2024. While it outlines progress to date, it is important to note that further actions will be required to fully address these complex issues. We anticipate that the work of the Referral Short-Life Working Group will play a crucial role in achieving greater consistency, reducing variation, and fostering cohesion across services.

Actions such as the proposed escalation process, the development of a shared referral template, promotion of the conflict resolution process and the widening of Inter Regional Group membership will all support a more efficient system. However, the short timescales for this work limits the scope for more comprehensive solutions, emphasising the need to balance urgency with realistic capacity of stakeholders across the estate. The request was to focus on improving access to services at medium secure services in particular, however the reduction in beds at the Orchard Clinic and limited capacity and staffing challenges within Rohallion Clinic are key factors impacting on capacity at this level of security. These issues cannot be fully addressed through streamlining processes. In order to achieve sustainable improvements, systemic issues require to be addressed, including staffing shortages and insufficient bed capacity in certain geographical areas, through long-term strategic planning and investment.

As the forensic estate transitions towards unified governance under the proposed Forensic Mental Health Board for Scotland, opportunities to further streamline processes, standardise practices, and enhance collaboration must be leveraged. The continued engagement of all stakeholders, combined with a commitment to providing adequate resources, will be essential to ensuring responsive and patient-centred forensic mental health services for Scotland.

Appendix 1: Attendees at Advisory Group Meetings

Meeting 1

05.11.24

Lindsey Bailie	General Manager	NHS Tayside
Dr Daniel Bennett	Consultant Forensic Psychiatrist	NHS Grampian
Dr Dawn Carson	Clinical Director	NHS Ayrshire & Arran
Dzidzai Chipuriro	Clinical Services Manager	NHS Lothian
Lianne Conville	Clinical Nurse Manager	NHS Forth Valley
Dr Jana de Villiers	Clinical Lead for Intellectual Disabilities	Forensic Network
Dr Rona Gow	Clinical Director	NHS Greater Glasgow & Clyde
David Hamilton	Social Work Manager	The State Hospital
Dr Mohammad Hussain	Locum Consultant Forensic Psychiatrist	NHS Fife
Claire Lamza	Executive Director, Nursing	Mental Welfare Commission for Scotland
William Lauder	General Manager	NHS Ayrshire & Arran
Dr Callum MacCall	Principal Medical Officer	The Scottish Government
Iain MacKenzie	Service Manager	NHS Lanarkshire
Stacey Malaney	Clinical Nurse Specialist	Surehaven Glasgow
Karen McCaffrey	Director of Nursing, AHPs and Operations	The State Hospital
Patricia McGuiness	Bed Manager	NHS Ayrshire & Arran
James Meade	General Manager	NHS Greater Glasgow & Clyde
Nicola Paterson	Forensic Mental Health Policy Lead	The Scottish Government
Dr Pradeep Pasupaleti	Consultant Forensic Psychiatrist	Priory Group
Dr Gavin Reid	Principal Medical Officer	The Scottish Government
Fraser Ross	Interim Clinical Service Manager	NHS Fife
Dr Stuart Semple	Consultant Forensic Psychiatrist	NHS Dumfries & Galloway
Dr David Walsh	Consultant Forensic Psychiatrist	NHS Tayside

Meeting 2

03.12.24

Dr Daniel Bennett	Consultant Forensic Psychiatrist	NHS Grampian
Ross Cheape	Service Manager	NHS Forth Valley
Dr Jana de Villiers	Clinical Lead for Intellectual Disabilities	Forensic Network
Dr Rona Gow	Clinical Director	NHS Greater Glasgow & Clyde
David Hamilton	Social Work Manager	The State Hospital
Claire Lamza	Executive Director, Nursing	Mental Welfare Commission for Scotland
William Lauder	General Manager	NHS Ayrshire & Arran
Dr Callum MacCall	Principal Medical Officer	The Scottish Government
Iain MacKenzie	Service Manager	NHS Lanarkshire
Karen McCaffrey	Director of Nursing, AHPs and Operations	The State Hospital
James Meade	General Manager	NHS Greater Glasgow & Clyde
Dr Pradeep Pasupaleti	Consultant Forensic Psychiatrist	Priory Group
Dr Gavin Reid	Principal Medical Officer	The Scottish Government

Appendix 2: Referral SLWG Terms of Reference

Guidance on Patient Referral to or within Scottish High and Medium Secure Services

Terms of Reference

Chair: Dr Daniel Bennett (Consultant Forensic Psychiatrist, NHS Grampian)

Timescales: October 2024 – March 2025

1. Background

In 2010, the Forensic Network published the "Admission Criteria to Scottish High and Medium Secure Units." Following significant changes in service configuration and legislation, this document was updated in 2019 and renamed "Guidance on Patient Referral to or within Scottish High and Medium Secure Services."

The updated guidance serves as a clinical consensus within the Medium and High Secure Estate, intended to support but not replace clinical judgment in individual cases or appropriate liaison between colleagues. It does not offer an inflexible set of criteria for each security level; rather, it provides a supporting framework to assist clinical teams. The guidance aims to enhance clarity in correlating the level of risk with the appropriate level of security. As a guiding principle, the needs of the patient and the risks they present are considered paramount.

The Guidance document was scheduled for review in 2022. However, in February 2021, an Independent Review into the Delivery of Forensic Mental Health Services was published. The Chair of the Review made 67 recommendations, the foremost of which proposed significant changes to the strategic planning and governance of forensic mental health services in Scotland. Consequently, it was agreed to postpone the review of the Guidance document until the outcomes of the Independent Review were fully decided.

In May 2024, the Inter Regional Group discussed and agreed that further postponement of the review of the Guidance was no longer feasible. It was acknowledged that during this review process, there may be announcements related to the structure and governance of forensic services or developments in high secure care for women, but the work should be progressed regardless.

2. Objectives

- Review the existing 'Guidance on Patient Referral to or within Scottish High and Medium Secure Services' document
- Identify issues and gaps, highlighting areas that need improvement or updating
- Discuss and reach a consensus view on the use of Structured Professional Judgement tools to support admission decisions (e.g. DUNDRUM Toolkit)
- Develop a revised Guidance Document

3. Membership

The group will be chaired by Dr Daniel Bennett (Consultant Forensic Psychiatrist, NHS Grampian). Membership will include a maximum of two representatives from each high and medium secure service in Scotland. Representation will also be sought from a representative from Rampton Hospital Women's Service, Forensic Network Clinical Leads and the Network Manager.

- The State Hospital
- Rowanbank Clinic
- National ID Service
- Orchard Clinic
- Rohallion Clinic
- Foxgrove NSAIS
- Rampton Hospital, Women's Service Lead
- Clinical Lead for Intellectual Disabilities
- Clinical Lead for Women
- Clinical Lead for Serious & Violent Offenders
- Forensic Network Manager

4. Working Arrangements

Meetings will be held monthly via Microsoft Teams, with flexibility to schedule additional meetings as required. Secretariat support will be provided by the Forensic Network office. Meeting papers will be circulated no later than 5 days in advance of meeting dates.

In addition to attending meetings, members may be expected to obtain feedback from colleagues within their services in order to progress the work of the Group. Members should expect that some of this work will take place outwith meetings.

W/c 03 February 2025	High Secure		Medium Secure							Low Secure															Private Sector			
	TSH Male MI	TSH Male LD	Orchard Clinic Male	Orchard Clinic Female	Rohallion Male	Rowanbank Male	Rowanbank Female	National LD Male	National LD Female	Beckford Lodge Male	Beckford Lodge Mixed Forensic Rehab	Bellsdyke Male	Bellsdyke Female	Leverndale Male	Leverndale Female	Leverndale Male LD	Rohallion Male	Blair Unit Male (as at w/c 20.01.25)	Blair Unit Female (as at w/c 20.01.25)	Stratheden Male (as at w/c 27.01.25)	Woodland View Male	Kirklands Hospital Mixed ID	Lynebank Male ID (as at w/c 27.01.25)	Strathmartine Male ID	Ayr Clinic Male	Ayr Clinic Female	Surehaven Male	Surehaven Female
Bed capacity	108	12	30	2	31	56	6	8	4	15	12	12	6	38	5	8	24	32	2	12 (2 beds in lodge)	8	2	10	8	36	20	15	6
No. of beds in use	86	15	30	2	28	50	4	6	2	15	12	9	4	38	4	8	18	36	3	11	7	1	8	8	35	20	15	6
No. empty beds	9	-3	0	0	3	6	2	2	2	0	0	3	2	0	1	0	6*	0	0	1 (in lodge)	0	1	2	0	1	0	0	0
No. available beds	9	0	0	0	1 rehab/1 admission	3 rehab	2	0	0	0	0	2	2	0	1	0	4	0	0	0	0	0	2 Regional	0	0	0	0	0
No. on waiting list for access to service	0	0	4	0	1	1	0	3	0	0	0	1	0	26	0	1	1	1	0	3	1	2	0	0	4	4	0	0
Current location of individuals on waiting list for access to service	NA	NA	1 x prison, 2 x TSH & 1 x Rehab ward in England	N/A	1 x TSH	1 x medium secure	N/A	TSH, Community & NHS Lanarkshire	N/A	N/A	0	1 x medium secure	N/A	Rowanbank & OOA		1 x private sector	1 x medium secure	1 x medium secure	N/A	1x IPCU, 1x private sector, 1x medium secure in England	1 x medium secure	2 x medium secure	N/A	N/A	2 x IPCU, 1 x acute & 1 prison	2 x acute, 1 x IPCU & 1 x low secure	N/A	N/A
No. on waiting list currently placed out of area	0	0	1	0	0	1	0	0	0	0	0	0	0	18	0	1	0	1	0	2	0	2	0	0	1	2	0	0
No. of patients on transfer list for lower security settings	7	1	6	1	8	10	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of patients on transfer list for higher security settings	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
No. of patients on transfer list for community or other services	0	0	4	0	0	3	0	0	0	2	0	3	0	10	2	2	9	5	0	0	1	0	4	0	4	3	1	0
No. of delayed discharges	0	0	1	0	0	1	0	0	0	2	0	1	0	2	1	1	4	5	0	3	1	0	3	0	0	0	0	0
No. of patients on transfer list fully accepted for transfer	3	1	0	0	4	13	0	2	0	0	0	0	0	9	0	0	0	0	0	0	0	1	0	0	3	4	0	0
No. of admissions in the last week	0	0	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of those admissions that were an emergency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No. of discharges in the last week	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Any foreseen potential issues this week in terms of capacity						High levels of enhanced obs and clinical acuity; 2x assessments ongoing		x1 bedroom out of commission requires major repairs	2x assessments ongoing			2 patients living in trial flat full-time, 1 patient living in trial living flat part-time	1 patient living in trial living flat full-time				* 1 bed unavailable due to outstanding repair work	These numbers include IPCU bed usage. In addition to the above we have 1 patient in adult wards	Utilising an IPCU bed for an AO patient. One other patient in a general adult ward.			Review of beds being undertaken by the service. Patient moved to beckford awaiting transfer to Rowanbank.						
Total Bed Availability Across Forensic Estate	27																											

Monitoring of Prison Transfers

No. of patients awaiting assessment/transfer from prison	4	1 x referral to Orchard Clinic; 1 x TSH, 2 x Rowanbank Clinic*
No. of cases on Problematic Case Register	2	

Bed Position Weekly Report Guidance
Bed capacity
No. of beds in use
No. empty beds
No. available beds
No. on waiting list for access to service
Current location of individuals on waiting list for access to service
No. on waiting list currently placed out of area
No. of patients on transfer list for lower security settings
No. of patients on transfer list for higher security settings
No. of patients on transfer list for community or other services
No. of delayed discharges
No. of patients on transfer list fully accepted for transfer
No. of admissions in the last week
No. of those admissions that were an emergency
No. of discharges in the last week
Any foreseen potential issues this week in terms of capacity

The number of beds the service has
The number of beds that are currently being used
The number of beds that are empty in the service (number of beds in use + number of empty beds should add up to bed capacity, if not please explain in foreseen potential issues)
The number of beds that are available for use (this may not be the number of beds that are empty e.g. due to damages, booked beds for patients on the waiting list etc.) Any issues affecting the number of beds
The number of patients on the waiting list for access to the service
The current location of individuals on the waiting list for access to the service (e.g. high/medium/low secure,
The number of patients who are on the waiting list but are currently accessing out of area beds in another
The number of patients on the waiting list for transfer to conditions of lower security
The number of patients on the waiting list for transfer to conditions of higher security
The number of patients on the waiting list for discharge back to community or other services
The number of patients clinically ready for discharge but cannot leave hospital e.g. due to bed availability,
The number of patients who have been referred and fully accepted by service referred to
The number of patients that have been admitted in the last 7 days
The number of patients who were admitted as an emergency rather than a planned admission
The number of patients that have been discharged in the last 7 days
Any foreseen challenges relating to bed use within your service over the coming week. (For example, reasons as to why admissions cant take place despite empty beds; staffing problems; beds closed for repairs; delays

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Head of Clinical Quality Corporate Planning Support Manager Clinical Quality Facilitators
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1. SITUATION

This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting. The report highlights activities in relation to Quality Assurance (QA) and Quality Improvement (QI) outlining how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital (TSH) to embed quality assurance and improvement as part of how care and services are planned and delivered.

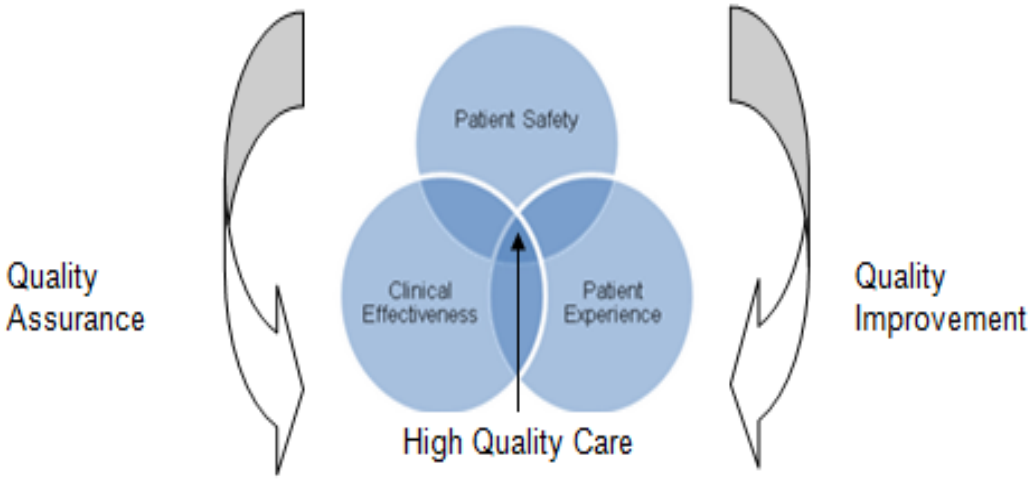
2. BACKGROUND

Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2024 – 2029. This strategy was presented to TSH Board in August 2024 and adopted as TSH current strategy to progress clinical quality. The Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. The vision for the outcome of this Strategy is to improve the experiences of care and health provided to our patients by working together to deliver quality care and support that is person centred and free from harm**.** It outlines the following aims to ensure the organisation remains focussed on delivering our quality vision.

With our quality vision aims being to:

- Deliver safe, effective and person-centred care based on available evidence and best practice.
- Achieve demonstrable improvements in outcomes including the patient experience.
- Demonstrate meaningful involvement of patients, carers, volunteers and all other stakeholders* in quality assurance and improvement activities.
- Provide assurance to Scottish Government and stakeholders, around safe systems and continuous improvement to quality of care whilst addressing any health inequalities in our patient population.
- Develop a culture of ongoing learning and continuous improvement.

TSH quality vision is to deliver and continuously improve the quality of care through the provision of safe, effective and person-centred care for patients.



3. ASSESSMENT

The paper outlines key areas of quality improvement and assurance activity over the reporting period, these include:

- The monthly report from the analysis of variance analysis tools and completion of three clinical audits:
    - RMO Contact with patients Audit.
    - Unvalidated Progress Notes Audit.
    - Nursing Progress Note per Shift Audit.
- An update on the work of the QI Forum including current training in progress for Q4 and TSH3030 proposal.
- An update on the actions associated with the Realistic Medicine portfolio.
- An overview of the evidence for quality including analysis of the national and local guidance and standards recently released and pertinent to TSH.

4. RECOMMENDATION

The Board is asked to note the content of this paper.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The quality improvement and assurance report support the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QA and QI.
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Not formally assessed for this paper.
Route to Board (Which groups were involved in contributing to the paper and recommendations)	This paper reports directly to the Board. It is shared with the QI Forum
Risk Assessment (Outline any significant risks and associated mitigation)	The main risk to the organisation is where audits show clinicians are not following evidence-based practice.
Assessment of Impact on Stakeholder Experience	It is hoped that the positive outcomes with the service level reports will have a positive impact on stakeholder experience as they bring attention to provision of timetable sessions.
Equality Impact Assessment	All the policies that are audited and included within the quality assurance section have been equality impact assessed. All larger QI projects are also equality impact assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This will be part of the project teamwork for any of the QI projects within the report.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN TSH DECEMBER 2024/JANUARY 2025

ASSURANCE OF QUALITY

Clinical Audit

The Clinical Quality Department carries out a range of planned audits. Over the course of a year there are usually 21-25 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group.

There have been 3 audits completed and actioned through the Commissioning Group:

- RMO Contact with Patients
- Unvalidated Progress Notes Audit
- Nursing Progress Note per Shift Audit

Following a request from TSH Borad, the Clinical Quality Department have developed a master audit sheet (below) reflecting the outcomes of all the local audits that have recently taken place and colour coded the compliance for each ward. Green shows that improvement areas are very minimal (and they should celebrate their excellent adherence), amber shows that the ward has been given some improvements that require to be actioned and red means we have concerns that there is a system/process failure within the ward for that audit.

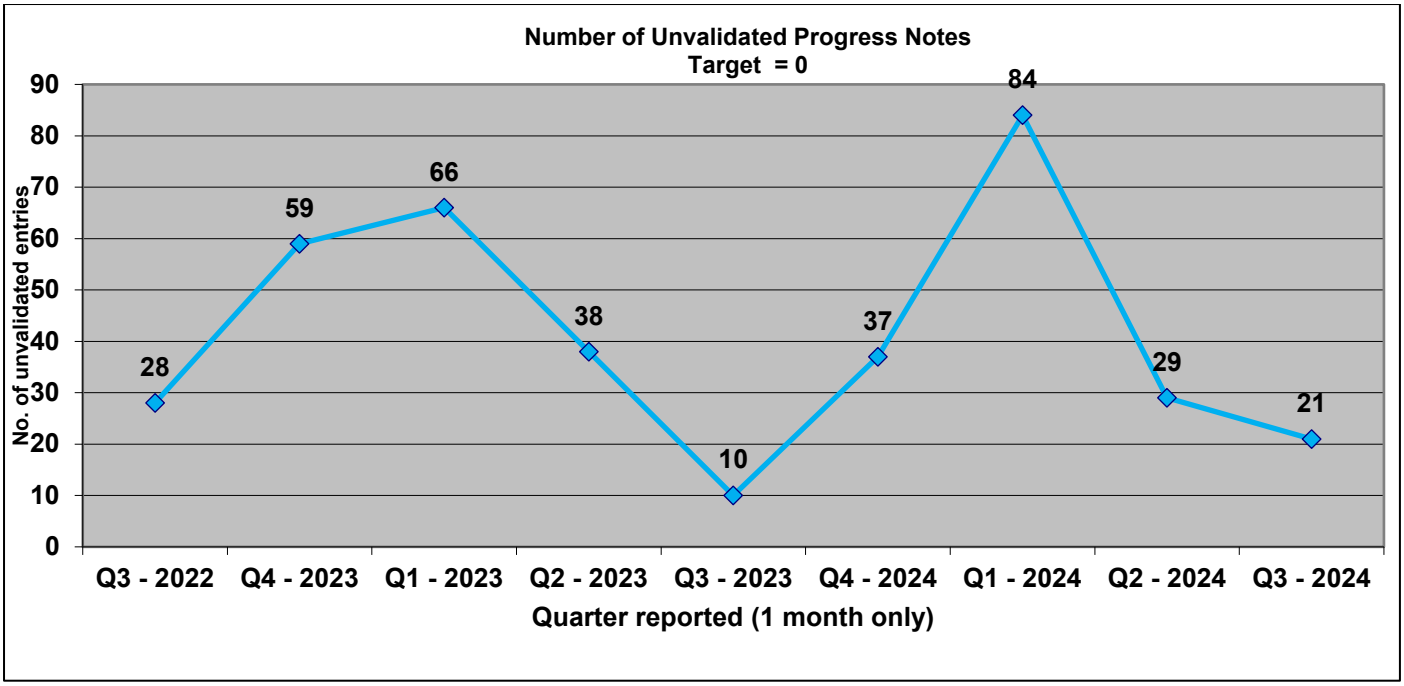
	Arran 1	**Lewis 1**	**Arran 2**	**Arran 3**	**Lewis 2**	**Lewis 3**	**Mull 1**	**Mull 2**	**Iona 1**	**Iona 2**	**Iona 3**
Medication Trolley Audit											
Medicine Fridge Audit											
HEPMA Audit											
PMVA Post Physical audit							n/a	n/a	n/a		
Unvalidated progress notes											
Nurse progress note on each shift											

RMO Contact with Patients

The hospital has a standard that all patients should be seen by their RMO at least once per month. The Q3 data gave us very good assurance that this standard is being met. Although there were 3 patients that had not been seen in December, all were seen the first week of January and all were separate RMOs.

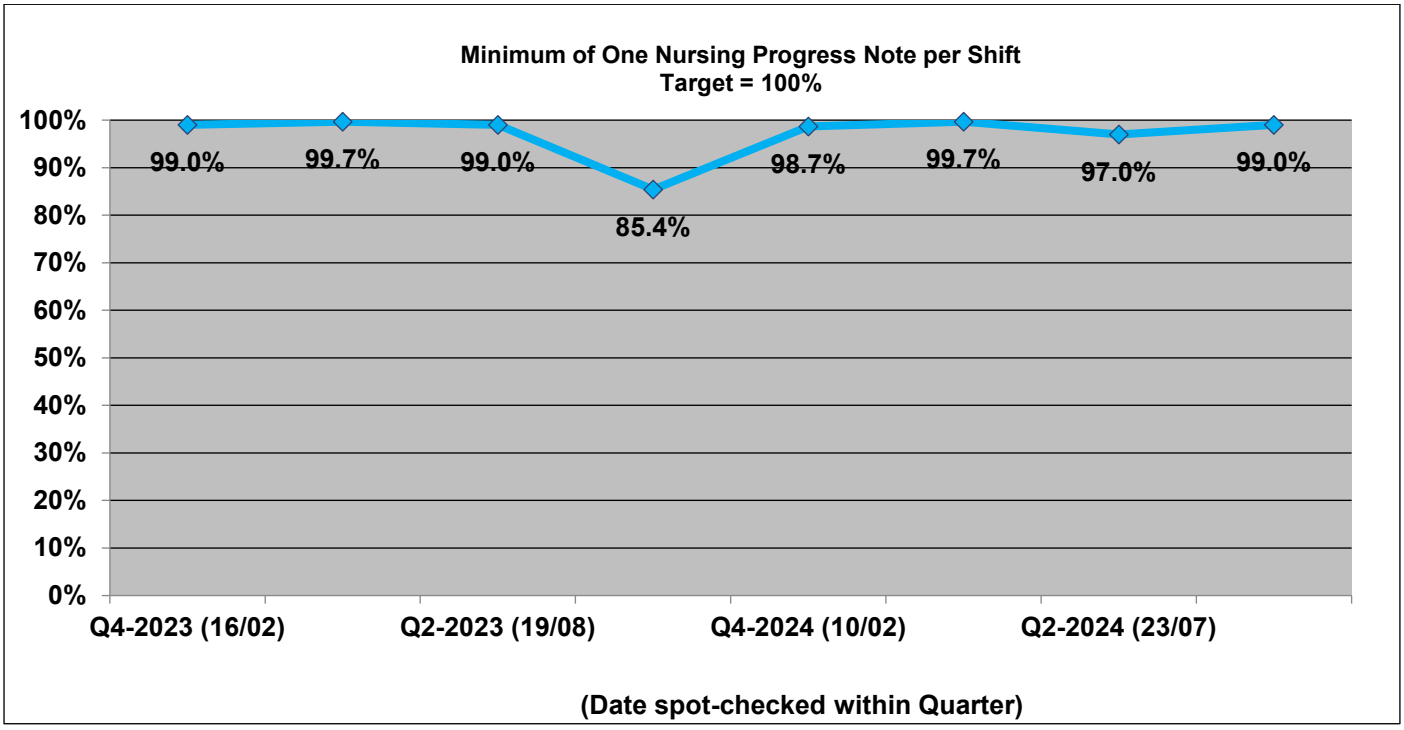
Unvalidated progress notes

The quarter 3 audit provided excellent assurance that progress notes are being validated within an acceptable timeframe. This is important to the organisation as the record is not seen as a legal entry until validated. On a monthly basis, there will be at least 9,500 progress notes made by nursing alone and this increases to approximately 11,000 when we include all other disciplines. For the month audited there were only 21 progress notes that had not been validated. This is an improvement from the previous quarter.



Nurse Progress Note per Shift

The quarter 3 audit provided excellent assurance that at least one nursing progress note for the patient is being entered on each shift. This is an improvement from the Q2 data where there was compliance of 97%. Q3 had a compliance of 99%.

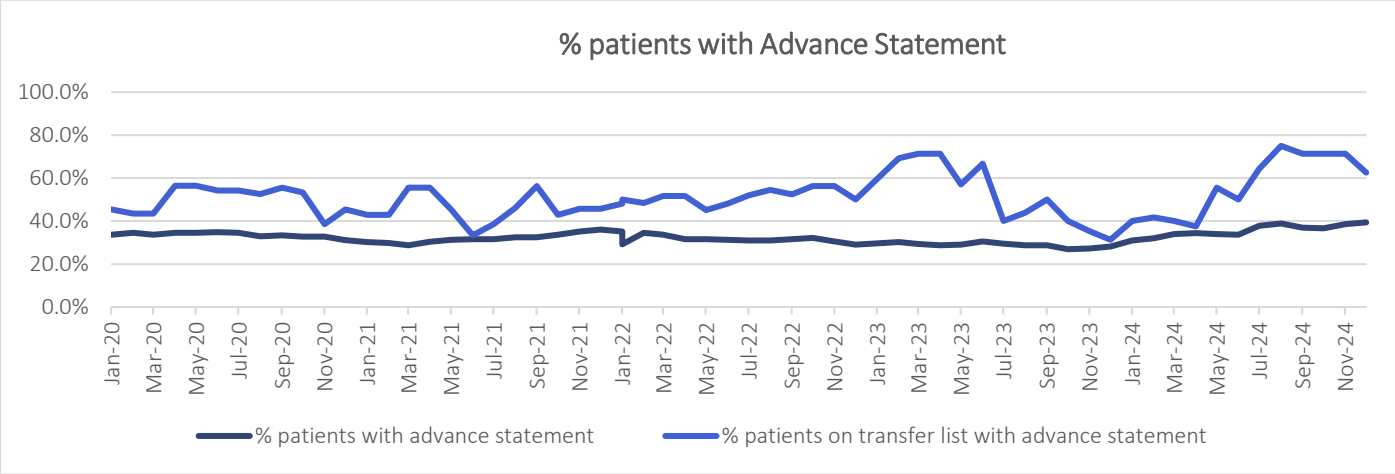


Year End data:

Patients with an Advance Statement

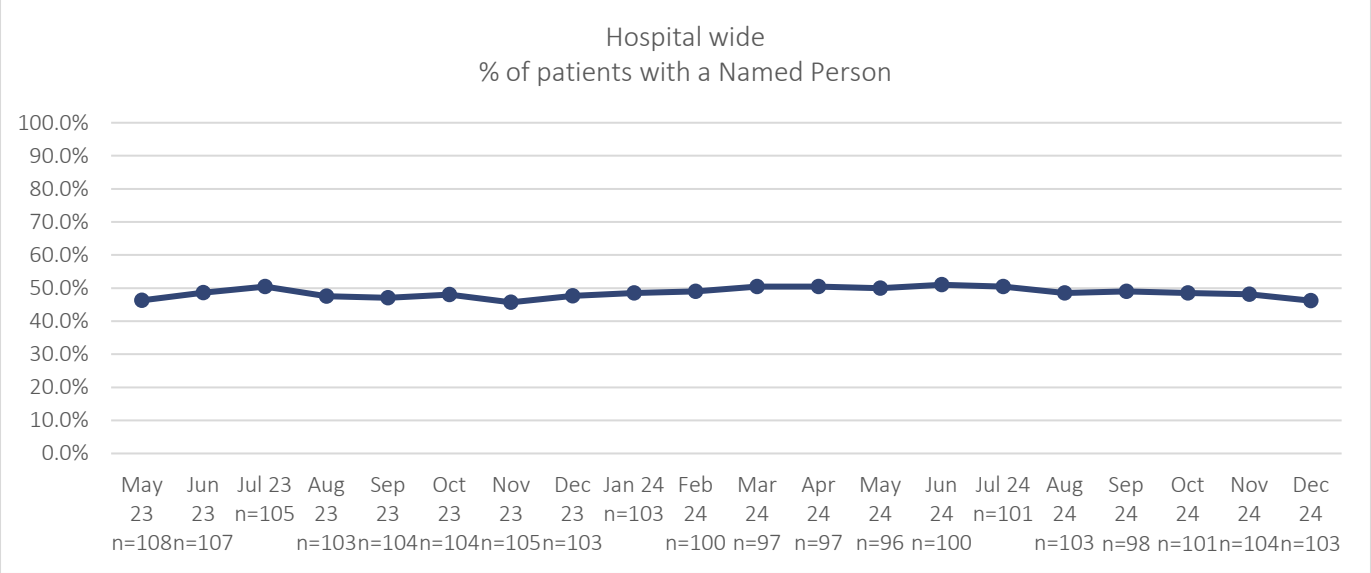
As can be seen below, we have seen improvements with the number of patients on the transfer list with an advance statement. It was agreed to prioritise this patient group so we are assured that they have an

advance statement in place as they enter the next stage of their recovery. We can see that from the end of Q1, we have sustained over 60% of patients on the transfer list having an advance statement. Advocacy remains the service that provides the most support with the advance statements. Overall, The State Hospital remains well above the national compliance of patients having an advance statement.



Patients with a named person

The number of patients with a named person has remained consistent, ranging from 46% to 51%. This is measured through the Mental Health Practice Steering Group.



Variance Analysis Tool (VAT) – Flash Reports

The most recent quarterly flash report was circulated in January 2025 and covers the period 1st October-31st December 2024. A number of improvements were noted when compared to the previous quarter.

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: Oct-Dec 2024

Overview and areas of good practice

This report refers to all annual and intermediate reviews held across the hospital in Oct-Dec 24.

The quarterly VAT report is split as follows:

Oct-Dec 24	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	1	2	3	99.2%	75% - decreased from 79% in previous quarter
Arran T & R	2	7	9	96.4%	83% - increased from 62% in previous quarter
Lewis T & R	7	3	10	100%	76% - increased from 64% in previous quarter
ID	5	4	9	99.6%	86% - increased from 81% in previous quarter
Transition	4	5	9	99.3%	64% - increased from 58% in previous quarter
Total	19	21	40	97.7%	77% - increased from 65% in previous quarter

In addition, data on individual Admission CPAs and Discharge CPAs will be reported to the appropriate service.

VAT form completion was excellent at 99.7% and increase from 98.4% in Jul-Sept 24.

Medical - There was improvement in all Medical interventions based mainly on improved VAT form completion - Medical completion increased from 91% in Jul-Sep 24 to 100%.

Nursing – Key worker/Associate worker attendance increased from 65% to 70% this quarter – still short of the 80% KPI target. Patient attendance increased from 53% to 80%.

Occupational Therapy – There was an improvement in all Occupational Therapy interventions – this coincided with new staff being appointed.

Skye Activity Centre – Provision of the Skye Activity Centre report increased from 82% to 100%.

Pharmacy - Provision of Pharmacy report was 100%

Social Work – all interventions continue at a good level

Dietetics – Dietetic attendance at Annual Reviews increased from 57% to 74%
Areas of concern
Nursing – Discussion of the report with the patient prior to the review decreased from 90% to 85%. Occupational Therapy - There is no dedicated Occupational Therapist in the Transition Service. Psychology – Discussion of the report with the patient prior to the review decreased from 96% to 79%.
Any challenges with the systems that are being addressed
None at present

QUALITY IMPROVEMENT

QI Forum

The QI Forum continues to meet on a 6 weekly basis focusing on its purpose to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. A significant area of leadership and planning for the QI Forum is the development and co-ordination of TSH3030

TSH3030

TSH3030 (pronounced “TSH thirty thirty”) is a simple idea, designed to engage staff and patients and remove barriers to improvement. Teams are invited to form and suggest an improvement proposal that they will then spend 30 minutes a day for 30 days testing their ideas. It is accessible, engaging, fun and effective. The QI Forum successfully ran two iterations of its TSH3030 initiative, in November 2018 and November 2019. In November 2018, 23 teams, over 100 staff and 30 patients took part in the first TSH3030. In November 2019, participation grew to 38 teams, 146 staff and 64 patients all actively involved in improvement work. TSH3030 had positive impact on staff and patent engagement and demonstrated that change and improvement was possible across a whole range of systems and processes within TSH. Most importantly perhaps, TSH3030 gave staff and patients the confidence to share their ideas and a method to test them. It made improvement everyone’s responsibility and showed that QI can be a routine part of our daily work at TSH. TSH3030 was awarded the RCPsych Award in 2020 for Psychiatric Team of the Year: Quality Improvement. The onset of the COVID19 pandemic in February 2020 disrupted plans for a third edition of TSH3030, after that the implementation of the Clinical Model was the priority for staff resource.

The QI Forum have invested resource in developing QI capability across TSH staff groups in 2023/24 with the ambition of running TSH3030 in 2025. The QI Forum presented a paper to CMT in February 2025 to request support from CMT to lead another cycle of TSH3030 over the month of May 2025. Planning for this initiative has now commenced with TSH staff and patients being invited to consider participation in this initiative. Following evaluation of the initiative, slight changes have been made to the requirements of teams taking part to minimise the resources required to deliver this.

QI Capacity Building

QI Essential Training continues with a feedback sessions organised in March 2025, whereby participates present the on their experiences and learning through QI. QI Essentials cohort four is currently being considered with the format of the course being reviewed to allow for a more varied cohort of students.

Scottish Improvement Leaders (ScIL) training is ongoing with two members of TSH staff currently undertaking this programme as part of cohort 46/47. ScIL cohort 50 commenced in November 2024 with three staff members successfully offered a place.

Realistic Medicine
The Realistic Medicine Team have received the provisional funding offer for 2025/26 to support embedding the principles of Realistic Medicine within the State Hospital. The Realistic Medicine lead attended the Board Development Session in January 2025, where positive feedback was received and ideas generated to be included within the Realistic Action Plan for 2025/26, which requires to be submitted to the Clinical Governance Group in February 2025 then submitted to the Scottish Government in March 2025.

EVIDENCE FOR QUALITY

National and local evidence-based guidelines and standards

TSH has a robust process in place for ensuring that all guidance published and received by the hospital is checked for relevancy. If the guidance is deemed relevant this is then taken to the appropriate multi-disciplinary steering group within the hospital for an evaluation matrix to be completed. The evaluation matrix is the tool used within the hospital to measure compliance with the recommendations.

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1st November 2024 to 31st January 2025, 32 guidance documents have been reviewed. There were 22 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance and 3 documents which were circulated for information and awareness. Four evaluation matrices are required to be completed with one additional MWC report resulting in actions to be taken for Clinical Governance Group. The 2 remaining guidelines from the Mental Welfare Commission will be reviewed by the Mental Health Practice Steering Group regarding relevancy.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required	Decision pending
SIGN	2	0	2	0
Mental Welfare Commission (MWC)	4	1	1	2
Healthcare Improvement Scotland (HIS)	2	1	1	0
National Institute for Health & Care Excellence (NICE)	24	1	1	0

There are currently four additional evaluation matrices which have been outstanding for a prolonged period. The Scottish Government document regarding substance use is tabled at the next MHPSG meeting for final agreement and sign of whilst the evaluation matrix process to review the remaining 3 documents is currently underway.

Table 3: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
Scottish Government	Responding to substance use amongst inpatients on mental health wards – A practical guide for mental health services	Mental Health Practice Steering Group	Review group met twice with draft evaluation matrix currently out for review. Ongoing issues re availability delayed finalising content. Tabled for MHPSG in February 2025 for final agreement	April 2024	February 2025
Scottish Government	Quality prescribing for antidepressants –	Medicines Committee	Review group met early January 2025. Identified the need to	August 2024	April 2025

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
	A guide for improvement 2024-2027		complete some further work to ensure members are fully informed prior to making a final decision re 2 recommendations.		
Scottish Government	Quality prescribing for Benzodiazepines and z-drugs – A guide for improvement 2024-2027	Medicines Committee	Gap analysis review group meeting in February 2025 to begin completion of evaluation matrix	August 2024	April 2025
HIS	Ageing and frailty standards for the care of older people	Physical Health Steering Group	Ongoing issues re availability of review group members. First meeting took place early February 2025 with another date set later in the month. Meetings arranged with 2 members who could not attend either review group to ensure multidisciplinary inclusion.	November 2024	April 2025

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE **CGC(M) 24/04**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 14 November 2024.

This meeting was conducted virtually by way of MS Teams and commenced at 09.30am.

Chair:	
Vice Board Chair	David McConnell
Present:	
Non-Executive Director	Pam Radage
In attendance:	
Health Psychologist	Alison Eadie [For Item 9]
Skye Centre Manager	Jacqueline Garrity [For Item 10]
Social Work Mental Health Manager	David Hamilton [For Items 6-7]
Acting Director of Estates and Resilience	Allan Hardy
Head of Psychology	Dr Liz Flynn
Chief Executive	Gary Jenkins
Senior Nurse Infection Control	Jonathan Lee [Item 11]
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Director of Nursing and Operations	Karen McCaffrey
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Head of Corporate Governance	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Professor Lindsay Thomson
Consultant Psychiatrist	Dr Gordon Skilling
Consultant Psychiatrist	Dr Khuram Khan [For Items 8-9]

1 APOLOGIES AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting and noted apologies from Mr Stuart Currie, Non-Executive Director and Ms Shalinay Raghavan, Non-Executive Director. It was noted that the Chair of the committee, Ms Fallon, was unable to attend the meeting today, and that the committee agreed that Mr McConnell would chair the meeting in her absence. Further, that Ms Radage was co-opted to join as a member for this meeting, and that on this basis the meeting would be quorate.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business on the agenda.

3 TO APPROVE THE MINUTES OF PREVIOUS MEETING

The committee approved the minute of the previous meeting held on 8 August 2024.

The Committee:

1. Approved the minute of the meeting held on 8 August 2024.

4 MATTERS ARISING / ROLLING ACTIONS LIST

The committee noted that there were no matters arising from the previous meeting.

In relation to the rolling action list the committee received the following updates:

- Action point 1 - Mr Jenkins noted that the work had been concluded on Skye Centre building in relation to the water leaks with a period of monitoring and evaluation being place. This action could be closed but should there be any further faults impacting on infection control, this would be notified to the committee.
- Action point 6 - Professor Thomson advised the committee that there has been a decrease in the number of incidents being considered to be Duty of candour (DOC) potentially, but then an increase in the number agreed to fall within the definition. Professor Thomson assured the committee that this is reported through the Corporate Management Team (CMT). It was agreed that this action could be closed on this basis.
- Action point 7 – Mr McNaught informed the meeting that discussion is still on going with Edinburgh University therefore, this will remain on the rolling action list.
- Action point 8 – Ms Merson noted that an information leaflet is being drafted to feed into staff inductions to raise awareness of the Quality Strategy, and an update would be brought to the next meeting.

The Committee:

1. Noted the updates from the Rolling Actions List.
2. Agreed to close Action point 1 following satisfactory conclusion.
3. Agreed to close Action point 6 following satisfactory conclusion.

5 CARER STRATEGY 2024/2027

The committee received the Carer Strategy 2024-2027 from the Director of Nursing and Operations. Ms McCaffrey led the committee through the detail of the strategy, highlighting its aims and objectives. She also outlined the process undertaken to develop the strategy, through the Person-Centred Improvement Group through a short life working group and taking into consideration the Carers (Scotland) Act 2016, and guidance from Scottish Government. She detailed the key priorities of the strategy including the Triangle of Care self-assessment tool and the work progressed to date to take on board feedback from carers.

Mr Moore thanked Ms McCaffrey and welcomed the work undertaken, which placed the State Hospital (TSH) in a good place. He noted that the development of the Family Centre during the Covid-19 pandemic, had led to positive improvements in the visitor experience, and that this should be recognised. He also enquired as to how often carers would be asked to complete feedback questionnaires, and Ms McCaffrey confirmed that there would be on-going communication with carers to obtain their views and feedback.

Mr Moore welcomed the work with the Forensic Network and asked if this strategy would be shared with other partner organisations. Ms McCaffrey confirmed that this would be shared with relevant partners e.g. Patient Advocacy Service, as well as through the National Carer forum. Mr Jenkins added that this would also be helpful through the wider forensic estate.

In response to a question from Ms Merson on monitoring the impact of the strategy, Ms McCaffrey advised that the delivery plan would encompass this, and that this would include a review of the impacts of the strategy in 12 to 18 months' time.

Professor Thomson thanked Ms McCaffrey and noted that this Strategy will place TSH in a good position in the context of the expected change in governance for forensic services nationally.

Although the strategy required to be specific to TSH, there were also benefits from a wider view for the forensic estate as a whole.

Ms Radage commented that the Carers Strategy was helpful and easy to read. She remarked on the number of responses received from carer questionnaires and asked about future engagement with the respondents, as it would be important to show how the feedback had been used to develop the strategy. She noted that a low number of respondents had identified themselves as carers; and asked what more could be done to build understanding of this role and the contribution made. Ms McCaffrey confirmed that there would be engagement with all carers to communicate the main themes raised within the questionnaires and what is being done in relation to these points. She agreed that there could be complexity in relation to the roles of the family members and how they see themselves, adding that help should be given to allow carers to recognise that they have an opportunity to be part of the work carried out by TSH regardless of how they refer to themselves.

Mr McConnell thanked Ms McCaffrey and committee members for the discussion and input. He added that, with the addition of remarks made by Mr Moore to add in more information regarding the Family Centre, the committee was content to endorse the Carer Strategy 2024-2027.

The Committee:

1. Agreed the content of Carer Strategy 2024-2027 and recommended that this should be submitted to the Board for formal approval.

6 CPA / MAPPA 12M REPORT

Members received the CPA/MAPPA 12 monthly report. Professor Thomson highlighted that this report focused on the transfer discharge Care Programme Approach (CPA) documentation and procedures. Mr Hamilton joined the meeting and presented the report, noting key areas and leading the committee through the detail in terms of each. He highlighted that for the fifth consecutive year there has been a 100% completion rate for transfer discharge CPAs within the Hospital.

Dr Flynn asked if consideration would be given to highlighting the responsible authority data and information within this report. Mr Hamilton agreed that this would be considered noting that although this information was captured within other areas, it would be beneficial to have it centralised and contained within this report.

Ms Radage welcomed the increase in Advocacy attendance at CPA meetings as noted within the report. Ms Radage also asked for clarity in relation to the timing for the move between using the ViSOR system to using the new MAPPS system. Mr Hamilton explained the usage of the ViSOR and MAPPS systems for the benefit of the committee, adding that the timescale for moving to MAPPS would potentially be in 2026. Mr Hamilton confirmed that training and development in relation to MAPPS has already begun. Mr Jenkins noted the key challenge moving to MAPPS presents and the need for a higher level of vetting for members of staff who have been identified to use and access the system. Mr Jenkins noted this challenge had been identified across health and social care settings and had been escalated to the Scottish Government.

Mr McConnell thanked Mr Hamilton for the report and welcomed the 100% completion rate for transfer discharge CPA’s as good practice.

The Committee:

1. Noted the CPA / MAPPA 12 Month Report.

7 CHILD AND ADULT PROTECTION 12M REPORT

Members received the Child & Adult Protection 12 Month Report**,** which also presented an update in respect of corporate parenting within TSH. The report was presented by Mr Hamilton who summarised the content. Mr Hamilton also noted that there had been an increase in child visits over the past year; from 48 facilitated in 2023 to 89 facilitated in 2024. He noted that credit should be given to the Person-Centred Improvement Team (PCIT) for the work undertaken to accommodate the visits.

Mr Moore considered the report to be comprehensive and that it offered assurance to the committee and the Board. Mr Moore also noted the action that had been taken to review the current arrangements in relation to the United Nations Convention on the Rights of the Child (UNCRC). Dr Flynn asked if consideration should be given to include Trauma Informed Care principles when compiling child friendly materials and carrying out the child search process. Mr Hamilton concurred that is the approach that would be taken in putting together the procedures for the child search process and child friendly material and that he would link in with colleagues on this matter.

Dr Skilling queried that, given the increase in Adult Support and Protection referrals, if the threshold was correct in relation to these. Mr Hamilton noted that the increase would reflect the adjustment to and settling of the Clinical Model. Ms McCaffrey also noted that staff were encouraged to start the referral process at the earliest opportunity if they had any concerns, which may not always trigger the threshold for formal processes.

Mr McConnell thanked Mr Hamilton for the report and noted the work undertaken by the PCIT in relation to child visits.

The Committee:

1. Noted the Child & Adult Protection 12M Report.

8 PHYISCAL HEALTH STEERING GROUP 12M REPORT

Members received the Physical Health Practice Steering Group 12 Month Report. Dr Khan and Ms Eadie joined the meeting. Dr Khan presented the report and provided a fully detailed overview of the report. This included the core activity in terms of the Health Centre, nutrition and health psychology, as well as occupational therapy and quality improvement activity. He also outlined the key objectives for the coming year.

Mr Moore noted the emphasis on health promotion and welcomed further discussion on how this could be extended, and the positive impact of the Sports Leadership initiative. Mr Moore enquired if the Unscheduled Care Short Life Working Group Report would be presented to the Clinical Governance Committee. This would be important in the context of changes being made in delivery of unscheduled care nationally. Dr Khan agreed that the Unscheduled Care Short Life Working Group Report would be presented.

It was noted that there appeared to be an anomaly in admission weight data, and it was confirmed that this would be reviewed. Ms Merson noted the need to track patient BMI over time to view progress and help to give patients manageable targets. Professor Thomson provided assurance that this is tracked by the Supporting Healthy Choices Oversight Group and reported through that route. Mr Jenkins added that there was continuing review of the Key Performance Indicator (KPI) for patient BMI, and how valuable the current metric was.

Professor Thomson emphasised that it was important to note that this report provided strong assurance in terms of the high level of care patients received for their physical health needs.

Mr McConnell noted the numbers of patients taking part in some of the initiatives was relatively low

in some areas and queried the reason for this and whether the aim should be to increase this over time. Professor Thomson agreed that it would be beneficial to have more patients involved with the Healthy Living Group and more capacity to accommodate this was to be established. She added that participation in some other initiatives is based on clinical need and advised by the Senior Dietitian.

Ms Eadie concurred with Professor Thomson's points regarding the need to engage more patients with the Healthy Living Group and added that the continued development of the Health Psychology role within the hospital would enable further expansion on different kinds of interventions being offered to support patients.

The Committee:

1. Noted the Mental Health Practice Steering Group 12M Report.

9 SUPPORTING HEALTHY CHOICES 12M REPORT

Members received the Supporting Healthy Choices 12M Report and Ms Eadie provided an overview of the reporting and the progress made over the past year by the Supporting Healthy Choices Group. Ms Eadie noted the enthusiasm within the hospital towards the focus of this group and the positive collaborative multidisciplinary approach that has been taken.

Mr Jenkins expressed thanks to Ms Eadie for supporting and complimenting the Supporting Healthy Choices team, and noted the work undertaken by Ms Eadie on the Public Health England Guidance. Mr Jenkins also welcomed the data management plan contained within Appendix 2 of the report.

Mr Moore expressed surprise over the expenditure in the patients shop and welcomed the introduction of a working group to look at this issue. Mr Moore also noted the need to achieve a balance between healthy living and to give patients choice on what they wish to purchase.

Ms Radage thanked Ms Eadie for the report and concurred with points raised by Mr Moore and noted the possible linkage between the shop spend and the rise in dental interventions. Ms Eadie agreed with the point raised in terms of the patient shop spend and informed the committee that the first meeting of the Patient Shop Life Working Group had taken place. This was a collaborative group with representatives from across the hospital with the shared aim of balancing individual choice, autonomy and rehabilitation along with patient physical health.

Ms Eadie also gave the view this would be a complex task with the need to balance legislation and patient views. Professor Thomson noted her support for the Patient Shop Life Working Group, however, highlighted the need to be mindful in terms of legislation in any changes that were proposed or introduced. Professor Thomson also noted the need to remain cautious that changes to the Patient Shop may lead to unintended consequences, diverting the issues into other routes. Mr McNaught commented that helping patients focus on other areas to spend disposable income would be beneficial and how this could be achieved should be explored, with Professor Thomson agreeing to these points.

Professor Thomson also highlighted that the first meeting has been held to assess KPI's around BMI and weight targets and if any changes should be considered.

The Committee:

1. Noted the Supporting Healthy Choices 12M Report.

10 PERSON CENTRED IMPROVEMENT SERVICE 12M REPORT

Members received the Person-Centred Improvement Service 12M Report. Ms Garrity joined the meeting and provided a summary of the content of the report. This included key activities during the period October 2023 to September 2024 led through the Person-Centred Improvement Group. This included a range of workstreams, patient and carer visiting and a wide range of supportive engagement mechanisms with patients throughout this time. The report provided background and detail of the key successes, particularly the development of the Carers Strategy, and supporting the Patient Partnership Group. Ms Garrity also asked the committee to note the change made in leadership for the PCIT, which now sat under her own remit. Lastly, she described the key initiatives that were planned for the next 12 months.

Mr McConnell thanked Ms Garrity for her overview, and the detail presented by the report.

Professor Thomson asked for clarification around the number of volunteer visitors there were, and Ms Garrity confirmed that there were currently three which includes a new volunteer visitor who is presently in a Higher Education student role.

The committee noted the report, and thanked Ms Garrity and her team for their helpful contribution.

The Committee:

1. Noted the Person-Centred Improvement Service 12M Report.

11 INFECTION PREVENTION AND CONTROL REPORT Q2

Members received the Infection Control (IPC) Quarterly Report for Quarter 2. Mr Lee joined the meeting and provided the committee with an overview of the content of the report. He advised that a refreshed approach had been taken to reporting, which presented IPC activity under the headings outlined in the Health Improvement Scotland (HIS) Infection Prevention and Control Standards 2022.

Mr Lee confirmed that in terms of governance, there had been no areas which had required escalation during this quarter. He asked the committee to note the compliance rates for training across the identified staff cohorts. He detailed the work progressed within auditing, and reporting of incidents and that there had been an outbreak of Covid -19 which had been well managed, with no further concerns. Mr Lee also noted the progress made in relation to review of policies and procedures.

The committee were content to note the report, and welcomed the refreshed format, which was found to be helpful

The Committee:

1. Noted the Infection Prevention and Control Quarterly Report Q2.

12 BED CAPACITY REPORT

The committee received the Bed Capacity Report from the Medical Director, to provide a summary of capacity within TSH, as well as well as across the wider forensic estate. Professor Thomson noted that this report was in the same format as the report received regularly by the Board and covered the period 1 August to 30 September. She provided an overview of the detail in terms of patient movement, including transfers within services in TSH, and confirmed that the number of patients awaiting transfer on to a different level of security had decreased, with seven patients on the transfer list as of today's date.

Professor Thomson provided further information around the capacity across the network, with a continuation of reduced capacity within the Orchard Clinic due to the need for repair work. She

asked the committee to note that the Scottish Government had asked the Forensic Network to carry out further work on capacity across the estate. The parameters of this were detailed within reporting, with an expectation for a short turnaround for this work to be completed.

Mr McConnell thanked Professor Thomson for reporting, and the committee noted the content of the report.

The Committee:

1. Noted the Bed Capacity Report.

13 CORPORATE RISK REGISTER - CLINICAL RISKS

Members received the Corporate Risk Register - Clinical Risks report from the Acting Director of Security, Resilience and Estates. Mr Hardy presented the key points, focusing on risks MD30 related to patient obesity and ND71 relating to the utilisation of nurse resourcing and the delivery of patient care. Work was being progressed through the Supporting Healthy Choices Workstream about how to assess and monitor this risk, linked to the definition of performance data, and this would come back to the committee. In relation to ND71, work continued to be progressed on refreshing this risk assessment in the context of the recent analysis undertaken to help define staffing resourcing compared to service need. This would also return to the committee with an updated position.

Mr McConnell thanked Mr Hardy for this overview, and the committee were content to note this update.

The Committee:

1. Endorsed the Corporate Risk Register - Clinical Risks as an accurate statement of clinical risk.

14 INCIDENTS AND PATIENT RESTRICTIONS REPORT Q2

Members received a report from the Acting Director of Security, Resilience and Estates, which provided an overview of activity in this respect for Quarter 2. Mr Hardy presented the report, advising that this meant the type and number of incidents received via Datix (the incident reporting system) as well as the restrictions placed on patients for this period. He provided the committee with a high-level summary of each area of reporting. Firstly, in relation to patient restrictions, this included trend analysis, in the context of comparative stats over time. Reporting also included data in relation to patient mail and telephone calls, room searches, and use of physical restraint.

Mr Hardy asked the committee to note the reported data across all incident types, which included staff resourcing as well as security incidents. He provided the updated position in relation to the progress of outstanding Serious Adverse Event Reviews (SAERs) and noted that the committee would receive high level reporting in terms of the learning from these, rather than the reports. Reporting included a summary in respect of health and safety incidents. This included detailed analysis of assault incidents and seclusion, with further insight of how these compared across service areas. Mr Hardy also asked the committee to note the further information contained in the report in respect of resourcing, and the range of other incident types recorded.

Mr McConnell noted that previously reporting had been received by the committee for SAERs albeit in a redacted format. Professor Thomson provided assurance that the full reports were reviewed through the Corporate Management Team and that the committee would receive reporting on the learning points taken, noting that this should be included in the workplan.

Action – Secretariat

Mr Moore commented on the helpful nature of reporting, which provided detailed and comprehensive information across a wide range of areas. The committee were content to note the report.

The Committee:

1. Noted the Incidents and Patient Restrictions Report, Quarter 2.

15 LEARNING FROM COMPLAINTS AND FEEDBACK REPORT Q2

Members received the Learning from Complaints and Feedback Report for Quarter 2, from the Head of Corporate Governance. Ms Smith presented a summary of the key points of reporting, noting the change made in the reporting format which now included both complaints and feedback.

Ms Smith noted that the numbers received had reduced in this quarter, although the number of complaints raised at stage 2 of the process had increased. She acknowledged that there had been an increase in the time taken to respond to complaints, particularly at stage 2, and advised that this had been due to both the complexity of complaints raised as well as the availability of staff to provide detailed information in response. This was reflected in the types of issues that had been raised, especially around clinical treatment. These had been carefully investigated, with a view to reaching resolution in each case. She also summarised the items of feedback received during this quarter from both patients and carers, which had included a letter received from a former patient with feedback about how positive his care experience had been at TSH.

Mr Moore commented on the feedback from carers particularly around the visiting experience, and that it was interesting to see this additional information through this route, linking it to the focus on carer engagement at today's meeting. Mr McConnell noted the reduction in the complaints in respect of staff attitude and behaviour, and asked of this was indicative of a downward trend. Ms Smith remarked that this was more likely to be natural variation, and this would be closely monitored in the next quarter's report.

Mr McConnell thanked Ms Smith and her team for reporting, and the committee noted the content of the report.

The Committee:

1. Noted the Learning from Complaints and Feedback Report, Quarter 2.

16 DISCUSSION ITEM - TRAUMA INFORMED CARE

Dr Flynn led the committee through a presentation on 'A Trauma Informed TSH' with the themes of what this would look like and why it would be desirable, as well as how to make this happen.

She explained the background to this in the context of the National Trauma Transformation Programme, and the related Roadmap. Dr Flynn then went on to discuss common exposure to trauma and adversity, and the essential elements required in the response for TSH patients, who were all likely to have experienced trauma. She talked through the benefits of this approach for both patients, as well as for staff.

Dr Flynn then went on to set out the ways in which services could become more trauma informed. This covered organisational culture and leadership, as well as staff support and wellbeing initiatives. It was important to build in feedback loops with a view to continuous improvement. She also underlined the need for power sharing with those who have lived experience, and the importance of patient involvement. She spoke about the need to understand levels of staff knowledge and training, as well as to understand the difference this may make. She linked this approach to the development and implementation of policies and processes, and the potential for

impact on service delivery. More prevention should mean less cost in the future.

Dr Flynn summarised the current agenda within this workstream including the appointment of a Trauma Champion, and the delivery of training and the use of reflective practice. Lastly, she set out future planning including a trauma Roadmap Self-Assessment and further analysis of patient needs.

Mr McConnell thanked Dr Flynn for this presentational piece and opened the discussion. Dr Skilling noted the need to really understand what this approach meant, and whether this was understood comprehensively presently. He thought that this approach could be developed further and be beneficial. It would require sharing a definition of what this approach meant for TSH and considering whether this was already embedded in existing practice.

This led to wider discussion of the risk of not understanding what this approach means and thinking that it was already being delivered. Ms McCaffrey commented on the need to consider trauma as part of how care was being delivered as common practice. She thought about the language being used, and whether this represented an organisation that was thinking in terms of a trauma informed approach across policy and practice as well as care delivery. She expanded this to think about the equalities framework as well, and if this should be linked. Ultimately, the key should be prevention and the nature of patients' journeys.

Professor Thomson noted the value of comparison with the model used within the Scottish Prison Service, and the work being led through NHS National Education for Scotland.

Mr Jenkins thought it was about this in terms of organisational need. It was a huge area of importance that would require careful and wide-ranging consideration on how the organisation valued this, and how to take this forward. It may be helpful to link this to other workstreams and dimensions like staff wellbeing, as well as patient care. Professor Thomson agreed that this was a complex area and thought that it may be taken forward though initial discussion with the different clinical professions about development of a coherent model.

Mr Moore thought this discussion had been helpful in raising awareness, and echoed Dr Skilling' comments about a shared definition, and whether a trauma informed approach was already part of practices and approach to treatment and care. He referenced the national agenda, and the need for TSH to consider this within that context. He suggested further discussion on understanding and expectations in this area of this within a Board Development Session.

Mr McConnell summed up the discussion, and particularly the different profile for this approach within TSH compared to territorial board settings. He thanked Dr Flynn for her presentation, which had been helpful and informative. It was agreed to plan a further discussion as part of a Board Development Session in six months' time.

Action – M Smith / L Flynn

<u>The Committee:</u>

1. Discussed and noted the content of the presentation.
2. Agreed that this approach should be considered further in a Board Development session in six months' time.

17 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

Mr McConnell invited members to highlight any areas of good practice along with any areas of concern. It was agreed that this should include the development of the Carers Strategy, as well as the 100% completion rate for CPA for patient transfers. Additionally, the increase in child visits supported through PCIT, and the standard of physical health care provided through the Health Centre.

18 COMMITTEE WORKPLAN 2024/25

The committee reviewed the workplan 2024/2025 and agreed that this was appropriate – there was one addition in terms of reporting from learning points from SAERs.

19 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Mr McConnell invited members to share any matters they felt required to be shared with the Board's Governance Committees. It was noted that the Carers Strategy would be submitted to the Board for formal approval. It was also noted that an internal audit had commenced on patient physical health, and that this would be reported through the Audit and Risk Committee initially prior to coming to this committee.

20 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

The committee noted some possible topics for the next meeting including – patient activity, how to measure patient progress and outcomes, triangle of care, structured clinical care activity. Further, an update on taking forward the Barron recommendations, should there be an update in this respect.

Professor Thomson would take this forward with Ms Fallon.

21 ANY OTHER BUSINESS

There was no other business raised at the meeting.

22 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 13 February 2025** at 09:30 hours via Microsoft Teams.

The meeting concluded at 1245 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 12b
Report Author:	Head of Corporate Governance
Title of Report:	Clinical Governance Committee – Summary Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Clinical Governance Committee meeting that took place on 13 February 2025.

1	Corporate Risk Register / Risk Reporting	The Committee reviewed the clinical risks within the Corporate Risk Register, and agreed that reporting represented an accurate statement of risk. The Committee noted the need for reporting to be focused in particular on clinical risks.
2	Annual Reports: Psychological Therapies Activity Oversight Group Clinical Governance Group	The Committee received assurance reporting in the form of 12 month or annual reporting across a range of areas, including Psychology Services and Activity Oversight Group, focusing on the improvement mechanisms outlined within reporting. Discussion was around the need to focus on care delivery to patients. Reporting was also received on the wide range of oversight undertaken by the Clinical Governance Group over the course of the last 12 months.
3	Nurse Resourcing:	Reporting outlined the position on resourcing, and the Committee considered the positioning of reporting within the governance framework – this will be reviewed/ The Committee focused on the impacts on patients and care delivery.
4	Infection Prevention and Control (IPC) Quarter 2 Report	The Committee received reporting to present IPC activity under the headings outlined in the HIS Infection Prevention and Control Standards (2022). The Committee found reporting, and the initiatives being undertaken within this remit to be helpful, and a balanced way to demonstrate assurance.
5	Bed Capacity Report	The Committee received a report to provide data across patient admissions and transfers. This report also provided background on patient movement through services within TSH, as well as the position on bed capacity across the wider forensic estate.

6	Incident Reporting and Patient restrictions	Reporting provided the Committee with the Quarter 3 position on the types and numbers of incidents, including RIDDOR reporting and serious adverse events (SAERs) and patient restrictions during this period. The Committee considered the range of metrics reported, and whether there could be improvement in this area.
7	Learning from Complaints & Feedback	The Committee received Quarter 3 reporting in relation to complaints and feedback, aligning these areas and streamlining reporting. Reporting highlighted the main issues raised, as well as the actions progressed as a result. A new member of the complaints staff joined the meeting to describe the initiatives she is taking forward.
8	People with Lived Experience	The Manager of the Forensic Network joined the meeting and led the Committee through a presentation on this workstream which was being progressed within the network. She described the different pathways of engagement through a participation ladder, and ways to strengthen this with stakeholders. The Committee received the presentation positively and reflected on the helpfulness of this approach within TSH.
9	Areas of good practice/concerns	The Committee noted good practice within complaint Shandling – especially the direct link from the Complaints Officer to patients, e.g. through the Patient Partnership Group to help build trust in the process. Further, how well infection prevention and control had been embedded across the organisation. The Committee highlighted the structure and process in place around patient risk assessments which may impact patient transfers, and the sharing of information across partner organisations and the potential for longer term challenge.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minute will be presented, once approved by the Committee.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously to the Board.
Workforce Implications	There are no workforce impacts be considered.
Financial Implications	None – this is routine reporting.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes in accordance with Standing Orders.
Risk Assessment (Outline any significant risks and associated mitigation)	This is not applicable to reporting. It is good practice to ensure that all Board members aware of activity across governance committees.
Assessment of Impact on Stakeholder Experience	No specific impacts.
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 13
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on overall workforce performance to 31 January 2025.

Information and analysis is provided to the Workforce Governance Group, the Operational Management Team and Corporate Management Team. Information is also provided on a 6-weekly basis to the Partnership Forum.

2 BACKGROUND

The State Hospital use a dashboard system called Tableau. The Workforce Dashboards are available for access by Tableau users. The system has the ability for managers to set up subscriptions to reports on particular days so that they receive an auto-notification.

The Tableau dashboards are updated on a daily basis with attendance information using information from the SSTS system, meaning that the information available is live and as accurate and up to date as the information input by managers.

The information is provided to the end of January 2025, including the national figures for sickness absence for completion of the rolling year.

3 ASSESSMENT

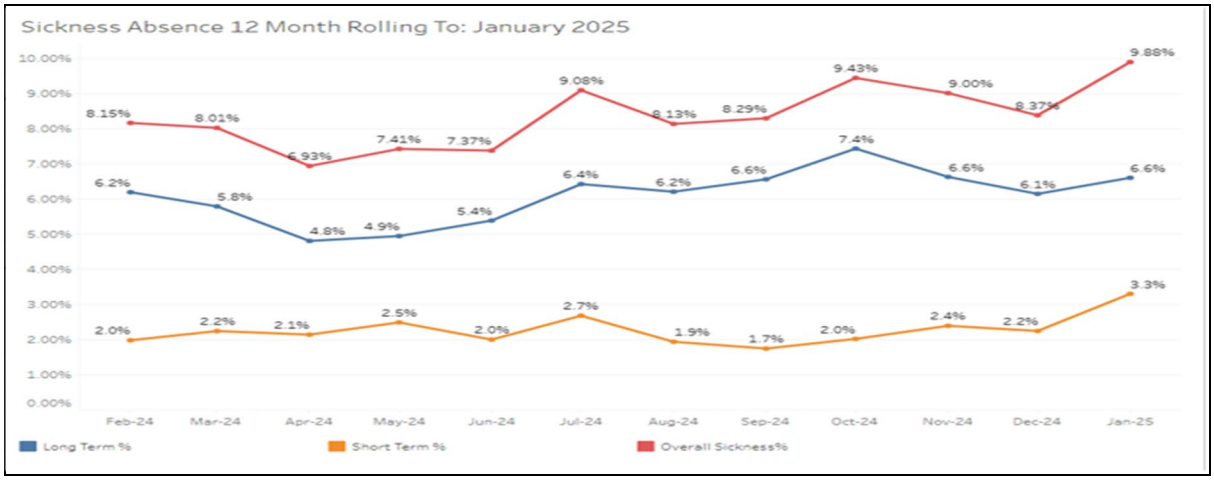
(a) ATTENDANCE MANAGEMENT

- **TSH Sickness Absence (Feb 24 to Jan 25)**

Sickness Absence remains a significant and ongoing challenge for TSH in ensuring sustained improvement.

In January 2025, sickness absence increased by over 1% Board wide as outlined in Graph 1 below:

GRAPH 1

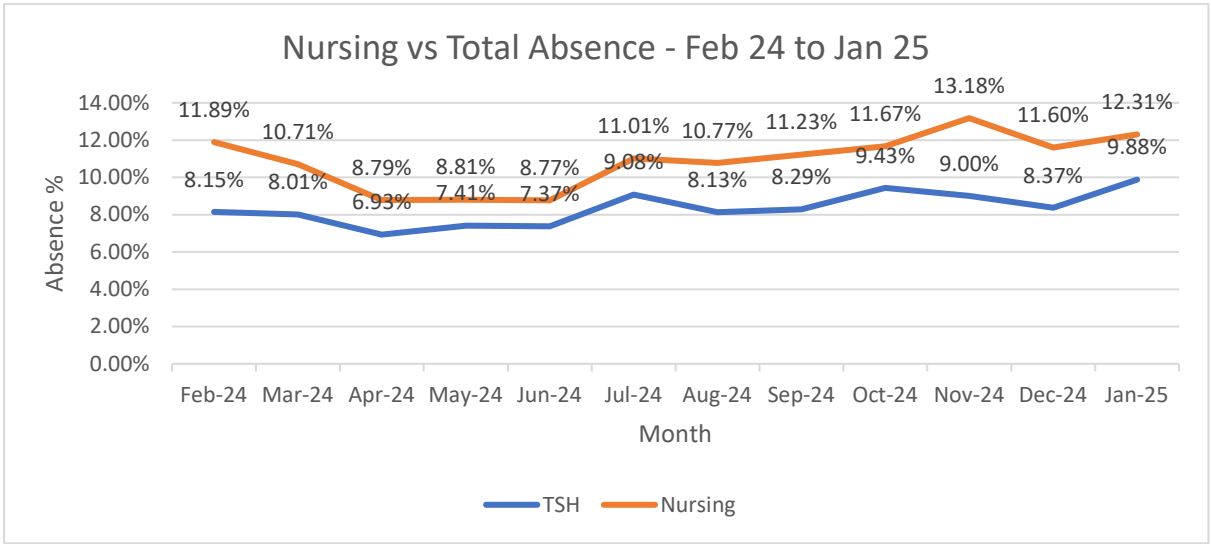


This increase reflects the seasonal trend and the high instances of coughs / colds and chest / respiratory infections in the early weeks of January: which is evidenced through the higher increase in short term absences (an increase of 625 hours of absence or approximately 83 days).

- **Nursing Sickness Absence (Feb 24 to Jan 25)**

Nursing sickness remains the major challenge for TSH with Nursing reaching 12.31% (2nd highest absence in the last 12 months). This increase saw short term absence exacerbating the already challenging long term position.

GRAPH 2

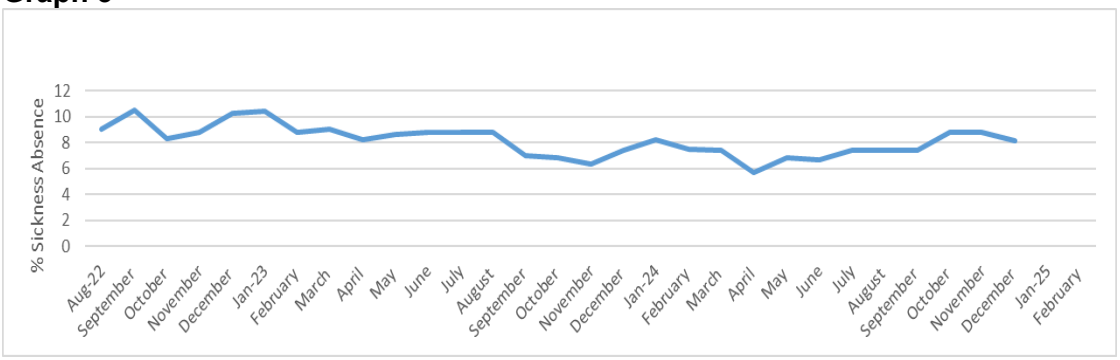


Significant focus is on systemic and sustained improvement across nursing, with the Lead Nurse and Head of HR leading meetings with Senior Charge Nurses in identified areas and developing action improvement plan and driving consistency of application in terms of policy implementation.

However, it is important that despite our ongoing challenge, the current increase should be considered alongside the longitudinal pattern of absence as described below in graph 3 below. It is clear that the levels of sickness absence post pandemic are enduring and systemic. Analysing absence rates over a longer period highlight that whilst peaks of 10% absence immediately post pandemic have not been seen since, the rate ranges from 9.4% at its highest (Oct 2024) to lowest 5.7% (April 2024) a fluctuation of 3.7%. The rate is consistently above the national target of 5%.

The range of data reinforces the continuing challenge we face in maximizing attendance as there have been only 2 occasions when the rate 'hovers' around the 6-7% and is sustained for 2 or 3 months before increasing again.

Graph 3



Despite this continual fluctuation from 6-9%, in comparing the average monthly absence for the year, there undoubtedly is a positive trend in terms of a slow downward trajectory as described below.

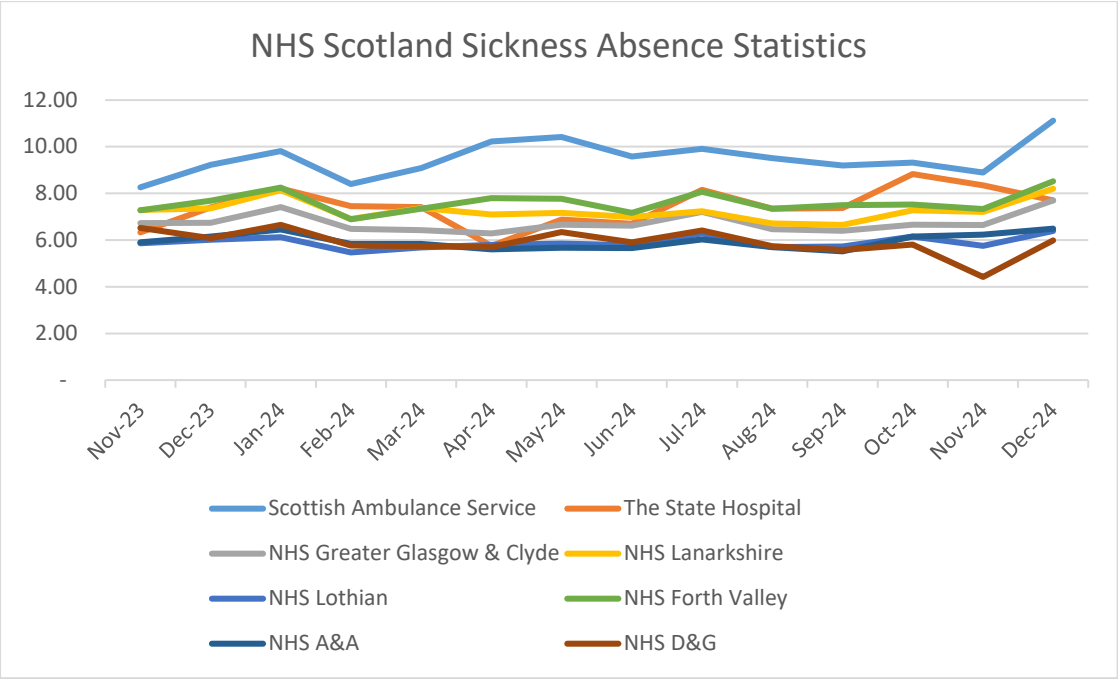
Table 1

Average	Year
9.4%	2022*
8.2%	2023
7.5%	**2024**

It is also important to recognise that the challenges we face are the same as reported by other boards across Scotland and in other services. Absence is undoubtedly a significant pressure across all workforces, with the need for sustained reduction.

This will be analysed further as more national figures become available however, graph 4 below outlines rates until December 2024 for a sample of Boards (West of Scotland and 1x other National Board with majority clinical staff - Scottish Ambulance Service). It should be noted that only 5 of 22 boards were under 5% at 31 March 2024.

Graph 4 – NHS Boards 12-month sickness absence trend



- **ATTENDANCE MANAGEMENT OBSERVATIONS**

Patterns/Trends for TSH:	1st Increase in total absence for 3 months (Driven by increase in short term, but long term (6.6%) remains above a sustainable level (ie in excess of total absence target of 5%). Nursing has seen a smaller increase in month, but remains the area of greatest pressure (again with focus on long term absence 1 to 3 months)	
Identified Departments of Concern:	Skye Centre (Activity Staff) Lewis 3 Mull 2 Lewis 2 Housekeepers	22.08% 18.93% 17.40% 17.26% 17.09%
Reasons:	**Key reasons for long-term absence:** Anxiety/Stress/depression/other psychiatric illnesses, Injury/fracture, other known causes. **Key reasons for short-term absence:** Cold/ cough/ flu, Anxiety/Stress/depression/other psychiatric illnesses, injury fracture problems.	
Activity:	At the time of reporting, for the month of January: - 12 staff were invited to a Stage 1 meeting - 4 invited to a Stage 2 meeting - 1 Stage 3 meeting was reconvened.	
Benchmarking:	Rowanbank Orchard Grove	11.83% 14.88%

(b) RECRUITMENT

Our Recruitment process continues to work proactively, with vacancies processed timeously to support services:

TIME TO HIRE	83 days (KPI of 75 days)	KPI impacted by small number of vacancies processed in January
SUMMARY OF NURSING VACANCIES:	Currently 5.8 wte Band 5 Registered Nurse vacancies	
	9.4wte Band 3 in process of onboarding, with proposed start date of 19th March (as approved at December Board Meeting)	

- **SUPERNUMARY STAFFING**

The month of January saw our reliance on supernumerary staff increase slightly across all areas, which is likely to be directly related to the increase in short term absence.

OT & EXCESS	46.21 WTE	An increase of 2.42 wte in month
NURSING	27.59 WTE	An increase of less than 1 WTE in month
SSR	10.05 WTE	An increase of under 1 WTE in month

(c) EMPLOYEE RELATIONS

- **LIVE CASES**

The table below provides a summary of current cases and timescales:-

- No new ER cases commenced in the month of January.
- The two cases in excess of 6 months are expected to conclude in February.

Ongoing ER Case Work					
	<1 month	1-3 months	3-6 months	6+ months	Total
Capability - formal	0	0	0	0	0
Conduct - formal	0	1	7	2	10
Bullying & Harassment - formal	0	0	0	0	0
Grievance - formal	0	0	0	0	0
Whistleblowing	0	0	0	0	0

Focus continues to support early resolution where possible, minimise formal cases and also reduce timescales for all ER cases that are required to progress.

(d) LEAVERS

Leavers

- There were 2 leavers in January 2025. YTD total is 45. The January figure is significantly less than monthly average.

- Turnover YTD is 6.42%, which is lower than this time last year (6.63%) and current national average.

(e) JOB EVALUATION

Job Evaluation remains in a positive position reflecting significant work and progress, summarised below:-

- **Progress**

- In January there was one Job Description received.
- There were two JE panels during January.
- There were two JD Sharing Requests received.

- **Status**

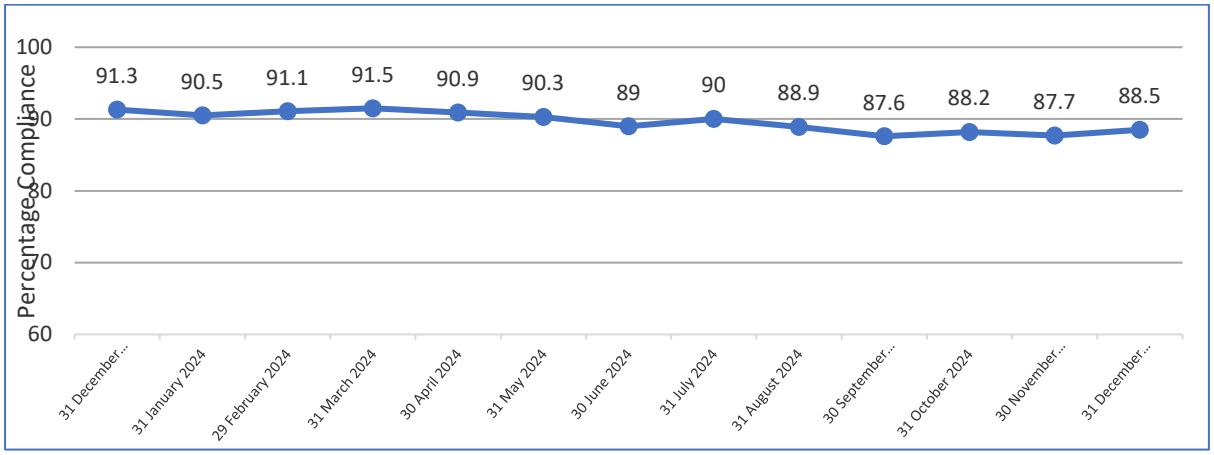
- At end of January, one post is outstanding, ready to progress to Quality Check panel in February
- February panel dates are scheduled.

- **Job Evaluation Steering Group**

The group continue to meet bi-monthly taking forward any issues raised via the JE Practitioners involved in panels and quality checking.

(f) PDPR COMPLIANCE

PDPR also remains stable, with a small increase in month to 88.5%, remaining above the national target of 80%. Focus remains on maintaining compliance and improving the quality, impact and outcomes for TSH Staff.



4 RECOMMENDATION

Members of the Board are asked to note the update on overall workforce performance.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A no proposal – update report Supports delivery of Staff Governance Standards and Workforce Plan
Workforce Implications	N/A
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance, Partnership Forum, WGG and CMT
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 14a
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Report Quarter 3 Update– 2024/25
Purpose of Report:	For Noting

1 SITUATION

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021.

As part of the Standard, a quarterly update on the number of whistleblowing cases is provided to the Board.

2 BACKGROUND

The SPSO (Scottish Public Services Ombudsman) developed a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services and this was formally published on 1 April 2021. The Independent National Whistleblowing Office (INWO) provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. For NHS Scotland staff, these standards form a 'Once for Scotland' approach to Whistleblowing.

3 ASSESSMENT

The Quarter 3 update is from 1 October to 31 December 2024. No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO. One case was raised with the Whistleblowing Champion, which did not meet criteria for whistleblowing and is being managed under Business as Usual.

In the performance year 2024/25, the State Hospitals Board for Scotland had no cases raised under Whistleblowing to date.

4 RECOMMENDATION

Members of the Board are asked to note the nil return for Quarter 3 of 2024/25.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	For noting
Workforce Implications	For noting
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	Ensuring that staff feel secure to raise any Whistleblowing concerns.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	As detailed previously – providing a safe and secure environment to raise any issues.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One **X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 14b
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Champion - Annual Update
Purpose of Report:	For Noting

1 SITUATION

To provide an annual update on the Non- Executive Whistleblowing Champion's role at The State Hospital.

2 BACKGROUND

On the 6 February 2025, the Cabinet Secretary for Health and Social Care wrote to Health Boards' Whistleblowing Champions.

He requested a short update on the Whistleblowing Champion's role at Board level, and detail of any work to ensure and promote a more positive and engaging culture within the Board.

3 ASSESSMENT

The Non-Executive Whistleblowing Champion has been in post since 16 January 2023 and has prepared an update, which is attached.

4 RECOMMENDATION

The Board are asked to note the draft response

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	As part of National Guidance for Whistleblowing set by the Scottish Government
Workforce Implications	Positive measure in support of Staff Governance Standards.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board awareness - requested by Scottish Government
Risk Assessment (Outline any significant risks and associated mitigation)	No risk identified
Assessment of Impact on Stakeholder Experience	Reporting on supportive mechanisms in place.
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	**X There are no privacy implications.** □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

APPENDIX A - DRAFT

Dear Mr Gray

Further to your letter of 6 February 2025, I am writing to provide an update regarding Whistleblowing arrangements at the State Hospitals Board for Scotland.

I have held the position of Non-Executive Director (Whistleblowing Champion) since . 16 January 2023 and I will provide further details in terms of your specific questions regarding Whistleblowing issues with reference to The State Hospital.

Regarding the specific issues raised in your letter I can provide the following information and assurance.

- Over the last 12 months, we have reviewed our approach to Whistleblowing and the promotion of a Speak Up Culture, which has been received positively by our staff. The appointment of a new HR Director and a new Organisational Development Manager within the last year has been noticeably beneficial to the State Hospital in creating and promoting a culture of openness and transparency which has featured heavily in our engagement on Organisational Development and our prioritising of 'Organisational Health' and staff wellbeing.
- The recent review of our processes resulted in material amendments to Whistleblowing procedures, with clear links to the process and how to access services on our Intranet (including how to raise complaints and the introduction of a specific email), the re-establishment, retraining and re-advertising of the availability of Confidential Contacts and a shift to the management of any complaints/concerns to be handled solely by our Corporate Team (aligned to our approach to Complaints). The change in the management of any concerns provides a clear separation between Whistleblowing concerns and 'Business as Usual'.
- I am content that our reporting arrangements are in line with Governance section of the Whistleblowing Standards: Whistleblowing is a standing item on the Staff Governance Standing committee and regular reports are brought to the Board in ensuring compliance with the Governance section of the Whistleblowing standards.
- Our new processes, and the management of those processes through our Corporate Team will limit the number of people required to manage the process. This is a significant step given that staff feedback in respect of whistleblowing has raised concerns around being assured about the confidentiality of the process. I have been reassured that the Board, Senior Management Team and the Corporate Team have demonstrated their commitment to protecting the anonymity of individuals raising concerns and have recognised that given the State Hospital's small size, they have been proactively engaging with neighbouring NHS boards to identify and utilise Managers from those boards to take forward any investigations at Stage 2. I'm reassured that by introducing these measures that the organisation is creating the conditions where individuals can feel safe in raising concerns and that these will be handled confidentially. Some further work is still required in terms of awareness raising with staff in relation to the changes to the process however there are clear plans and strategies in place to do this on an ongoing basis.

- We will continue to review all relevant data to help capture nursing, and other staff views on whistleblowing, and more generally their working environment and their well-being. This has also been captured through face to face engagement by our OD team where significant numbers of staff were involved in this process. At a more general level, my impression is that staff are reluctant to speak up for a variety of reasons and in particular thinking that they will not be taken seriously or listened to by more senior managers and the power imbalances that exist in those relationships; that even if they speak up things may not change and more particularly the perception of other staff and how this will affect their working environment if they raise issues. Whilst the impression of staff being concerned for safety with specific reference to whistleblowing was not raised previously via the OD route, I have discussed and agreed with the HR Director and the OD Manager that this will form a key element of ongoing OD work following this engagement. This will look at working environment for staff, with a focus on physical and psychological safety and the impact on Health and promoting a Speak Up culture. I see this is as a very positive step by the organisation in seeking to systemically embed whistleblowing in its processes.
- As above, the local I-matter data was analysed in line with OD engagement and response to our recent Wellbeing survey.
- Speak Up Week 2024 was heavily promoted by our Board and used as a means to publicise the changes in our approach to Whistleblowing. We had messages in our Core Brief from the Chairperson and myself as Whistleblowing Champion, along with reminders of the Whistleblowing Policy and how to access, pledges made by the Corporate Management Team, activities within our well being Centre and a desk at reception throughout the week to promote Speak Up and Whistleblowing. This was very well received by staff, who seemed positive, interested and pleased at our ambition to really promote an open and transparent Speak Up culture.
- Work continues on highlighting the requirement for Staff and Managers to complete the on-line module on the Whistleblowing Standards and update to date is:
  Introduction for all Staff – 568 (97% of target group)
  Managers Training – 85 (88% of target group)

I am confident that the Board has been able to fulfil its governance role regarding the standards and is embarking on a programme of development and improvement which will contribute to the promotion of a positive organisational culture.

Other related Board actions include, learning from iMatter reports, continuous review of the culture element of the Corporate Governance Improvement action plan and oversight of the delivery of the Boards Workforce and Staff and Volunteer Wellbeing plans.

The content of this response was shared with Board members at the State Hospital Boards for Scotland on 27 February 2025.

Yours sincerely,

Shalinay Raghavan
Whistleblowing Champion
The State Hospital

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2024
Agenda Reference:	Item No: 15a
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Equality Outcomes Report
Purpose of Report:	For Decision

1 SITUATION

Mainstreaming equality is a specific requirement for public bodies in Scotland, laid out by The Scottish Government. It is a means of ensuring equality is woven into all aspects of what we do and by the development of specific equality outcomes every 4 years, provides focus on specific areas we have identified as requiring improvement.

The equality outcomes outlined in the 2025–2029 plan do not account for all our actions but provide detail on specific areas of focus for the organisation and actions taken to achieve the outcomes and evidence of compliance with the legislative requirements of the Equality Act 2010.

This report outlines the Board's approach to the 2025-2029 plan and attaches a draft copy of the plan as Appendix A.

2 BACKGROUND

In preparing our Equality Outcomes, it was apparent that we have in the past focused more closely on Patients and Carers. Whilst we recognised the importance of this area, we were keen that as a board we developed a broader, all encompassing approach to this agenda.

Therefore the nature of the outcomes have broadened, and some may appear simpler in the sense that we wish to ensure that we have the correct basis on which organisationally to work towards a truly inclusive workplace and environment.

3 ASSESSMENT

The key priorities as listed in the attached document are:

Priority 1 – The establishment of a Workforce Equalities Group which focus primarily of Workforce issues, developing annual action plans, promoting an inclusive environment and to monitor and report in line with governance framework

Priority 2 – Ensure that the state hospital are compliant with Equalities legislation and national drivers and reestablish links with National Equality Groups

Priority 3 – Ensure Equality considerations are factored into the scoping of a woman's service

Priority 4: - Understand our internal capacity to support this agenda and to seek external support as required.

Priority 5 – Ensuring we are listening to all those with lived experience and integrating this learning into our annual plans

Priority 6: To review our approach to, and develop new ways to deliver equality and diversity training in all forms

Our list of identified priorities did not reflect the extensive considerations we had, but did reflect our general approach:-

a) A reset on our approach to equalities (building on some of the good progress made previously, but broadening its impact)
b) Creating equal focus between Workforce and Patients and Carers.
c) Simple meaningful priorities which will have clear impacts on our organisation
d) Priorities which will set us on a path of continuous improvement, embedding of good practice and working towards an open and inclusive work environment for all at TSH.

Alongside the new priorities, and to ensure a streamlined, simple approach to governance that reflects the seriousness of this agenda, it is suggested that Equalities Updates are provided directly to the Board, comprising combined Workforce and Patient issues on an agreed frequency.

4 RECOMMENDATIONS

The Board are asked to approve the final draft of TSH's Equality Outcomes Report for 2025-29 and to approve the amended governance route through the Board directly.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Meets legal requirement to publish Equality Outcomes
Workforce Implications	Forms key element of working towards an open and inclusive work environment
Financial Implications	N/A
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Workforce, Nursing, PCIG, Planning & Performance, OD contributed to the report
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Equalities Outcomes and Mainstreaming Report 2025-29

1. Introduction

Our organisational values are at the very heart of care delivery within the State Hospital, we strive to deliver the highest standard of Safe, Effective, Person-centre care for all our patients to promote recovery of their physical and mental health. As an employer we aim to create the conditions to ensure that staff feel supported, valued and enabled to realise their full potential.

1.1 Aims of the Report

This report aims to summarise our progress within this area and allow for greater focus on the areas in which we can improve: - this will highlight the progress made to date regarding priority areas, as well as demonstrating how we adhere to all equality legislation. It will also provide an understanding of the unique setting at the state hospital and describes governance in place within the State Hospital Board.

1.2 Why we need to mainstream and have equality outcomes

Mainstreaming equality is a specific requirement for public bodies in Scotland, laid out by The Scottish Government. It is a means of ensuring equality is woven into all aspects of what we do and by the development of specific equality outcomes every 4 years, provides focus on specific areas we have identified as requiring improvement. The equality outcomes outlined in the 2025–2029 plan do not account for all our actions but provide detail on specific areas of focus for the organisation and actions taken to achieve the outcomes and evidence of compliance with the legislative requirements of the Equality Act 2010.

A final update for the Equality Outcomes for 2021-25 has also been included within this report demonstrating the excellent progress made against the previous identified priorities. (Appendix 1).

The State Hospitals Board (the Board) is committed to ensuring that service delivery is informed by the experience of those who are impacted. Due to the nature of the care environment, service commissioners cannot personally experience the impact of outputs. The Board therefore invests significantly in its structures to support patients and carers to share the experience of local and national drivers, which impact on care. In addition to quantitative data, qualitative data is considered imperative to highlighting and acting on experiences, which indicate inequalities of experience within the protected characteristic groups.

1.3 The Legislation

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (as amended) require listed authorities, including TSH, to publish equality outcomes at intervals of not more than four years and to publish a report on the progress within every two years.

The Public Sector Equality Duty (general duty) requires public authorities to:

- Eliminate discrimination.
- Advance equality of opportunity.
- Foster good relations for relevant protected characteristic groups (age, disability, gender, gender reassignment, pregnancy/maternity, marriage & civil partnership, race & ethnicity, religion & belief, sexual orientation).

2. About the State Hospital

The State Hospital is the national high secure forensic mental health care provider for Scotland and Northern Ireland. The organisation currently provides specialist individualised assessment, treatment and care in conditions of high security for male patients with major mental disorders and intellectual disabilities. As noted in this year's outcomes, the State hospital is moving towards providing a high secure provision for female patients. This will be reflected in our equality outcomes going forward. The patients, because of their dangerous violent or criminal propensities cannot be cared for in any other setting. Working closely with partners in the Forensic Network for Scotland the organisation is recognised for high standards of care, treatment, research and education. TSH leads on the delivery of exceptional and innovative care, treatment and risk management to support patients in their recovery journey and improve their mental health. TSH aims to support patients to actively participate in their treatment, experience improved overall health and well-being whilst ensuring public safety within a high secure environment.

TSH has 120 beds available for patients, 108 beds for patients with Major Mental Illness and 12 beds for patients with Intellectual Disabilities. TSH site also has protected patient space on site as a resilience and contingency measure if patients were required to move from the current wards.

TSH is one of the 22 NHS Boards that make up NHS Scotland. It is a national board with responsibility for the provision of high secure Forensic Mental Health Services for men in Scotland and Northern Ireland, working from a single site in Carstairs, South Lanarkshire.

Although The State Hospital (TSH) shares the same values, aims and challenges as the rest of NHS Scotland, it has the unique, dual responsibility of caring for very ill, detained patients as well as protecting everyone from harm.

The last Equality Outcomes report focused on specific areas of work and ensured that equality and diversity considerations were woven within these. This time round there was a consensus that the focus should be related to the size and unique nature of this board and how this provides both opportunities and challenges regarding key aspects of compliance with the Equalities Act and embed equality outcomes within the fabric of the organisation. We also recognised that regardless of whether you are a patient or a staff member the standard you should expect apply across both, the difference is in how they are at times delivered. Given the size the board there was also a risk that any work in relation to equality and diversity was the remit of a very small number of staff. Not only is there a risk when work is person dependant but also if fails to reinforce the duties and responsibilities of all staff within the organisation. Therefore, we are considering the appropriate forum to meet all Equality and Diversity needs within the State Hospital.

2.1 **Patient Profile**

An audit is undertaken at least once every year to identify any trends and better understand where there may be commonalities of inequitable experience within the patient group:

- Age: range: 18 - 65.
  Individual ages: *20s - 21, 30s - 38, 40s - 20, 50s - 19, (teens and over 60s, numbers too low to disclose due to risk of patients being identified.)*
- Disability: several patients identified as having a physical disability.
- Gender reassignment: 0 patients.
- Marriage / Civil Partnership Status: 92 patients identify as being single, – other patients are married/divorced/separated however numbers are too low to disclose.
- Race / Ethnicity: the majority of patients identify as white (BAME numbers too low to disclose due to risk of patients being identified).
  Religion and / or Belief: *33 patients have no religion, 17 are Roman Catholic, 14 Church of Scotland, 13 not known and other faiths (Protestant, Muslim, Buddhist, Agnostic, Atheist, Mormon, Jehovah's Witness, Orthodox Catholic Church and Russian Orthodox Church were also identified (numbers too low to disclose due to risk of patients being identified).*Sexual orientation: *'This data is collected from patients but not currently available to statistical purposes'.*

The December 2024 audit relates to a total patient population of 104 at that time. In comparison to an aging population within the community, TSH patient group is predominantly less than 50 years of age.

TSH provides psychiatric care limited to in-patient male patients who are detained in conditions of maximum security as they are deemed to pose a risk to themselves and / or others. Due to the complexity of caring for patients with a range of mental health conditions who are protected by the Mental Health (Scotland) Act 2015,

'gender' is not a straightforward characteristic to navigate as the processing skills required to identify with gender may be impacted by a patient's wider mental health issues, which may be fluid in nature.

Average duration of stay in TSH is 5 years, however there are of course some patients whose journey is more rapid and some who remain in the care of TSH for a considerably longer period of time.

2.2 Stakeholder Engagement

'Public involvement' mechanisms differ from stakeholder engagement approaches adopted by other public authorities, due to the nature of the very limited and specialist patient and carer group. TSH works closely with external regulatory and supporting organisations, third sector partners, carers, volunteers, independent partners and Forensic Network colleagues to ensure that local practice is reflective of community services, where this is possible.

Alongside this approach, the establishment of our Workforce Equalities Group will allow a live and continuous link with key stakeholders in terms of our workforce. Greater focus will move to the experiences of our workforce, the review of relevant data relating to equalities and ensuring that we learn and develop from 'Lived Experiences'.

2.3 Monitoring, Governance and Reporting

Responsibility for monitoring progress to Equality Outcomes is detailed within each outcome.

However, there will be two key streams in terms of monitoring:-

Workforce Equalities Group

The ongoing monitoring of delivery of Equality Outcomes will now be monitored by the Workforce Equalities Group, who will meet 5 times throughout the year and will assess progress in terms of equality outcomes and our own Equalities Annual Action Plan. The Workforce Equalities Group will report bi-monthly to the Workforce Governance Group and quarterly to Staff Governance Committee.

Person-Centred Improvement Group (PCIG)

The Person-Centred Improvement Group (PCIG) meets monthly, this group ensures the organisation is compliant with legislative requirements and responds appropriately to national drivers relating to person centred care and equality related to patient care and treatment. The group operates to an agreed annual workplan to support the delivery of the above objectives. The PCIG are tasked with reporting annually to the Hospital Board and six monthly to Clinical Governance Group/Committee.

2.4 How we are embedding equality

The strengthening of the governance support delivery of equality within TSH is a key mechanism to ensuring this is embedded into the fabric of the organisation.

The group will be responsible for ensuring the following existing practises remain fit for purpose and completed as required:-

- Equality Outcomes: evidence based, targeted improvements relating to identified inequalities impacting on Protected Characteristic groups.
- Equality Impact Assessments: all policies/protocols, service change initiatives are informed by Equality Impact Assessments (EQIA).
- Patient Pre-Admission Specific Needs Assessment: prior to admission, patient needs highlighted and reasonable adjustments assessed to prioritise human rights and support continuity of equitable access to all aspects of service delivery.
- Patient Equalities Monitoring: TSH Person Centred Improvement Group monitor patient profiles to inform the need for service change.
- Staff Equalities Monitoring: reports from a staff perspective regarding workforce and staff governance.
- Understanding, directly, 'lived experience of both the workforce and the patients and seeking to make necessary improvements in conjunction with relevant stakeholders.

3 Equality Outcomes for 2025-29

TSH equality outcomes must represent marked improvements to service delivery, which have a positive impact on improving the experience of those who experience discrimination and disadvantage. Relevant local equality evidence, linked to societal inequality evidence ensures a wider lens is applied to the marginalised TSH staff & patient groups and has been considered in the prioritisation of those outcomes included within the 2025-29 plan.

3.1 Development Process

We developed a focus group who reviewed a wide range of data and national drivers were scrutinised to identify priority areas for inclusion in this report. On reflecting the group considered the specialist nature and size of the board and considered what the board are able to provide independently and identified areas where external support would be required. The group also recognised the significant change the introduction of a women's service would bring and have also included this as a key priority.

One inequality has not been included within the revised outcomes:

- Inequity of financial support for patients – result of legislation which differentiates between patients admitted to the State Hospital via the Criminal Justice System and those transferred through the Mental Health system.

3.2 The State Hospital's Prioritised Equality Outcomes 2025-29

Equality Outcome No 1: The establishment of a Workforce Equalities Group which will focus on both workforce and patient issues, developing annual improvement plans. Promoting an inclusive work environment and to monitor and report on progress, as part of the Boards formal Governance framework.
Relevant protected characteristic groups ALL
Rationale (this will include any supporting evidence/ risk consequence of failure to address) The establishment of a Workforce Equalities Group will highlight a revised approach to Equalities within TSH. This group will be key in:- - Acting as monitoring conduit in the Governance Framework for Equalities in TSH - Monitoring and assessing progress against annual improvement plans and our Equalities outcomes. - Provide a safe forum for all staff to highlight their thoughts and concerns on the building of truly inclusive work environment. - Opportunity to learn from 'Lived Experience' and to review relevant workforce data which relates to equalities. - Liaising with the Patient Group to ensure Patient Equality issues are also fully considered.
Actions and milestones (how much by when) By April 2025, the group will have developed their first Improvement Plan. Bi Monthly updates will be provided to Workforce Governance Group and Quarterly updates to Staff Governance Forum on Equalities. Annual update will be provided on progress against Equalities Outcomes and also local improvement plans.
Measures demonstrating progress • TOR • Minutes • Workplan • Outline structure • Quarterly/6 Monthly/ Annual Reports
Update (Same time frames as Group reports and annually and publish bi-annually)
Responsible for development of action plan, including outcome measures, ongoing monitoring and annual reporting

Executive Lead(s): Stephen Wallace
Delivery Forum: Workforce Governance group

Equality Outcome No 2: Ensure that the State hospital are compliant with Equalities legislation and national drivers and reestablish links with National Equality Groups
Relevant Protected Characteristics ALL
Rationale Ensure that the Board are proactive in responding to the evolving nature of this agenda and that we respond and communicate such changes. By ensuring appropriate links with relevant national groups, this will support a more proactive approach to Equalities
Actions and Milestones - Ensure identified reps to national groups and appropriate feedback forums - Review communication strategy surrounding equalities to ensure that equalities update are front and centre.
Measures - Minutes of WEG and PCIG to reflect national input and changes - Increased communications
Updates Regular reporting from WEG and PCIG
Responsible Leads **Executive Lead(s):** Stephen Wallace/ Karen McCaffrey **Delivery Forum**: WEG/ PCIG

Equality Outcome No 3: **Ensure Equality and diversity considerations are factored into the scoping of a women's service**
Relevant Protected Characteristics ALL
Rationale • Ongoing review of the Project Plan and the implementation of the womens service as the project develops.
Actions and Milestones Key reviews at: - Development of Project Plan - Implementation - Project Review - Identify Training and development needs

- Identify policy and procedural reviews required to incorporate the needs of a womens service.
Measures Standing item as part of Project Group Meetings
Updates Equality considerations should be included in updates to the Board on the progress of the Project.
Responsible Lead for development of action plan, including outcome measures, ongoing monitoring and annual reporting **Executive Lead(s):** Project Lead **Delivery Forum**: Womens Service Project Group

Equality Outcome No 4: Understand what we are able to achieve internally regarding Equality and Diversity and where we require external support
Relevant Protected Characteristics There is a recognition that due to the size of the board we may not have the ability to provide the same support services which ensure anonymity is protected. It is also acknowledged that we may not have access to certain areas of expertise and there may be a requirement to seek collaboration across other Boards. Focus on how we ensure that external sources support feedback into the organisation so we can make any necessary changes from lessons learned or feedback provided.
Rationale The board has limited resources and the small scale also affects the ability to anonymise, therefore we require to consider if we can collaborate more effectively with other boards. A good example would be minority forums within NHS Lanarkshire, which are an excellent resource for other staff, but ensure that learning from these groups is fed back to our main groups (WEG and PCIG)
Actions and Milestones Embed into WEG and PCIG Agendas. Ensure that where collaboration is used, feedback is included in our own learning
Measures Review use of external organisations and collaborations with other services in the development of our approach to Equalities. Where gaps are identified seek external support from neighbouring boards.
Updates As part of summary updates to the Board
Responsible Lead for development of action plan, including outcome measures, ongoing monitoring and annual reporting

Executive Lead(s): Stephen Wallace/ Karen McCaffrey
Delivery Forum: WEG/ PCIG

Equality Outcome No 5: Ensuring we are able as an organisation to hear from those with lived experience (patients, Staff and Carers)
Relevant Protected Characteristics ALL
Rationale As a listening organisation, we need to take the opportunities to listen attentively and learn from the experiences of those involved with our services (Workforce, Patients, and Carers). We need to build on our existing mechanisms to ensure that we have multiple forums and means of engaging with key stakeholders and providing feedback. Whilst we have effective general mechanisms for concerns being raised we need to consider how we support sensitive issues and concerns regarding equality being raised.
Actions and Milestones Provide assurance of a safe space to report equality concerns. Ensure regular awareness of opportunities for all to provide feedback Review how we respond to these concerns Develop 'Lessons Learned' sessions to address broader organisational learning.
Measures Feedback directly through the Workforce Equalities Group or PCIG Review of Incident related information for patients and staff Development of a Speak Up Culture
Updates Embedded as part of the regular updates by the relevant lead group.
Responsible Lead for development of action plan, including outcome measures, ongoing monitoring and annual reporting **Executive Lead(s):**Director of Workforce/Director of Nursing **Delivery Forum**: WEG/ PCIG

Equality Outcome No 6: **To review our approach to and to implement different ways to deliver equality and inclusion training, both as Statutory and Mandatory Training and as additional lead on training.** **We should also consider the requirement for bespoke Equality and Inclusion Training for TSH and our unique environment.**

Relevant Protected Characteristics ALL
Rationale • A full review of our current approach to Equalities and Diversity Training, with a focus on induction and Statutory and Mandatory Training. • Ensure appropriate systems to review and monitor compliance. • Develop refresher training which is bespoke to TSH and provides greater awareness of other follow on training through NES and TURAS.
Actions and Milestones Align progress to current Protected Learning Time work undertaken nationally, which should align approach to Statutory and Mandatory Training, with review annually Review Compliance position for the Board. Assess impact of bespoke training
Measures Demonstrating Progress • Compliance Reports • Greater staff awareness • Reduction in Equality related incidents.
Updates Annual
Responsible Lead for development of action plan, including outcome measures, ongoing monitoring and annual reporting **Executive Lead(s):** Director of Workforce **Implementation Lead(s):**Workforce Team **Delivery Forum**: WEG

4. Workforce Monitoring

Under The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, public bodies are required to produce an annual Workforce Monitoring Report which outlines their ongoing commitment to meeting the regulations contained therein. As a public body, the State Hospital is compelled to produce such a report, which must include details of:

• The number of staff and their relevant protected characteristics

• Information on the recruitment, development and retention of employees, in terms of their protected characteristics.

• Details of the progress the public body has made to gather and use the above information to enable it to better perform the equality duty.

Workforce Monitoring for 2024 has been provided in a separate report, alongside 2023/24 Gender Pay Gap reporting (both available in the TSH website).

5. Gender Representation

The Gender Representation on Public Boards (GRPB) 2018 Act requires that 50% of public board's non-executive members are women, detailed as the Gender Representation Objective (GRO) for the boards of listed Scottish public authorities. Appointing persons and public authorities are required to take steps towards achieving the GRO. The GBRP Act encourages public bodies to take positive action measures intended to address the disadvantage experienced by groups sharing a protected characteristic.

The Scottish Government Public Appointments Team is responsible for all appointments that are regulated by the Ethical Standards Commissioner, including the appointment of non-executive members of The State Hospitals Board for Scotland.

Throughout recruitment processes, positive action measures have been taken to encourage applications from women through positive advertising, underlining the value of different experience and points of view. Advertising aspired to realise applications from a wide range of talented people, irrespective of their religion or belief, sex, age, gender identity, disability, sexual orientation, ethnic origin, political belief, relationship status or caring responsibilities. It has been highlighted that applications would be particularly welcome from people with protected characteristics who are under-represented, such as women, disabled people, LGBTI+ people, those from Black, Asian and Minority Ethnic communities and people aged under 50.

Currently, non-executive membership overall is 57% male and 43% female. This includes the appointment of the Employee Director as a stakeholder member. Within the remainder of the non-executive cohort, membership is 50% male and 50% female. Female non-executives chair two of the three standing committees.

6. Summary

This equality outcomes report highlights the progress we have made to date, it seeks to build on this progress and strengthen the governance structures to support delivery across both workforce and patient groups. There are robust practices in place to ensure the equality is embedded into everything we do. However, we do recognise the limitations that come with being a small specialist board and the challenge to create safe anonymous spaces for those who need them whether it is for support guidance or help shape the culture of the organisation as the equality issues evolve.

Whilst there are very good mechanisms in place to gather feedback from staff patients and carers we do recognise that there is little feedback regarding equality issues. In improving both our feedback methods and forums with equality in mind,

we hope that this will encourage greater contributions. We remain committed to listening attentively and responding quickly to all concerns.

TSH welcomes feedback and / or suggestions / queries which may be helpful to inform future iterations of this dynamic document. Please contact the Person Centred Improvement Team via tsh.personcentredimprovementteam@nhs.scot or our Workforce Team on TSH.HRenquiries@nhs.scot

Appendix 1(SB) Final update) is it closed / ongoing/ superseded)

Equality Outcomes 2017-21 (MM Template to report progress one page)

Equalities Outcomes 2017 – 2021

Final report

Equality Outcome 1	Update end 2023	Status
Aim - The State Hospital will ensure the needs of vulnerable patients with a mental health diagnosis are protected by embedding implementation of section 22 of the Mental Health (Scotland) Act 2015 Objective - All patients within the State Hospital are advised of their right to have a Named Person, who is informed of the responsibilities of this role.	Evidence to support process in place to ensure that all patients are advised of their right to have a Named Person. Named Persons provided with information explaining the role and support available where there are any challenges **Response from Jon Patrick** Since the submission of the last report, the new CPA document has been finalised. This was after a lengthy and substantive consultation process with internal and external stakeholders. This included the MWC, MHTS, Restricted Patients Team at The Scottish Government and The Risk Management Authority. Internally, all disciplines including the advocacy service at TSH, the PPG and PCIT were involved in discussions leading up to the document being completed. Feedback has been that the document is now more user-friendly and patient-focussed with an	Closed

	emphasis on more approachable patient-centred language. With the completion of the document, the MHPSG has been developing a new set of procedures that will aim to increase the efficiency of the CPA process more generally and integrate it more fully with TSH's electronic patient record. The CPA meetings themselves will now have a greater degree of patient feedback about their treatment plan alongside a shift in emphasis towards ensuring care is recovery focussed. There has been a test of the system in Summer 2024 with a further live test planned for the end of November 2024. All being well, the new document and associated processes should be embedded in TSH by end of financial Q4 24-25.	
Equality Outcome 2	Update end 2023	Status
Aim - The State Hospital will implement individually tailored healthy lifestyle plans which support the physical health and wellbeing of all patients within the Hospital.	Healthy lifestyle plans now in place and continue to evolve.	Closed
Objective - Healthy lifestyle plans are in place, which engage patients, carers and staff in supporting a holistic approach to physical health and wellbeing, contributing to patient weight loss.		
Equality Outcome 3	Update end 2023	Status
Aim - The State Hospital will deliver services which enable all patients within the Hospital to benefit from equitable access to care and treatment.	There are established systems of recording and monitoring physical activity	Superseded –

Objective: Individual patient Care and Treatment Plans are explicit in terms of identifying and making provision for needs which may impact on a patient's ability to meaningfully engage in care and treatment processes and contribute to the review of progress.	uptake across the hospital for our patients. Staff record periods of physical activity within RiO (EPR) which is noted within the individual patient timetables. This data is available to multidisciplinary staff via the individual patient dashboards within RiO and supports weekly discussions within the Clinical Team Meetings. The master indicator data is also reviewed on a monthly basis and is fed back to Service Leadership Teams. Should any concerns arise this is escalated to the Senior Charge Nurses.	Service Leadership Teams review patient data Activity Oversight Group monitor activity levels across all services.
Equality Outcome 4	Update end 2023	Status
Aim - All TSH patients are cared for in ward cohorts which reflect the patient's current stage of recovery, enabling a person-centred model of care which delivers least restrictive practice. Objective: Current mixed ward model results in inequalities relating to freedom of movement, choice and impacts on quality of life for patients whose mental health supports a less restrictive approach.	The Clinical Model project was closed in July 2023 with patient moves completed in May 20243. Clinical Guidance was completed and passed to newly established leadership group. In 2023 the hospital introduced a new clinical model, which is underpinned by the ethos that every patient should receive the right care by the right team at the right stage in their journey (i.e. care should develop around the individual as opposed to the individual fit the care system). Within the new model care is delivered across four services: Admission and Assessment, Treatment and Recovery, Transitions and a dedicated Intellectual Disabilities service. The clinical model has a recovery-focused approach, with a progression for patients experiencing major mental	Closed

	illness to move through the 3 services of Admission and Assessment, Treatment and Recovery and Transitions. The risk management thresholds within each of these services is tailored to the specific service, meaning that as each patient progresses through their care journey they can expect to see and experience progress towards lower, tailored security measures. The clinical model oversight group have overview of patients across the service. As the clinical model embeds, the progression of patients will be reviewed to ensure that patients move through the services when they are ready to. The tailoring of security measures for Transitions patients is in development with the Transitions Service Leadership Team tasked with taking this forward. Progress will be monitored to understand how this is being implemented.	
Equality Outcome 5	Update end 2023	Status
Aim - TSH will introduce use of digital platforms, enabling patients to communicate safely, effecting reciprocity of access with people who experience mental health.	Ongoing as part of the overall digital programme, subject to resourcing.	Closed
Objective: The majority of TSH patients currently have no access to virtual technology and many lack the skills to engage in this way. Those who have skills in this respect, with prolonged lack of use, are likely to become de-skilled and will therefore be disadvantaged when leaving TSH. Increasing use of virtual platforms to engage in physical health appointments with external organisations, engage in Mental Health Tribunals, attend Court proceedings and maintain contact with family and friends has highlighted this gap in access and skills.		
Equality Outcome 6	Update end 2023	Status

Aim - Tailored processes, adopting a least restrictive approach are in place to support reciprocity of access to TSH physical environment for all patients.	Some of the work that has been completed within Iona Hub are the mural art work, which is now complete. ID service were involved in the new grounds access policy, so least restrictive for our ID patients.	Closed Closed
Objective: Some areas of TSH environment are not accessible to all patients (particularly those with complex needs) as a result of mental / physical health presentation, location, security restrictions. Work is required to review policies which influence decision making in this respect and reasonable adjustments made to support equitable access where it is safe to do so.	Sensory boxes are being used for a select group off our patients. A garden or gardening group currently **superseded by** The ID service are currently working on their Medium term plan with a sensory room currently being worked on for Iona 1, if this is successful we will look at doing this in Iona 2 & 3**.** The service has most recently discussed an IPad with Makaton to be able to communicate with one specific patient.	Closed **Superseded** **Ongoing**
Equality Outcome 7	Update end 2023	Status
Aim - Every member of staff and volunteer will be signposted to and have access to informal, independent, individually tailored Pastoral Support which reflects a holistic approach to staff wellbeing.	This is covered in detail in the Induction and the services are advertised within the Wellbeing Centre and on an ongoing basis throughout the year by Staff Brief	Closed
Objective: To help provide support to our employees we offer a number of different networks, to aid mutual support, provide a collective voice and ensure appropriate representation and inclusion. This service is currently based within NHS Lanarkshire but is open to our employees here at the state hospital. Peer support can be vital, having the opportunity to chat to someone else around issues they are currently facing or even share positive experiences.		

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE **SGC(M)24/04**

Minutes of the meeting of the Staff Governance Committee held on Thursday 21 November 2024

This meeting was conducted virtually, by way of MS Teams, and commenced at 9.30am

Chair:	
Non-Executive Director	Pam Radage
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Non-Executive Director	Shalinay Raghavan
In attendance:	
Organisational Development Manager	Graeme Anderson
Head of Organisational Learning and Development	Sandra Dunlop
Chief Executive	Gary Jenkins
Lead Nurse	Stuart Lammie
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
RCN Representative	Richard Nelson
Head of HR	Laura Nisbet
Head of Corporate Governance	Margaret Smith
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting. There were no formal apologies, and it was noted that Mr Lammie would attend for this meeting on behalf of Josie Clark, Associate Nurse Director.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business on the agenda.

3 MINUTES OF THE PREVIOUS MEETING

The Committee received the minute of the previous meeting held on 15 August 2024.

The Committee:

1. Approved the minute of the meeting held on 15 August 2024.

4 MATTERS ARISING AND ROLLING ACTIONS LIST

Ms Radage noted that most of the actions would be covered during the meeting however, highlighted that Action 3: the Meet the Board Videos would now take place in 2025.

In relation to Action 7: the next Occupational Health Report was due to be presented at the meeting in February 2025, which would provide an opportunity to ensure the report would meet the needs of the committee and for any refinements to be made.

The Committee:

1. Noted the updates from the Rolling Actions List.

5 CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

The committee received the Corporate Risk Register - Staff Governance Risks quarterly report presented by Mr Wallace, who detailed the current position on the four risks that sit under the Workforce Directorate. He advised that a newly formatted report would be presented at the next meeting and would reflect the standardised reporting format.

He provided an overview of the actions underway to mitigate each risk and noted that all had been reviewed within the relevant timeframe. He highlighted that compliance with PMVA level 2 training had been moved to a medium rating and provided the rationale for this and the measures in place to address it. He noted that there had not been a large uptake in engagement in relation to the Agenda for Change Band 5 review within the State Hospital (TSH). He noted that due to this being an open-ended process, it should remain on the register for monitoring. In response to a question from Ms Fallon if it would be possible for TSH to apply an end date, Mr Wallace advised that it would not be possible, as it was nationally led.

In relation to PMVA level 2 training, Mr Jenkins noted that ways to ensure a backlog did not build up should be explored, and Ms Radage agreed. Mr Wallace added that steps would be put in place to identify patterns in relation to peaks and troughs in uptake, along with measures to ensure training was spread out consistently throughout the year.

In response to a question from Mr Connor on the steps in place to review Risk HRD111 relating to information leaks, Mr Wallace confirmed that this continued to be closely monitored. There was discussion around the benefit of this being included in the register, and also on how to consider mitigation through positive culture change in the organisation. It was agreed that it would be useful to link in with wider practice across NHS Scotland, and that this could be discussed in more detail at a future Board Development Session.

Action: Ms Smith

The Committee:

1. Agreed that the Corporate Risk Register – Staff Governance update represented an accurate statement of risk.
2. Add to discussion topics for Board Development Sessions in 2025

6 EVALUATION OF THE STAFF & VOLUTEER HEALTH & WELLBEING STRATEGY 2023/24 – KEY IMPACTS

The committee received the Evaluation of the Staff and Volunteer Health and Wellbeing strategy presented by Mr Anderson who provided the context to the report and highlighted the key areas, observations, and findings.

He noted the high level of awareness of the Wellbeing Strategy and the Wellbeing Centre within TSH, however, there were issues in terms of accessibility of services for certain areas of staffing,

particularly nursing. Since the previous survey in 2021, line manager support had increased with more managers feeling able to help and support staff using the tools available. Although the line management support component had improved by 20%, this was not in all departments, and it was suggested that further support and training should be developed. Areas of improvement would include looking at ways to achieve accessibility for all areas. Mr Anderson also highlighted the intention to remain committed to the wellbeing strategy as well as the areas noted for improvement and asked for feedback on the five recommendations within the report.

Mr Jenkins welcomed the report and noted that the work undertaken around organisational health correlated with the survey. He suggested that to address the issue of accessibility, it may be beneficial to create bespoke plans for each staff group and that an increase in nursing staff may help to improve access to the various services on offer.

Ms Fallon thanked Mr Anderson for the report and reiterated the points raised by Mr Jenkins. She noted concern around staff feedback on safety and psychological distress and the impact that may have on the care given to patients. She queried if more consideration could be given to capturing any successful approaches being led by senior managers, and how this could be shared for learning. Ms Fallon also noted that the survey appeared to focus more on staff, with only a brief mention of volunteers.

Mr Anderson replied that in relation to the quantitative and qualitative survey, 95% of returns were received from staff and so the report communicated data in relation this group. He agreed with the comments around staff safety and psychological distress and referred to the recommendation suggesting incorporating the Wellbeing Strategy into the wider Organisational Development Strategy which would allow this to be addressed. Mr Wallace agreed and added that in relation to staff mental health and feeling safe, the current work being undertaken to implement the reduced working week and change shift patterns, provided a unique opportunity to address this and other issues.

Mr Jenkins noted the importance of focusing on staff mental wellbeing and that a number of interrelated pieces of work were being undertaken to evaluate and refine current procedures, to improve this and set the direction going forward, and confirmed that development of this would be led through the Corporate Management Team (CMT) including the suggestion of a development day to take a deeper dive into this and bring back reporting to the committee.

Action – Mr Wallace

Ms Radage welcomed the report and agreed that including all the components within this report were helpful in providing context to sickness absence rates.

The Committee:

1. Noted the Evaluation of the Staff & Volunteer Health & Wellbeing Strategy 2023/24 – Key Impacts, and endorsed the recommendation contained therein.
2. Noted the oversight and leadership taken through the CMT.

7 STAFF GOVERNANCE MONITORING RETURN

The committee received the Staff Governance Monitoring Return presented by Mr Wallace who provided an overview of the report, including assurance of the continued support for the workforce, effective partnership and working through staff governance standards. He advised that a response had been prepared in partnership with the Employee Director and provided the context for the benefit of the committee.

Mr Wallace sought the agreement of the committee to sign off the Staff Governance Monitoring Return and this was agreed by the committee.

The Committee:

1. Approved the submission of the Staff Governance Monitoring Return.

8 EQUALITIES UPDATE

The committee received the Equalities Update presented by Mr Wallace who highlighted work already undertaken and the actions to be carried out. One key action was to establish a Workplace Equalities Group, subject to the staff governance standards.

Ms Fallon queried if the group would focus on both staff and patients. Mr Wallace confirmed that the focus would be on staff however, the impact on patients would be addressed. Mr Jenkins noted the difference between TSH patients compared to NHS Scotland generally, this would be overlaid with the Person Centred Improvement Team agenda, and that Ms McCaffrey would lead on this aspect. He further noted the importance of voluntary staff involvement, in addition to being mindful of ensuring that the TSH equalities and diversity agenda was meaningful.

Ms Fallon asked about the potential for non-executive involvement, and it was agreed that further consideration would be given to this.

Action – Mr Wallace/ Ms Smith

Ms Radage welcomed the report on behalf of the committee, and the work being progressed in this area.

The Committee:

1. Noted the Equalities Update.

9 WORKFORCE GOVERNANCE GROUP REPORT

The committee receive the Workforce Governance Group (WGG) Report which provided an update on the group's activity. Mr Wallace highlighted the focus on performance, quality, and compliance in relation to workforce KPIs which looked at the performance of the Board and individual departments. Reporting had been altered to a dashboard view to allow information to be viewed more clearly. He further noted a key role of the group was monitoring the progress and implementation of the Workforce Plan.

Mr Currie welcomed the work undertaken by the group, especially on taking forward consideration of changing approaches to existing practice. Ms Fallon thanked Mr Wallace for the layout and content of the report. Mr Jenkins also thanked Mr Wallace for the work undertaken and in progressing with the group. Ms Merson complimented the changes to the dashboard view and supported the monitoring of the workforce plan.

Ms Radage also welcomed the report as being very positive, and demonstrated sharp focus being taken which worked well with the delivery of services. She noted the size of the group's membership and Mr Wallace confirmed that this would be reviewed as the group progressed. Ms Radage also added that the Staff Governance committee had been omitted from the chart in appendix 1.

Mr Wallace agreed the membership was large and added that it would be reviewed as the group progressed, as would the frequency of the meetings to ensure the group fed meaningfully into the committee. Mr Wallace agreed to amend the chart structure in appendix 1 to include the committee.

Action: Mr Wallace

The Committee:

1. Noted the Workforce Governance Group Report.

10 WHISTLEBLOWING REPORT Q2

The committee received the Whistleblowing Report Q2 presented by Mr Wallace who confirmed that there had been no new cases. He advised that further training had been provided to confidential contacts and the updated list was available on the intranet. There are currently six internal confidential contacts and the option for staff to contact NHS Lanarkshire's confidential contacts.

Mr Moore welcomed the link with NHS Lanarkshire confidential contacts and noted the benefit of resources from validated and experienced people to undertake stage 2 investigations. Mr Connor acknowledged that there had been no cases in the last 12 months which could indicate staff are using other mechanisms and asked what could be done to increase staff confidence to use the whistleblowing process.

Mr Wallace replied that some staff had engaged during the recent Speak Up week with concerns raised via the dedicated email address. He added that communication to promote the whistleblowing process would be included within staff bulletins and this would reference that concerns had been raised and include measures taken to address these. In addition, support for managers would be explored to help them to be able to respond when concerns raised with them.

Ms Radage and Mr Currie both noted the difficulties in engaging staff with whistleblowing process and asked what more could be done to encourage staff to report concerns. Ms Raghavan agreed and noted the importance of staff being able to raise concerns in a way that was comfortable for them, and ensured they are confident they would be listened too and added that the procedures in place could be developed, which was the aim of the Board.

Mr Jenkins suggested that it would be useful to build the whistleblowing process into the series of measures on wellbeing health and to embed this into the range of options available for staff to raise concerns, and to view these as measures, rather than in isolation. Ms Radage concurred and noted the importance of ensuring that iMatter questions around this issue are in line with other Boards.

Mr Wallace agreed with all points made and highlighted that whistleblowing should be a last resort, or for significant issues. He added that staff should be able to raise concerns initially with line managers, with a focus on managers understanding how to respond and deal with concerns brought to them.

Mr Anderson added that whistleblowing had been identified through the organisational development diagnostic as an area to be aligned and incorporated into the wider component of organisational health, and how this could be integrated.

The Committee:

1. Noted the Whistleblowing Report for Q2.

11 ORGANISATIONAL DEVELOPMENT (OD) STRATEGY – HEALTH & PERFORMANCE

The committee received the OD Strategy - Health and Performance Report presented by Mr Anderson who provided context on how the diagnostics were carried out and highlighted key findings and future plans. He noted that direction, leadership, and the working environment were the three key areas identified across all groups, the work carried out had created momentum over the year and the importance of ensuring the alignment of this with the Wellbeing Strategy and the

Workforce Plan to ensure the improvement of the health and performance of the organisation. He emphasised this as foundational work to help build a new approach, and the need for staff to feel part of the process.

Mr Jenkins welcomed the work undertaken and noted this had created the foundation to allow positive changes for 2025/26 in relation to culture and enhanced well-being overall and the empowering of frontline leaders.

Ms Fallon also welcomed the report and noted that it demonstrated linkage between different strategies and asked how this translated into the clinical model. She further asked about any financial impact of this work, and Mr Anderson replied that the strategy was in the creation stage and that costings would become clearer as it progressed. Mr Jenkins added that any costs may be a by-product of this work. He further noted that the work carried out for the OD Strategy in terms of the health and performance diagnostics, and the importance of linking this to the continuing development of the clinical model within TSH. Mr Anderson agreed on the points raised around aligning this work with the clinical model.

Mr Currie agreed that organisational change was preferable 'with' rather than 'to' an organisation and noted that the same three areas were being highlighted across all groups which provided a good starting point. He noted that in a time, it may be this approach became more valuable and cost effective. Mr Jenkins agreed with Mr Currie and added that professional standards should be set when staff commence employment and reiterated that work carried out had created a foundation to make changes to increase engagement.

Ms Radage also agreed with the points raised and expressed that the work carried out was a good example of how change embedded into an organisation naturally and easily and that focusing on only a few areas would enable effective delivery. Lastly, she welcomed the team working with Ms Merson in relation to engaging with the organisation.

Mr Jenkins added that consideration should be given regarding the launch approach of the next steps to take full advantage of the opportunities that created.

The Committee:

1. Noted the OD Strategy – Health & Performance.

12 iMATTER ANNUAL UPDATE

The committee received the iMatter Annual update presented by Ms Dunlop who highlighted the 72% response rate from staff, which was higher than the national average, and that 90% of teams within the hospital received a detailed report following the survey. Ms Dunlop provided an overview of questions asked and responses received and noted that most scores were comparable to the national average. She added that the employee engagement index score remained unchanged since the launch of iMatter and expressed interest in exploring the integration of iMatter with the OD Strategy and how this could potentially increase the index score. An update on actions to follow the outcome of the survey was also provided.

Mr Nelson noted that only 47% of teams completed an action plan within the timescale and asked if the reason for this was known and what could be done to improve this. Ms Dunlop replied that for clinical teams particularly, scheduling time to have the relevant discussions with all team members could be challenging and could be a significant factor. She added that a substantial number of teams have since completed their action plan and work was ongoing to support the teams who have yet to do so. Mr Anderson agreed with Ms Dunlop's response to Mr Nelson regarding the number of action plans not completed within time scale and that the OD diagnostic had picked up on a lack of skill in the ability to have difficult conversations with staff, which may provide insight as to why action plans were not completed.

Mr Currie noted that the table containing the scores and responses had remained consistent over time and added that the responses are useful and tied in with other work being undertaken such as the OD Strategy. Ms Dunlop agreed that the information from iMatter was useful and allowed comparison with other data collected within the organisation.

Ms Fallon referred to the question around Board members visibility and asked if it was possible to map out events in the hospital, especially with patient and carer involvement to allow Board members to meet key stakeholders and interact in a less formal setting. Ms Smith noted that dates had been scheduled for informal walkrounds where two non-executive members would be present, supported by a member of the Corporate Services Team to capture the conversations and allow feedback and common themes to be identified and reported on. Ms Smith agreed with Ms Fallon's point around planning of hospital events to support Non-Executive Director involvement and would explore how this could be achieved.

Action: Ms Smith

Mr Moore commented that staff also appreciated the attendance of the Chair and Non-Executives at events and the impact of this should not be underestimated. He also added that given the possibility of significant changes in relation to future governance, and where the hospital would sit in terms of a national forensic mental health board, it was not surprising that some outcomes showed uncertainty in terms of direction. Mr Jenkins agreed and added that focus should be on ensuring the organisation had confidence within itself which would allow protection from the changes surrounding it.

Ms Radage thanked members for the points raised and context provided, and Ms Dunlop for the report. She noted that the valuable data it contained provided a level of assurance that could not gained elsewhere.

The Committee:

1. Noted the iMatter Annual Update.

13 WORKFORCE (HR, LEARNING & WELLBEING, & OD) REPORT

The committee received the Workforce (HR, Learning & Wellbeing, & OD) Report presented by Ms Nisbet who provided an overview of the content and highlighted that October saw an increase in sickness absence slightly higher than in previous years. The rolling year average remained low and would be reviewed to assess whether the downward trajectory had impacted on this. Focus meetings had taken place to look at long-term and short-term absence and the test of change that had been developed within the nursing team. This change was based on the RAG status documentation that allowed focus on ward areas that required extra resource and support. Finally, Ms Nisbet noted that staff engagement with attendance at occupational health increasing.

Ms Dunlop highlighted the high levels of compliance for performance development reviews and statutory and that mandatory training was being maintained. Also of note was that 13 additional staff had been recruited as peer supporters. The Staff Excellence Awards were scheduled to take place in February and 87 nominations had been received. Finally, a new leadership development provision was being delivered in collaboration with other West of Scotland NHS Boards which targeted senior level leadership, heads of service and departmental heads and 11 members of staff were involved in this programme.

In relation to PDPR compliance, Mr Currie noted that staff for whom their review was overdue, were missing an opportunity to have important conversations. He also noted the importance of the Staff Excellence Awards. Mr Wallace replied that the percentage of staff on long-term absence contributed significantly to number of PDRs outstanding and added that the average completion of PDRs in other Boards was around 40 to 50%. He further noted that through the WGG individual areas would be identified and plans would be put in place to ensure a route to improvement.

Ms Fallon commended the exit interview process and noted the good initiative of the Anchors Strategy to fit into sustainability. She noted that it may be beneficial if relatives were invited to the Staff Excellence Awards, as this could be an effective way of demonstrating the good work carried out by the hospital and its staff. She noted that 15 members of staff had applied to become peer supporters and 13 had been appointed and enquired why two of the applicants had not been successful. Mr Anderson advised that all potential candidates required endorsements from their manager in terms of workload capacity, and the two staff members did not have that endorsement.

Ms Radage welcomed the report and highlighted the number of Staff Excellence Award nominations as being very positive.

The Committee:

1. Noted the Workforce (HR, Learning & Wellbeing and OD) Report.

14 ONCE FOR SCOTLAND POLICY LAUNCH UPDATE

The committee received the Once for Scotland Launch Update presented by Ms Nisbet who provided context and highlighted the slight change on how changes of headlines from policies will be communicated to each management group.

Ms Fallon asked how volunteers were inducted and made aware of policies within the organisation. Ms Nisbet assured Ms Fallon that she would link up with the team that support volunteers, to ensure that this support was in place.

The Committee:

1. Noted Once for Scotland Launch Update.

15 PARTNERSHIP FORUM APPROVED MINUTES

The committee received and noted the approved minutes from the Partnership Forum meetings which had taken place in July and August 2024.

The Committee:

1. Noted the approved Partnership Forum minutes.

16 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

The following areas were highlighted:

- Engagement work as part of development of Medium-Term Plan
- The way in which reporting to this meeting linked well across workstreams showing a joined-up approach.

The committee discussed and reflected that this had been a positive and constructive meeting overall, and succinct reporting and presentation had supported focused consideration of the business. It was agreed that this may be a good way forward across all committees.

17 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTIEES

There were no matters to be shared with other committees on this occasion.

18 ANY OTHER BUSINESS

There were no additional items for discussion.

19 DATE OF NEXT MEETING

The next meeting would be held on Thursday 20 February 2025 at 0930 hours via Microsoft Teams.

The meeting concluded at 12:30

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 16b
Report Author:	Head of Corporate Governance
Title of Report:	Staff Governance Committee – Summary Report
Purpose of Report:	For Noting

This report provides an update on the key points arising from the Staff Governance Committee meeting that took place on 20 February 2025.

1	Corporate Risk Register Quarterly Update	The Committee received the quarterly report detailing the corporate risks assigned to the Workforce Directorate. The Committee noted the activity in this area to review current risk assessments, and provide oversight of movement across the framework,
2	Occupational Health Service	The Committee reviewed the Service Level Agreement with NHS Dumfries & Galloway, noting the importance of this service and endorsing the decision to extend this agreement. There was review of the Key Performance Indicators as a means of monitoring delivery going forward.
3	Workforce Equalities Group	The progress in this area was welcomed, with the group established and active across this remit, with reporting progressing to the Board. A Non Executive Director would take up the role of Equalities Champion.
4	Maximising Attendance	The Committee received reporting with detailed data analysis across a range of metrics demonstrating the position for the State Hospital (TSH) in comparison to wider NHSScotland, as well as within service areas across the hospital itself. This was placed in the context of the management strategies in place to maximize attendance, and the packages and pathways in place to support staff. The Committee discussed and reviewed this in detail, underlining the need to make improvement and how to embed good practice and ownership across the organisation.
5	Workforce Governance Group	The Committee noted the further progress made in this area of governance, and that the minutes of the meetings will be submitted to give oversight.
6	Whistleblowing Report	Reporting for Quarter 3 of 2024/5 confirmed that there had been no new cases for consideration under the standards, with one case being directed to business as usual pathway.
7	Workforce Planning	There was an update on the progress towards delivery of

		workforce planning as set out at a national level.
8	OD Learning and Wellbeing Update	Reporting was received across a range of areas including staff induction and coaching, and the development of the OD strategy. Further, the planning of the Staff Excellence Awards and the suite of activities being delivered for staff wellbeing. Reporting also provided an update on the Peers Support Network.
9	Statutory and Mandatory Training	The Committee noted the update on the position which showed good compliance across the hospital. An internal audit had been conducted which showed good practices, as well as having some recommendations for improvements. The Committee was assured that these were being taken forward.
10	Nurse Practice Development	The Associate Nurse Director provided a six monthly update which included monitoring the Clinical Care Policy, improving nursing engagement with clinical supervision, the first year support programme for nursing staff, and promoting forensic healthcare as a career choice for nurses. The Committee received assurance form the work underway and planned for the coming year, and widened this to consider further the training and developments needs of all staff groups.
11	Partnership Forum	The Committee received the approved minutes of meetings of the forum over the last quarter, taking assurance from the range iof business considered.
12	Areas of good practice / Concerns	The Committee noted the clear focus on maximising attendance, as well as the work progressed in planning the upcoming Staff Excellence Awards. Further the constructive nature of conduct of the Partnership Forum to support partnership working. The Committee also noted the work of management and estates staff to support the hospital during Storm Eowyn. The Committee noted that the concise nature of papers had helped to support discussion on key issues.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minute will be presented, once approved by the Committee.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously.
Workforce Implications	There are no specific impacts to be noted.
Financial Implications	None as part of routine reporting.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes as per Standing Orders.
Risk Assessment (Outline any significant risks and associated mitigation)	No risk identified, but good practice to ensure that all Board Members are aware of committee update.
Assessment of Impact on Stakeholder Experience	None
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 17
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Corporate Governance
Title of Report:	Corporate Objectives 2025 - 26
Purpose of Report:	For Decision

1 SITUATION

The State Hospitals Board for Scotland undertakes a review of its corporate objectives annually to provide a high-level statement of strategic goals for the following year. This brings together the priorities for the Board across each strand of governance.

2 BACKGROUND

This document sets out the draft Corporate Objectives for The State Hospital (TSH) for the period 1 April 2025 until 31 March 2026. This summarises the strategic priorities for the coming year in a transparent way, and is a means through which the Board can set out its key aims.

The Corporate Objectives should align with the operational business model for TSH through the Annual Delivery Plan for 2025/26, which will in turn delivered within the wider context of the Medium Term Plan for 2025/28. Therefore, the Corporate Objectives focus on the aims of delivering safe and secure patient care, within a sustainable financial plan; as well as reflecting the organisational aim for a sustainable workforce, who feel supported in the workplace.

3 ASSESSMENT

The draft Corporate Objectives are attached (**Appendix A)** and group the key aims around the themes of Better Care, Better Health, Better Values and Better Workplace.

- Improve the quality of care for patients by targeting investment and focus at improving services with the high security environment and for providing the most effective support for all. **(Better Care)**

- Improve health and wellbeing by promoting and supporting healthier lives and choices, addressing inequality and adopting an approach based on recovery, care and treatment. **(Better Health)**

- Increase the value from, and financial sustainability of, care by making the most effective use of available resources through efficient and effective service delivery **(Best Value)**

- Improve the engagement of staff and opportunity for development through effective values based leadership resulting in a culture of quality and accountability **(Better Workplace)**

The performance management framework underpinning delivery of these objectives is through:

Annual Review

Scottish Ministers hold the Board to account through an annual review of performance, and this was last undertaken formally on 18 November 2024, led by the Minister for Social Care, Mental Wellbeing and Sport. The Minister wrote to the Board following this to formally outline the outcome of this review, and this was received in December 2024. This was supportive of the work progressed by the Board through the period April 2023 to March 2024, with no significant concerns raised, and is published on the TSH website.

Further oversight of performance will continue through the quarterly sponsor meetings held between the Executive leadership and the Scottish Government colleagues.

TSH Board

The Board and its committee structure holds the Executive Team accountable through a wide range of assurance reporting, as well as audit reporting.

The Board continues to review its governance structures, in the context of the NHSScotland Blueprint for Good Governance, and has a Board Improvement Plan in place. This is reported to the Board at six monthly intervals. The Board welcomes the opportunity for a further self-assessment exercise, led by NHS Education for Scotland, with the expectation that this will be rolled out to all NHS Boards in the coming year.

Executive Leadership

The Corporate Objectives form the basis for setting the individual objectives for each of the Corporate Directors, with detailed oversight of performance then taken by the Remuneration Committee within the structure of the NHSScotland National Performance Monitoring Committee. The Remuneration Committee takes active consideration of the way in which it seeks assurance and related evidence base for its consideration of individual performance.

This process underpinned by structured directorate performance meetings, led by the Chief Executive. These provide a conduit through which each directorate can highlight areas of excellence or any potential area of concern, to build engagement toward improvement where necessary.

The Board is also asked to note that the Corporate Objectives have been drafted within the context of review of the national framework for delivery of forensic mental health services in NHS Scotland, led by Scottish Minsters, and which may impact the strategic direction for the organisation in a significant way.

4 RECOMMENDATION

The Executive Team was asked to review and contribute to the draft Corporate Objectives, with approval through the Strategic Planning, Performance and Governance Group.

The Board is asked to recommend any changes required before providing approval of these objectives for 2025/26.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	To present the draft corporate objectives to the Board for their consideration and approval.
Workforce Implications	The Corporate Objectives detail our key strategic aims for a better workplace; providing a framework through which impacts on the workforce can be considered through any strategic planning for the year.
Financial Implications	To underpin the key aim of better value for the organisation, stating the intent that this will underpin strategic planning and financial management.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Requested as part of the Board's workplan, and reviewed by the Strategic Planning, Performance and Governance Group.
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk assessment made, this supports the organisational delivery of key objectives.
Assessment of Impact on Stakeholder Experience	Key stakeholders and the need to align the corporate objectives to these is outlined in the paper.
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No issues identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Appendix A

THE STATE HOSPITALS BOARD FOR SCOTLAND

CORPORATE OBJECTIVES 2025/26

1. Better Care

a. Implement the Annual Delivery Plan and the Medium-Term Plan, aligning the organisational aims and direction to the health priorities set out in Scottish Government Policy, aligning to NHS Reform across NHSScotland.

b. Tailor the Clinical Model to better reflect the graduated clinical and security steps for patient progression on their care and treatment pathway.

c. Eliminate the use of Day Time Confinement to all but very exceptional circumstances.

d. Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk.

e. Ensure the principles of the rehabilitative care are applied optimising opportunities for meaningful patient activities, educational development and occupational development across all service areas.

f. Develop and implement an interim women's service model, in line with the project initiation. In the context of the State Hospital's Clinical Care Model, this will be an admissions ward, with equivalence of service provision to that of male patients in the existing admissions service.

g. Develop and implement an outreach service model for women from high security to medium security providers and the Scottish Prison Service. The aim of the outreach service is to work in partnership with service teams in the management of patients who may require admission, or who are displaying behaviours that could necessitate a high security referral.

h. Oversee the development and implementation of a capital development following the outcome, and preferred option, from a professional design team feasibility report. This development will create a dedicated care and treatment centre for women with tailored person-centred care packages aligned to the three phases of the Clinical Care Model: Admissions, Treatment & Recovery, and Transitions.

i. Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events.

j. Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system.

k. Deliver a programme of Infection Control related activity in line with all national policy objectives.

l. Monitor the use and recording of restrictive practices (including seclusion practice and use of soft restraint kits) in accordance with Mental Health legislation and the definitions

published by the Mental Welfare Commission.

m. Be accessible to patients, their family and visitors ensuring their views and experiences are reflected in service improvements, implementing the Carer Strategy 2025/28.

n. Embed the principles of Realistic Medicine, through the Realistic Action Plan for 2025/26.

o. Work with stakeholders and Scottish Government representatives to enhance the reputation and healthcare 'profile' of the State Hospital.

p. Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment.

q. Take forward national collaboration and interface work with the Healthcare in Custody Network.

r. Support the development of a national framework for collaborative working in the delivery of forensic mental health services across NHSScotland.

2. Better Health

a. Tackle and address the challenge of obesity, through delivery of the Supporting Healthy Choices programme.

b. Continued improvement of the physical health opportunities for patients.

c. Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient.

d. Address the overall social wellbeing issues for patients undergoing treatment.

e. Utilise connections with other health care systems to ensure patients receive a full range of healthcare support.

f. Ensure that patients have a seamless transition from the State Hospital to other care providers as part of their care pathway when clinically appropriate. This will align with the aims and ambitions of medium secure provision and other treatment pathways.

g. Ensure the organisation is aligned to the values and objectives of the wider mental health strategy and framework for NHSScotland.

3. Better Value

a. Meet the key finance targets set for the organisation and in line with Standard Financial Instructions.

b. Develop a sustainable finance model within the available finance allocation that supports the sustainability and growth of the organisation.

c. Deliver all Scottish Government financial budget and resource reporting and monitoring requirements for NHSScotland national matters, through Board Chief Executive, Director of Finance and Human Resource Director groups.

d. Work collaboratively across public sector bodies to ensure that best value is achieved in

service planning, design and delivery, including through National Board collaboration and the Anchors Strategy

e. Deliver programme of sustainable working and progress to net zero recognising the impacts of climate change and financial constraints.

f. Enhance and strengthen digital innovation for the organisation; and the digital inclusion programme for both staff and patients.

g. Ensure delivery of a cohesive approach to information governance and records management standards, including delivery of the newly formulated Records Management function.

h. Deliver the actions identified by the NIS audit, to maintain cyber security and resilience.

i. Complete the security upgrade and move towards the development of the core security quality indicators.

j. Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance.

k. Support quality improvement approaches, embedding a cohesive approach.

l. Ensure the continued delivery and development of the organisation's performance management framework.

4. Better Workforce

a. Development and delivery of the three-year Workforce Plan 2025/28 within the context of the planning framework and guidance from Scottish Government.

b. Continue to support and build partnership working so that this is embedded across the organisation.

c. Deliver and monitor staff resourcing aligning to the Health and Care (Staffing) (Scotland) Bill (2019) across the State Hospital, and in conjunction with the local delivery of the national e-rostering programme, through the Workforce Governance Group.

d. Maximise workforce sustainability through delivery of the State Hospital's Recruitment and Retention Strategy, through modern, inclusive recruitment practice and continued development of a supplementary workforce.

e. Promote and deliver a framework of wellbeing within the framework of a Staff and Volunteer Wellbeing Strategy

f. Develop and implement the Organisational Development Strategy, and action plan, using Organistional Health approach.

g. Building on iMatter and staff governance principles to deliver an inclusive staff engagement programme in partnership to support the wellbeing of all employees.

h. Mainstreaming equality in line with Scottish Government guidance for public bodies – as a means of ensuring equality is woven into all aspects of the organisation and by the development of specific equality outcomes.

i. Sustain a safe working environment for staff with a focus on risk management across all

aspects of the organisation.

j. Implement the 'Once for Scotland' suite of Human Resources policy, aligning with the national rollout.

k. Ensure accessibility and support internal and external services for staff who require them, including a cohesive Occupational Health Service.

l. Review and action absence related issues and prioritise support mechanisms and staff wellbeing to provide staff and line managers with the support required; and where absence is required, support staff to return to work at the earliest opportunity. Strengthen leadership and develop positive culture.

m. Continue to support training and development for all staff at every level across the organisation.

n. Support the Independent National Whistleblowing Standards and support this workstream locally including promoting awareness for staff. Re-fresh local approach to delivery of standards, and collaborative working where possible.

o. Maintain an appropriate Health and Safety governance framework that demonstrates continual improvements and a commitment to fulfil our compliance obligations.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 18
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Business Support Corporate Planning, Performance and Quality Project Support Mgr
Title of Report:	Q3 2024/25 Corporate KPI Performance Report
Purpose of Report:	For Noting

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q3: October 2024 to December 2024. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are Psychological Therapies Waiting Times and Sickness Absence. Additional local KPI's are reported to the Board and are included in this report. Board planning and performance are monitored by Scottish Government through the Annual Delivery Plan (ADP) for 2024-25 which was approved by the Scottish Government in June 2024.

2. BACKGROUND

Members receive quarterly updates on KPI performance as well as an annual overview of performance and a year-on-year comparison at the Board meeting each June.

The calculation for a quarterly figure is an average of all three month's totals.

3. ASSESSMENT

The following sections contain the KPI data for Q3 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have missed their targets.

There is a total of 12 corporate KPI's. Eight KPI's have reached and / or exceeded their target this quarter and there are four KPI's which are off target, these are:

Reached and / or exceeded their target	Off target
• Patients will be engaged in psychologist treatment. • Patients will be engaged in off-hub activity centres. • Patients will undertake an annual physical health review. • Staff will have an approved PDR. • Patients transferred/discharged using CPA. • Patients requiring primary care services will have access within 48 hours.	• Patients have their care and treatment plan documentation reviewed at 6 monthly intervals. • Patients will undertake 150 minutes of moderate exercise each week. • Patients will have a healthier BMI. • Sickness absence rate.

• Patients will commence psychological therapies <18 weeks from Referral. • Patients have their clinical risk assessment reviewed annual. •	

Performance Indicator	Target	RAG Q4 23/24	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	R	R	A	A	90.2%	This indicator remains in the amber Zone.
Patients will be engaged in psychological treatment	85%	G	G	G	G	93.20%	This indicator remains in the green zone.
Patients will be engaged in off-hub activity centers *(This includes drop-in sessions which took place in hubs, grounds and Skye Centre)*	90%	G	G	G	G	93.67%	This indicator remains in the green zone.
Patients will undertake an annual physical health overview by the practice nurse	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients will undertake 150 minutes of moderate exercise each week	70%	R	G	A	R	52.33%	This indicator moves from the amber to red zone.
Patients will have a healthier BMI	25%	R	R	R	R	10%	This indicator remains in the red zone.
Sickness absence rate	5%	R	R	R	R	8.3%	This indicator remains in the red zone
Staff have an approved PDR	80%	G	G	G	G	88.1%	This indicator remains in the green zone
Patients transferred / discharged using CPA	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients requiring primary care services will have access within 48 hours	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients will commence psychological therapies <18 weeks from referral date	100%	G	G	G	G	100%	This indicator remains in the green zone.
Patients have their clinical risk assessment reviewed annually.	100%	A	R	A	G	96.03%	This indicator moves from the amber to the green zone.

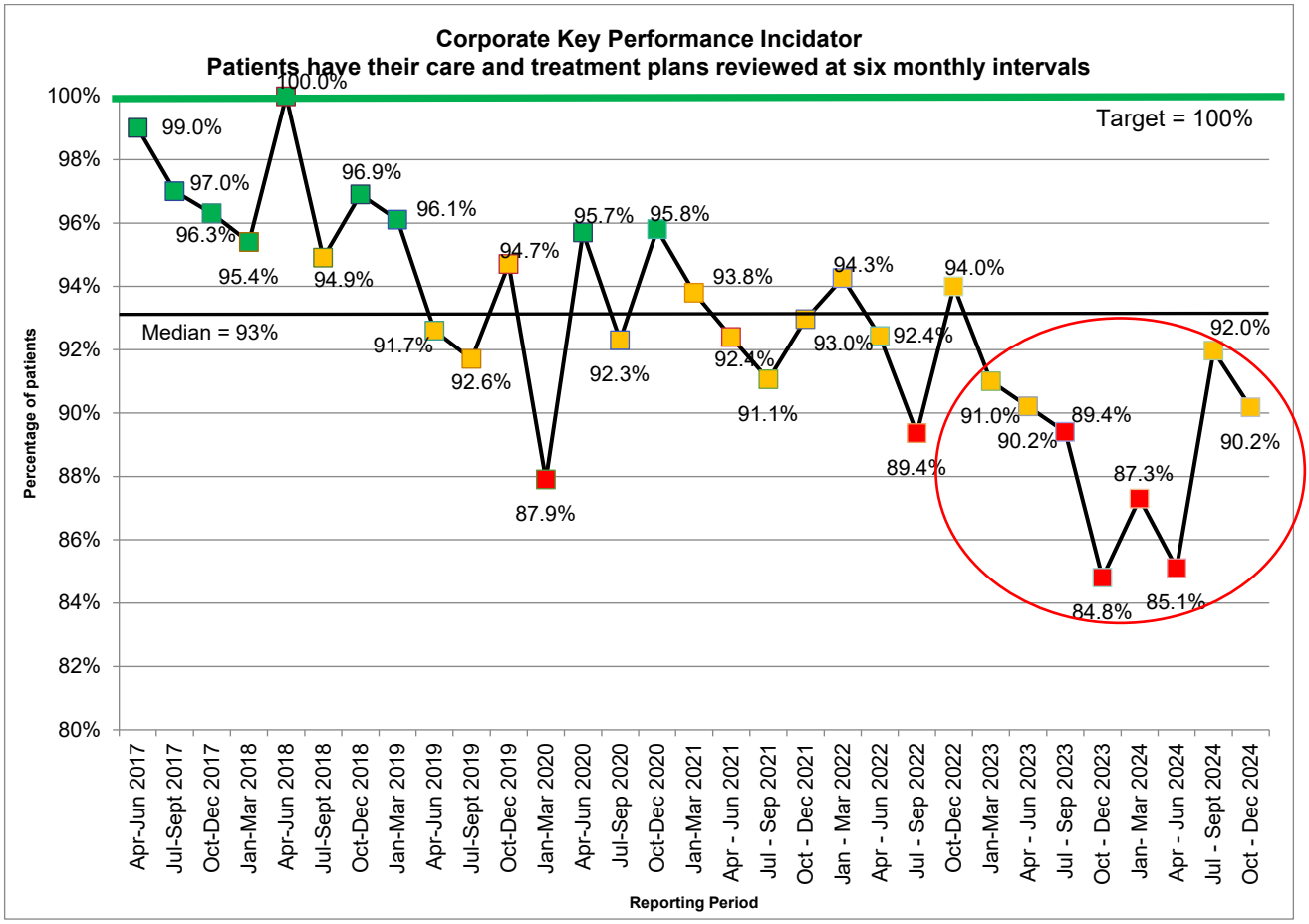
Definitions for red, amber and green zone:

- For all but items 6 and 7 green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target.
- For item 6: 'Patients have a healthier BMI' green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target.
- For 7 'Sickness absence' green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target.

No 1: Patients have their care and treatment plan documentation reviewed and uploaded to RiO at 6 monthly intervals

Target: 100%
Data for current quarter: 90.2%
Performance Zone: Amber

This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance of patients receiving intermediate and annual case reviews and uploaded onto RiO within one month of the review. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.

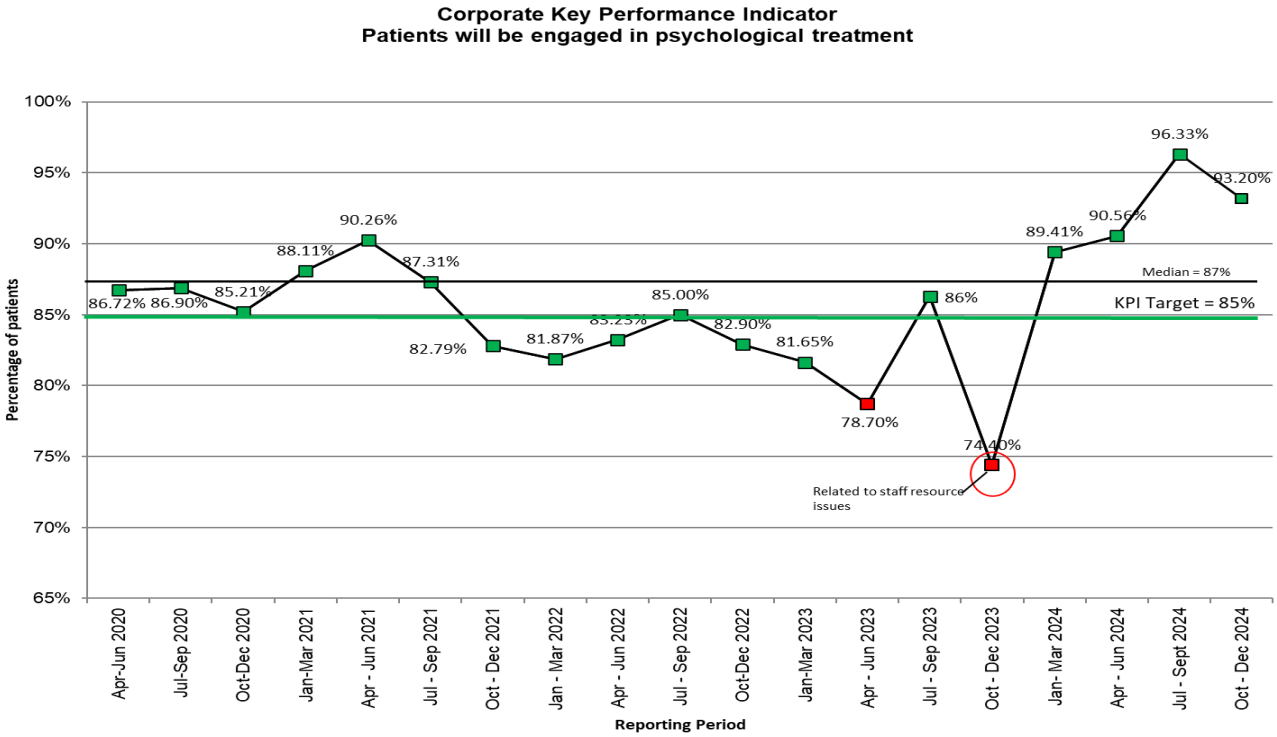


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In Oct 2024 the compliance was 88.9%, November 2024 was 91.3% and in December 2024 compliance was 90.3% giving a quarterly compliance of 90.2%. This indicator remains in the amber zone. The median sits at 93%, the area circled in red shows the shift continuing, therefore as detailed in Q2 report the pattern is likely to be attributable to something within the process and unlikely to just be a result of random variation.

No 2: Patients will be engaged in Psychological Treatment

Target: 85%
Data for current quarter: 93.20%
Performance Zone: Green

This indicator is a main priority of National Mental Health Indicators. This indicator measures the percentage of patients who are engaged and involved in psychological treatment.

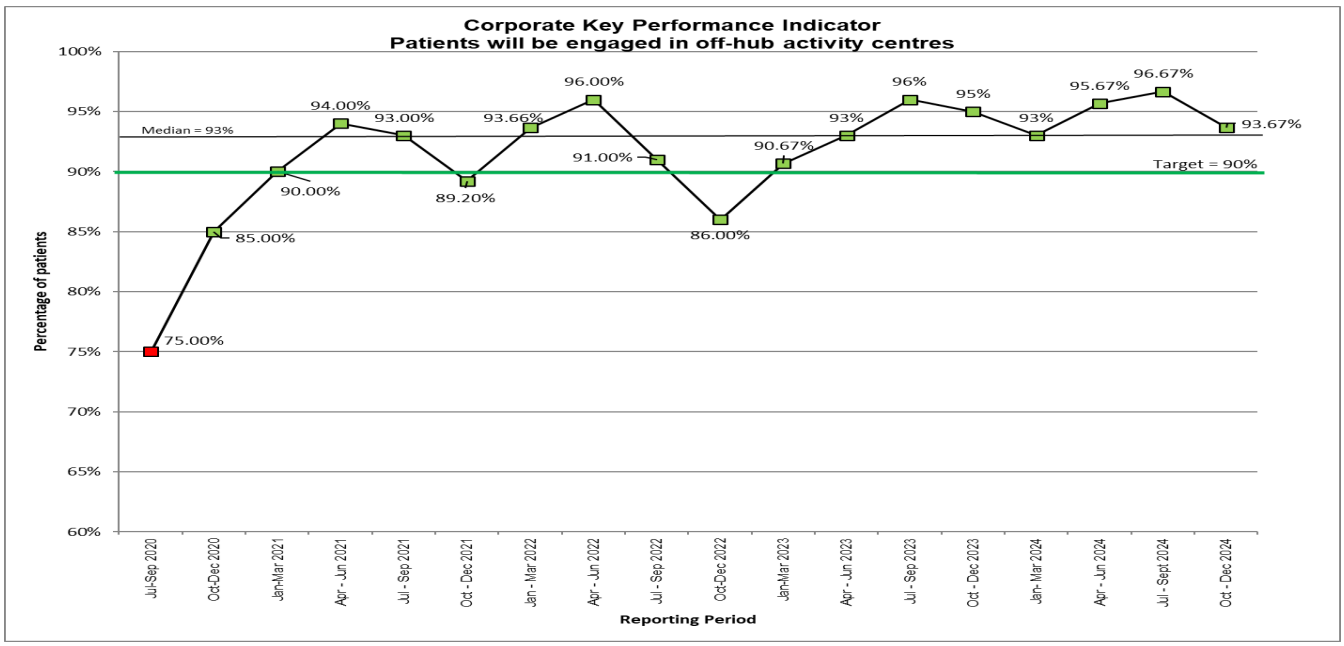


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This indicator has remained in the green zone, although has decreased slightly by 3.13% since Q2 and the target of 85% has been exceeded continually since Q4 2023/24.

No 3: Patients will be engaged in Off-Hub Activity Centres

Target: 90%
Data for current quarter: 93.67%
Performance Zone: Green

This measures the number of patients who are engaging in some form of timetable activity which takes place off their hub. The sessions may not necessarily directly relate to the objectives in their care plan however are recognised as therapeutic activities. This indicator includes data gathered pertaining to scheduled activity in addition to all off-ward drop-in activity rates at the Skye Centre.



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This KPI remains in the green zone, although decrease by 3% since the last quarter,

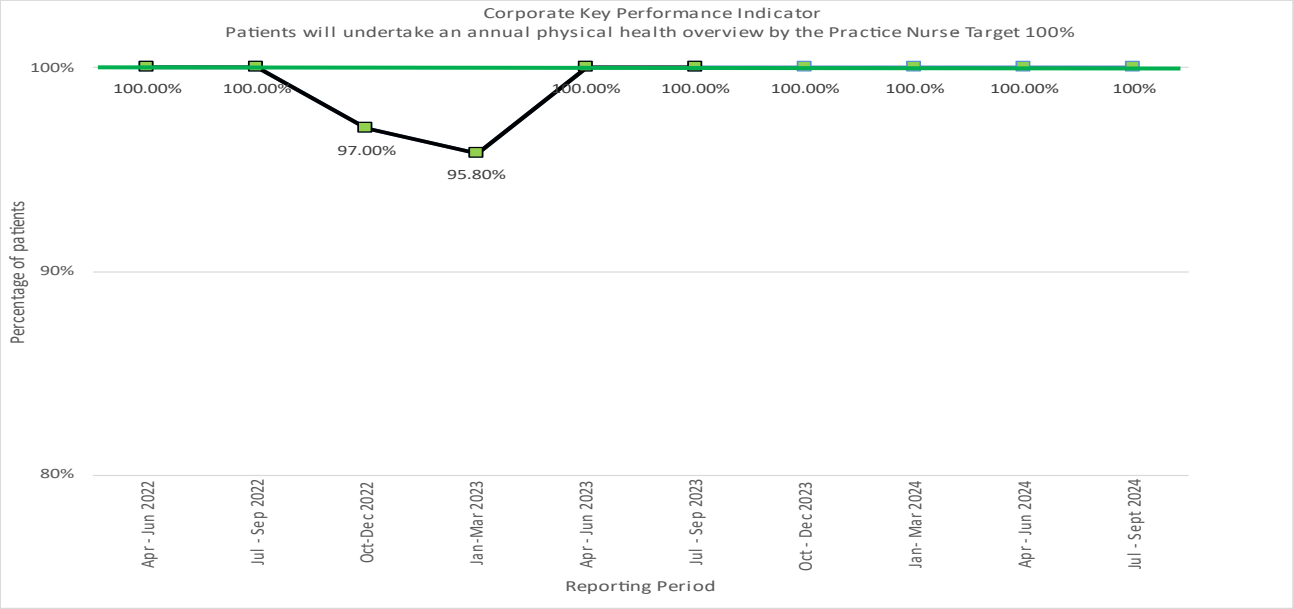
which is likely to be due to the public holidays in December 2024. This KPI has remained above the target of 90% since Q4 2023/24. The median for this KPI sits around 93% showing random variation.

No 4: Patients will undertake an annual physical health overview by the Practice Nurse

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator measures the uptake of the annual physical health review. The target was increased in Q1 of 2022 to 100% from the 90% target to recognize that the annual physical health reviews should be carried out for every patient every year.

This KPI was amended to incorporate the uptake of an annual physical health review by all patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse then refers appropriate patients on for face to face review by the GP. The GP conducts these consultations to complete the physical assessment of the annual health review.

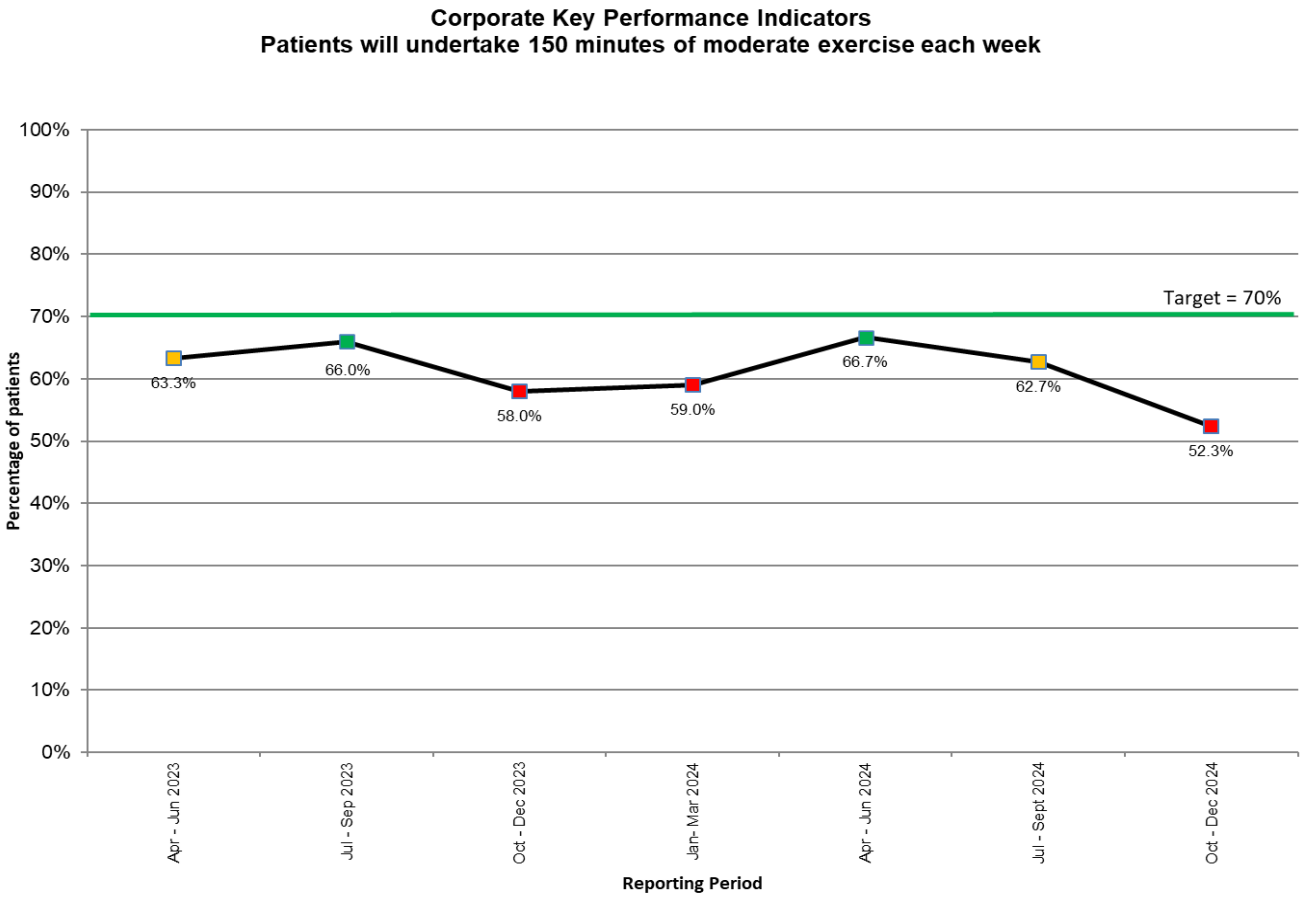


No 5: Patients will undertake 150 minutes of moderate exercise each week

Target: 70%
Data for current quarter: 52.33%
Performance Zone: Red

This KPI links with national activity standards for Scotland. This measures the percentage of patients who undertake 150 minutes of moderate exercise each week.

This data is recorded and calculated when patients participate for more than 10 minutes of moderate exercise and does not include patients being escorted / or using grounds access to and from the Skye Centre (unless it has been agreed by the patient's keyworker). It does include all other types of exercise as per the patients timetable entries e.g. escorted walks, grounds access, football, hub gym.

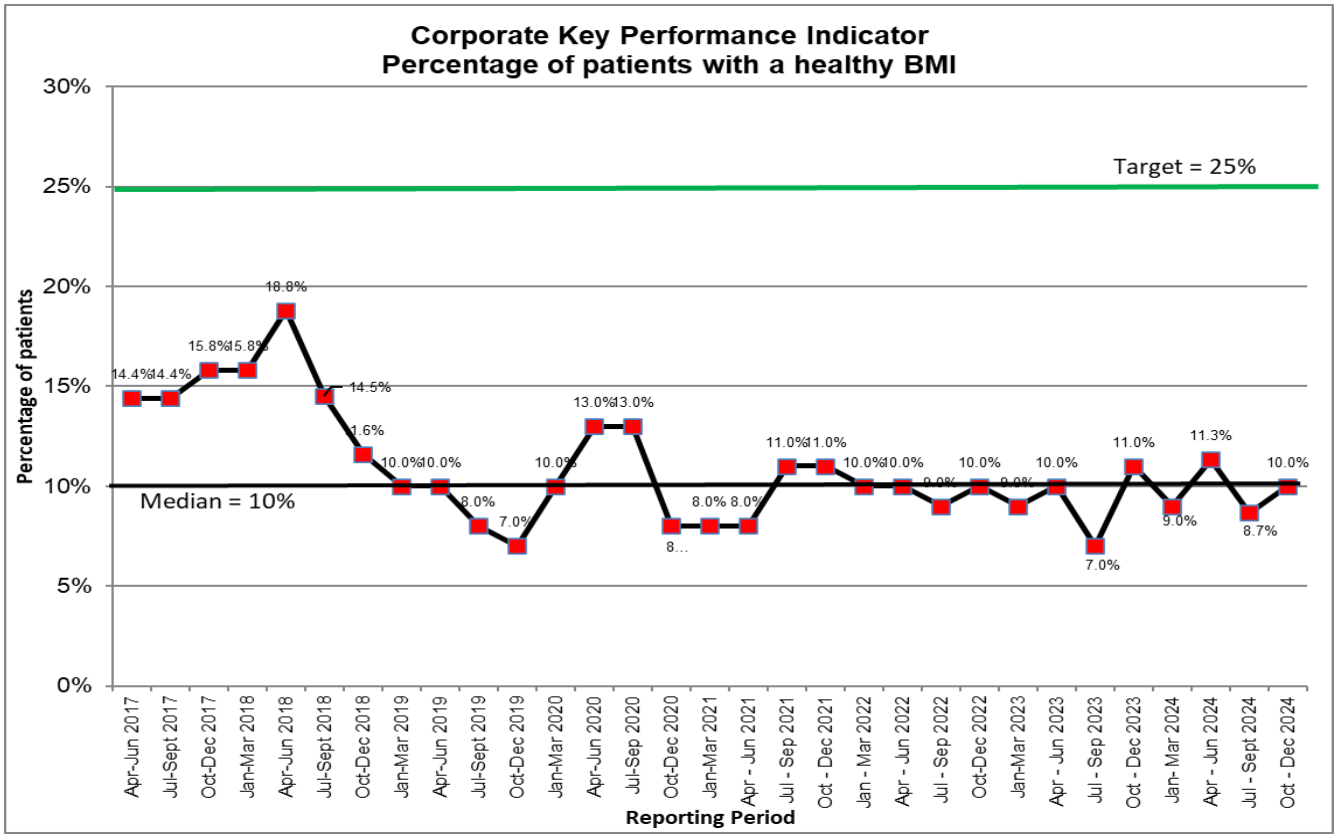


Since Q2 there has been a decreased of 10.34% and moves from amber to red zone in Q3. The monthly compliance data shows there been a continual decrease over the three month period. October 2024 the compliance was 56%. In November the compliance remained at 56% and in December the compliance dropped to 45%. Reduced compliance may have been due to the following contributing factors: Reduction in grounds access to 3.00pm, ongoing ground / PAA works impacting access to grounds, resourcing issues, increased festive events and 2 public holidays.

No 6: Patients will have a healthier BMI

Target: 25%
Data for current quarter: 10%
Performance Zone: Red

This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of the patient group.



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This KPI remains in the red zone, decreasing by 1.33% since the Q2. This KPI has never reached the agreed target of 25%. The median for this KPI sits around 10%, which is lower than the agreed target of 25%.

The monthly collections for the quarter are that in October 2024 11% of the patient population has a healthy BMI, in November 9% and in December 10%. Development of improvement projects via SHC is continuing.

Although compliance remains poor, recent trends across other BMI categories show positive movement in that numbers of Overweight patients are increasing (median increase from 35% to 40%) whilst numbers of Obese 1 patients have reduced. In addition, the median of Obese 2 patients has also reduced (from 17% to 14%).

In relation to the monitoring of 5% of patient weight gain across the first 12 months following admission, for the year April 2022 to March 2023, of 31 admissions 23 (74%) patients completed a 12 month stay. Of these 23 patients, five (22%) remained within the 5% weight gain limit. One patient gained 2.9% of their admission body weight during the 12 months whilst the remaining four patients lost weight (1.1%, 4.2%, 4.5% and 4.9% reduction of their admission body weight).

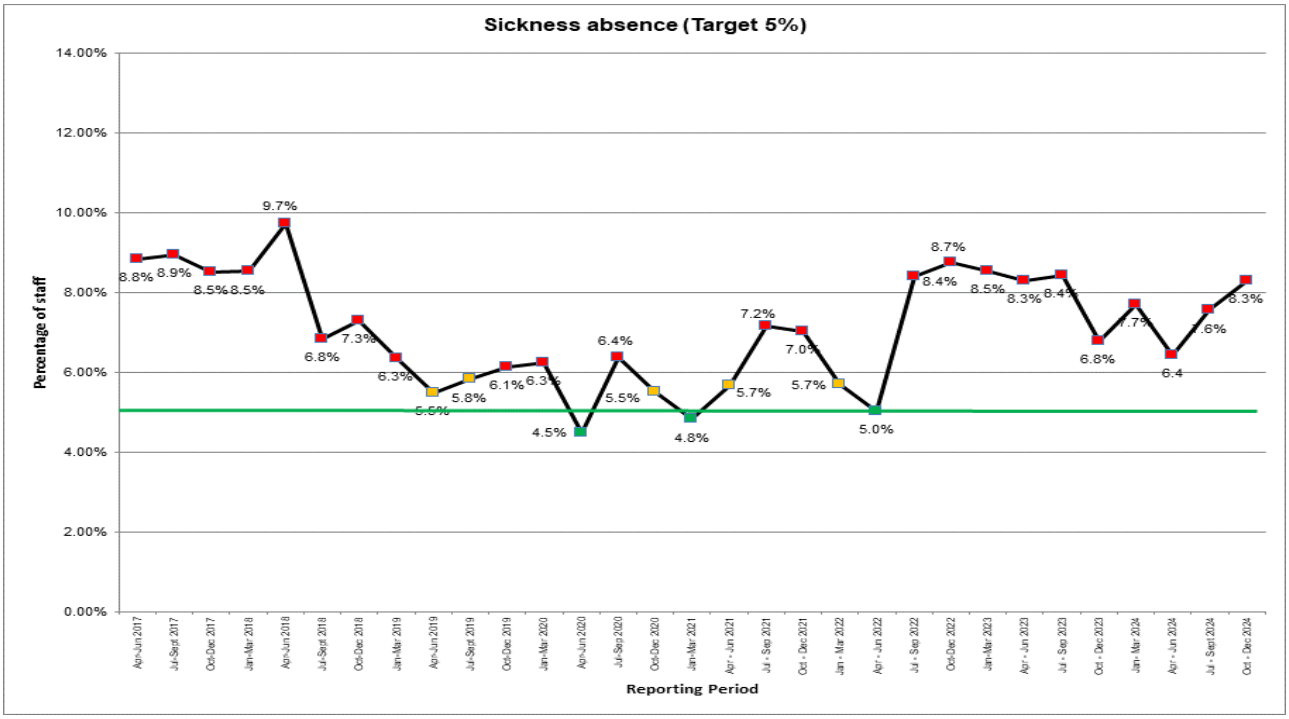
So far, for the year April 2023 to March 2024, of 21 admissions 10 (48%) patients completed a 12 month stay. Of these 10 patients, three (30%) remained within the 5% weight gain limit. One patient gained 4.5% of their admission body weight during the 12 months and the remaining two patients lost weight (2.8% and 7.2% reduction of their admission body weight). This does indicate a possible improvement since this local KPI was introduced however we will need to wait for the full year to be completed before final data can be provided.

It should be noted that discussions have taken place within the Supporting Healthy Choices Oversight Group and work is ongoing to review the suitability of this KPI and what measure, if any, could better report the current situation.

No 7: Sickness Absence

Target: 5%
Data for current quarter: 8.3%
Performance Zone: Red

This relates to the National Workforce Standards and measures how many staff are absent through sickness. This now includes COVID-19 related absences, these had been measured / reported separately until 31st March 2024, and from 1st April 2024 these are now part of the overall absence figure. The State Hospital uses the data provided from SWISS for this KPI to align with all NHS Scotland Boards to ensure valid comparisons across Scotland can be achieved. The figures provided via SWISS data slightly differ from SSTS figures; this is due to the SWISS contractual hours being averaged over the 12-month period and the figures from SSTS are based on the contractual hours available within that month.



Levels of absence have seen a seasonal winter spike in Q3 (This is likely to be slightly higher than previous winters as COVID absences are no longer identified as Special Leave). Alongside the ongoing challenge of long term absence, principally between 29 days and 3 months, we have seen a creeping increase in short term absence, principally relating to cold, flu and respiratory illnesses.

During this period, we have been focusing on selected Maximising Attendance Initiatives including the use of dashboard reporting at Workforce Governance Group to escalate areas of concern, RAG status meeting with Senior Charge Nurses within the Nursing Hub to focus on activity within their areas, along with reviewing current absence pathways to shorten and streamline processes.

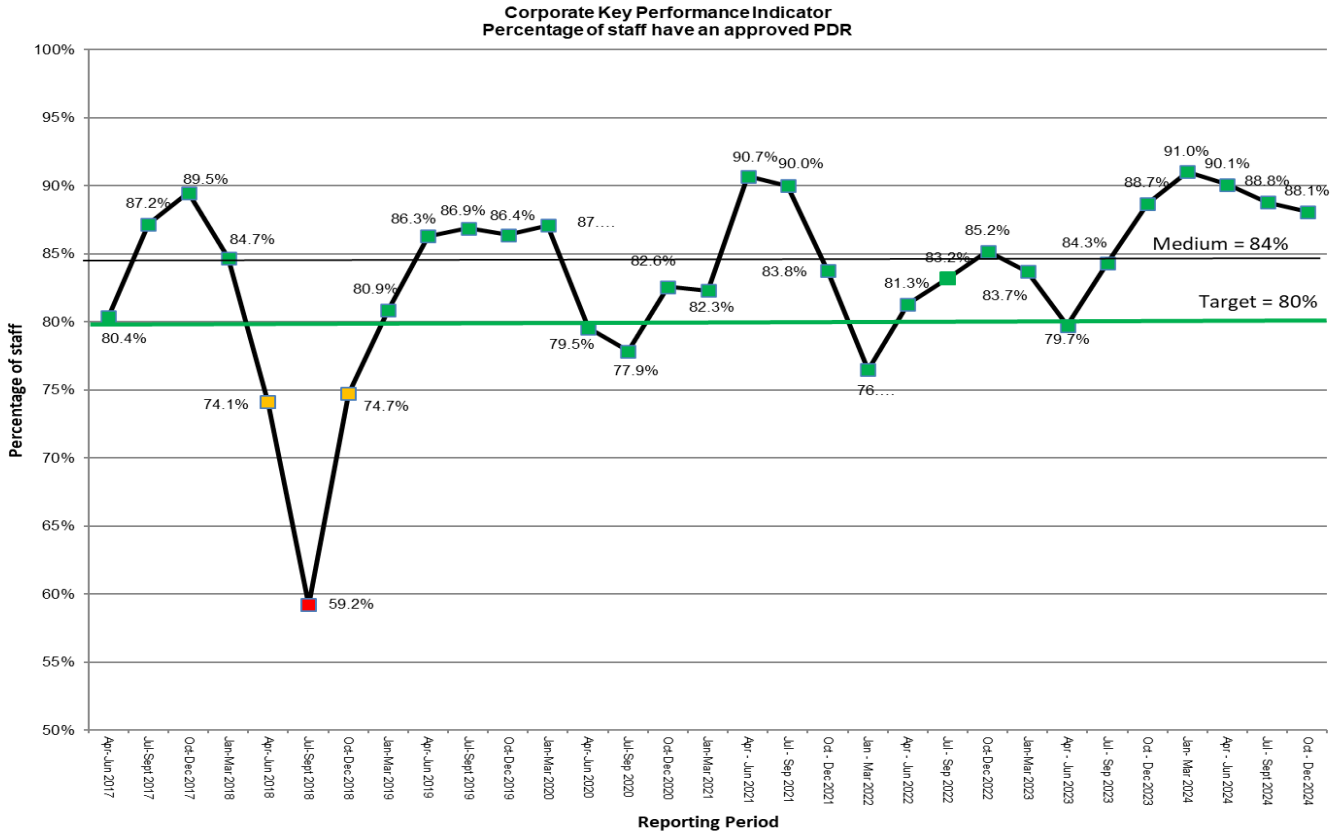
We are working with service managers to ensure that our approach is person centred and in line with National Policy, but also balanced with a focus on the impact of and the sustainability of high levels of absence on the provision of our service.

We continue to work proactively with Service Managers, Occupational Health and staff side representatives to support and address all forms of absence, along with a focus on continuous improvement in terms of our processes.

No 8: Staff have an Approved PDR

Target: 80%
Data for current quarter: 88.1%
Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.

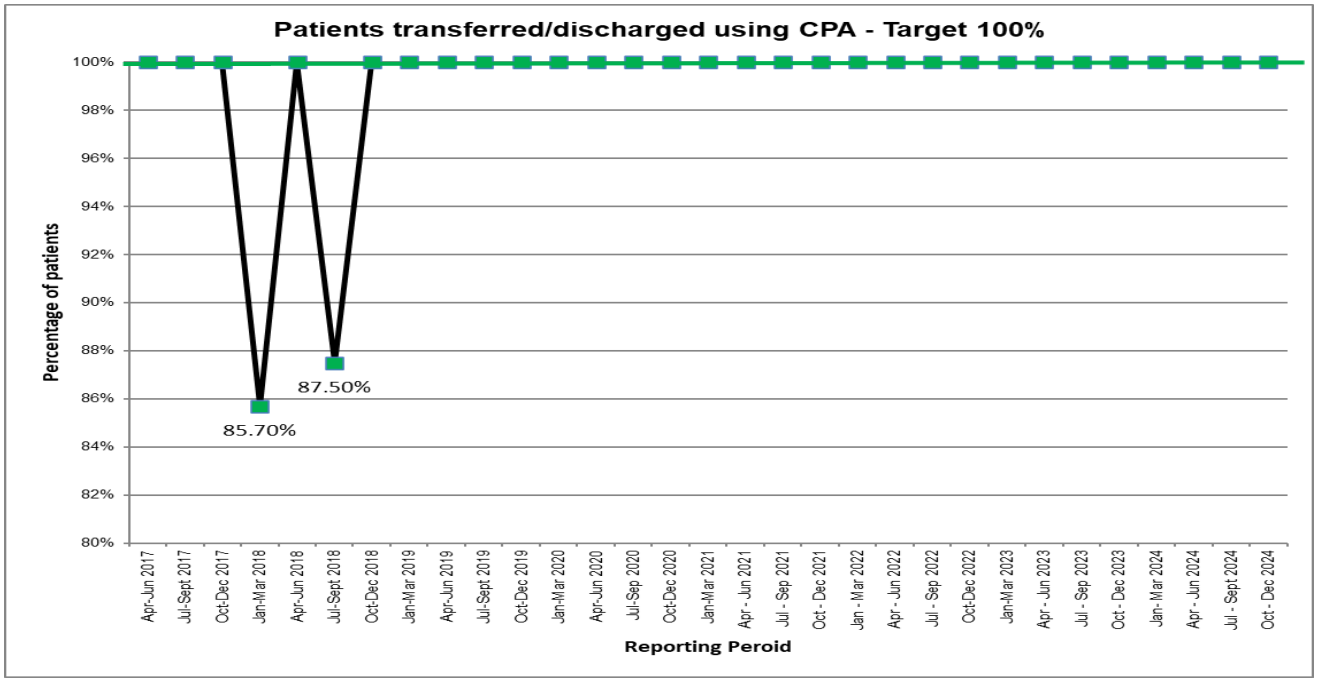


This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In October 2024 the compliance was 88.2%, November 2024 was 87.7% and December 2024 was 88.5% giving a quarterly compliance of 88.1% This indicator remains with the green zone and exceeding the currently target of 80%.

No 9: Patients are transferred/discharged using CPA

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

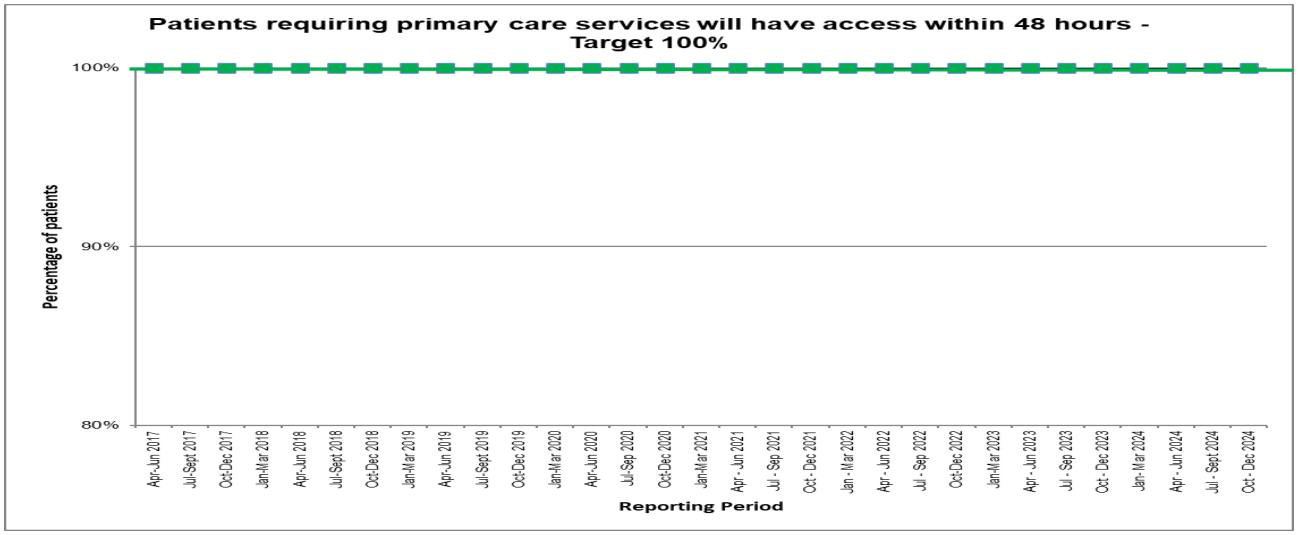
The indicator is linked to the Mental Health Act 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.



No 10: Patients requiring Primary Care Services will have access within 48 hours

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

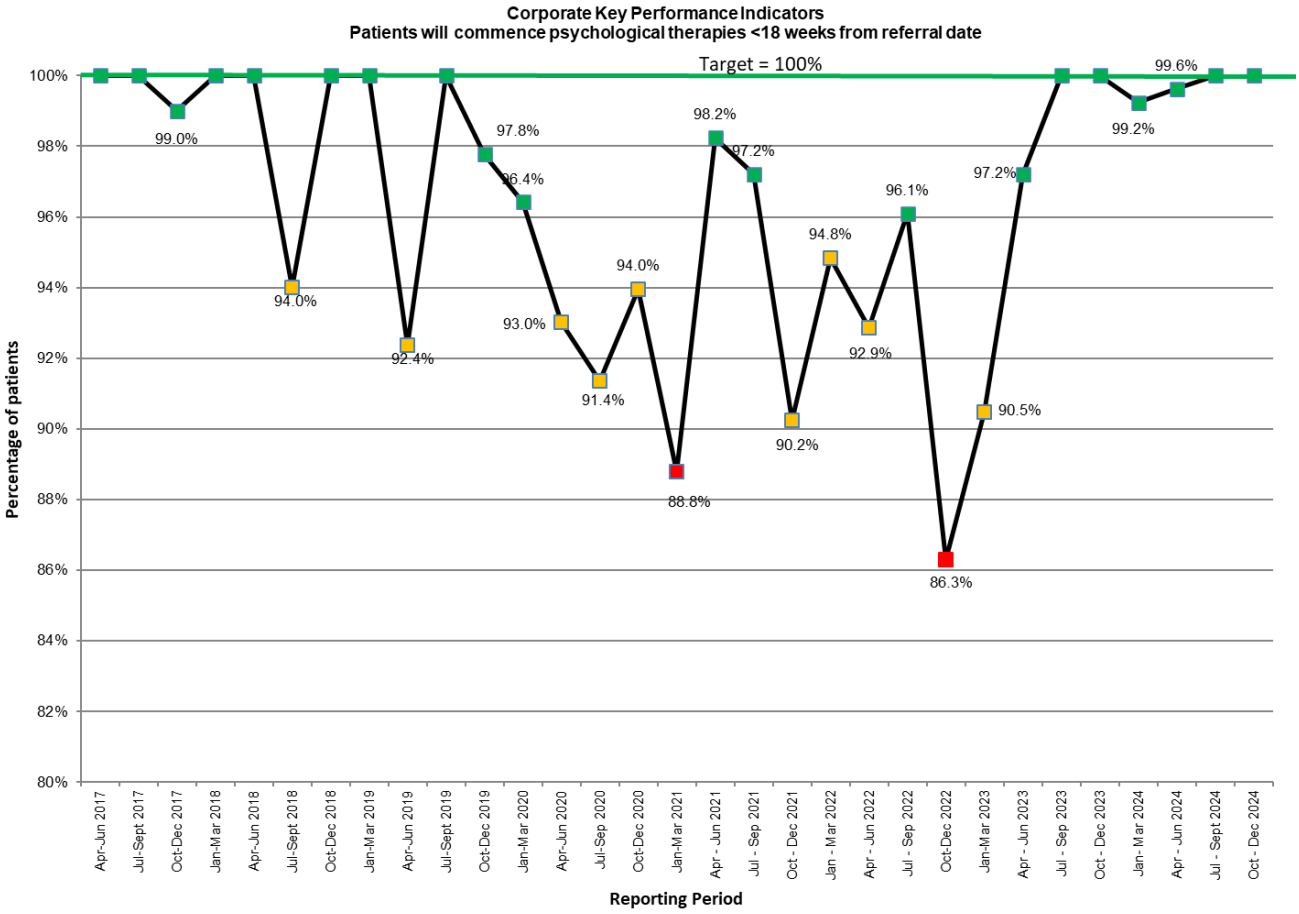
This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.



No 11: Patients will commence Psychological Therapies <18 Weeks from referral date

Target: 100%
Data for current quarter: 100%
Performance Zone: Green

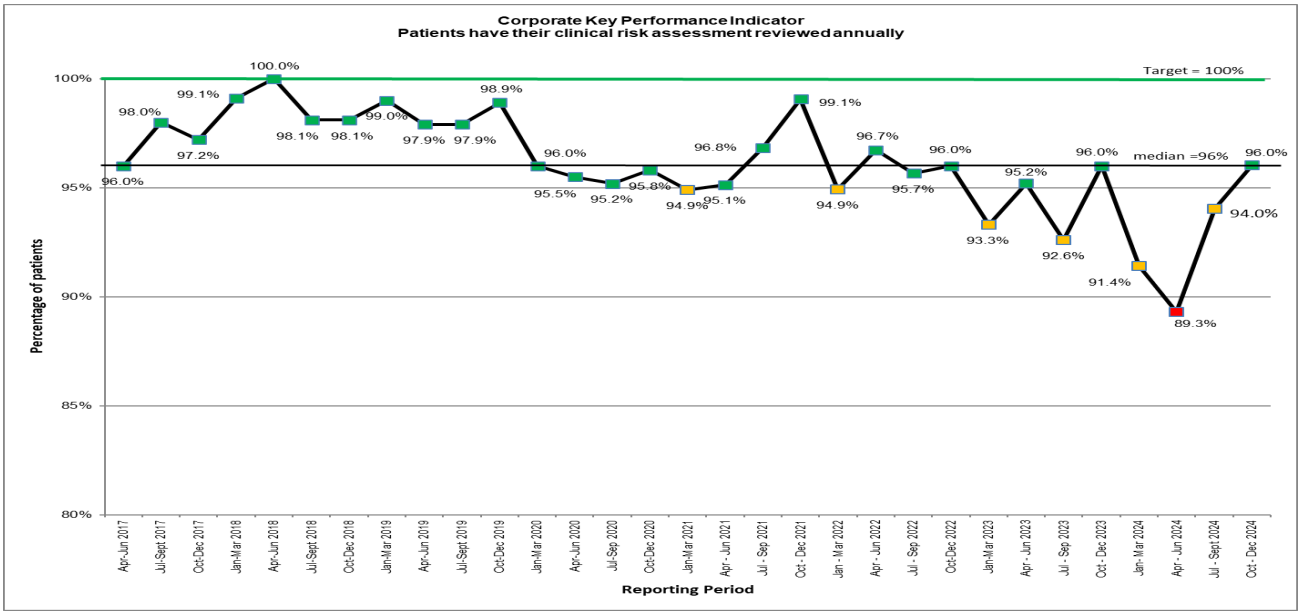
The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy. The data required for this calculation are the number of patients waiting to engage in a psychological intervention to which they were referred who has not already completed another psychological intervention whilst waiting.



No 13: Patients have their Clinical Risk Assessment reviewed annually

Target: 100%
Data for current quarter: 96.03%
Performance Zone: Green

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.



The number of risk assessments which were not closed off within RiO by their expected submission date. In October 2024 the compliance was 96.7%, November 2024 was 95.7% and December 2024 was 95.70% giving a quarterly compliance of 96.03%, which is a 2% increase from Q2 2024/25.

This indicator moves from the amber zone to the green zone. The Head of Psychology continues to monitor this KPI monthly to improve the target compliance.

No 15: Professional Attendance at CPA Review

Target: Individual for each profession

Local priority area set out in within CPA guidance. The reasoning behind this indicator is that if patients have all the relevant and important professions in attendance, then they should receive a better care plan overall.

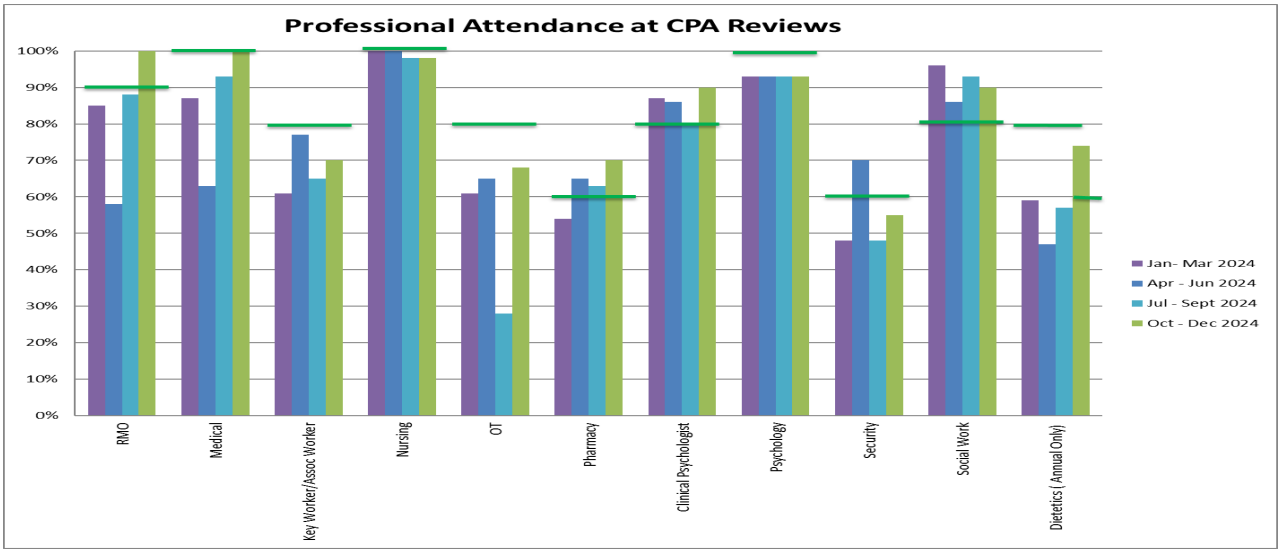


Table 1 shows Q3 broken down into months attendance

Profession	Oct 24 (n=9)	Nov 24 (n=20)	Dec 24 (n=11)
RMO	100%	100%	100%
Medical	100%	100%	100%
KW/AW	56%	70%	82%
Nursing	100%	95%	100%
OT	67%	65%	73%
Pharmacy	33%	85%	73%
Psychologist	100%	85%	91%
Psychology	100%	90%	91%
Security	33%	70%	46%
Social Work	100%	90%	82%
Skye Centre	0% (n=3)	25% (n=8)	0% (n=4)
Dietetics	60% (n=5)	78% (n=9)	80% (n=5)

The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over five years. Attendance at case reviews was recorded as both physical and virtual attendance.

RMO (Target 90%) – attendance for this profession has increased from 88% in Q2 2024/25 to 100% in Q3 2024/25 and is the highest percentage attendance since Q3 2020-21. This indicator moves to the green zone.

Medical (Target 100%) – attendance for this profession has increased from 93% in Q2 2024/25 to 100% in Q3 2024/25 and is the highest percentage attendance since Q3 2020-21. This indicator moved from the amber to the green zone.

Key Worker/Associate Worker (Target 80%) – attendance figures increased from 65% in Q2 2024/25 to 70.00% in Q3 2024/25. This indicator moved from the red to the amber zone.

Nursing (Target 100%) – attendance for this profession remains the same as Q2 attendance at 98%, therefore remaining in the green zone, which it has done since Q4 2023/24.

OT (Target 80%) – attendance has increased from 28% in Q2 2024/25 to 68% Q3 2024/25, this profession remains in the red zone.

Pharmacy (Target 60%) – attendance for this quarter has increased slightly 63% in Q2 to 70% in Q3. This profession remains in green and over target.

Clinical Psychologists (Target 80%) – this profession's attendance has increased from 80% in Q2 2024/25 to 90% in Q3 2024/25. This indicator remains in the green zone.

Psychology (Target 100%) – this professions attendance has remains at 93%, the same as indicated in Q1 & Q2 2024/25 reports. This indicator remains in the amber zone.

Security (Target 60%) - attendance from security has increased from 48% in Q2 to 55% in Q3. Security moves from the red zone into the amber zone.

Social Work (Target 80%) – attendance has decreased in Q2 2024/25 from 93% in to 90% in quarter and remains in the green zone and over target.

Dietetics (Target 60%) – attendance is only recorded for annual reviews. This target was changed in August 2024 following approval at the Clinical Governance Group from 80 to 60%. Basing this profession results at the new target of 60% attendance has increased to 74%, therefore moving into the green zone. This is the first time that this target has been reached since Q1 2022-23.

4. RECOMMENDATION

The Board is asked to **note** the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of TSH Key Performance Indicators links to both the TSH corporate objectives and the Annual Delivery Plan 2024-2025. The KPI's provide assurance to TSH Board on key areas of performance. Some of the KPI's are national targets which TSH is held accountable for performance nationally, others are local priorities for TSH Board. The TSH Performance Framework proves an overview of how performance is managed across TSH. Scottish Government will receive this report following approval from TSH Board as an indicator of TSH performance.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board	Via Strategic Planning and Performance Group

Which groups were involved in contributing to the paper and recommendations.	
Risk Assessment (Outline any significant risks and associated mitigation)	If KPI's are off target the improvement plan to address this is detailed in the paper
Assessment of Impact on Stakeholder Experience	Not formally assessed
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 19a
Sponsoring Director:	Acting Director of Security, Resilience & Estates
Author(s):	Head of Estates & Facilities
Title of Report:	Business Continuity Planning / Whole System Infrastructure Planning
Purpose of Report:	For Noting

1 SITUATION

The Scottish Government have introduced a new approach to Strategic Infrastructure Planning and Investment across NHSScotland. This was announced via a Directors' Letter that was issued on the 12 February 2024. It requires each NHS Board to prepare and submit to the Scottish Government, a Programme Initial Agreement (PIA) which sets out a deliverable, whole-system service and infrastructure change plan for the next 20-30 years. Individual capital projects will not be considered for investment by the Scottish Government until a PIA has been approved by the respective NHS Board and the Scottish Government.

2 BACKGROUND

NHS Boards will no longer be required to prepare and annually update a Property and Asset Management Strategy, as currently required by CEL35 (2010). The PIA will also constitute the first step in the business case process, thus enabling individual capital investment projects to proceed straight to Outline Business Case stage, once agreed with Scottish Government. This also replaces the requirement for Initial Agreements to be submitted for individual capital investment projects, as currently stipulated by the Scottish Capital Investment Manual. A new Scottish Capital Investment Manual document is available to assist NHS Boards in the preparation of their Programme Initial Agreement.

NHS Boards shall submit their Do Minimum Business Continuity Option to the Scottish Government by 31st January 2025. The whole-system PIA, which incorporates the Preferred Way Forward Option, has a subsequent target date for submission of 31st January 2026. Earlier submissions may be possible, subject to prior agreement with the Scottish Government. The PIA shall then be regularly reviewed by the NHS Board, with any material changes reported to the Scottish Government on an annual basis. The PIA will be updated and resubmitted to Scottish Government for further approval every 5 years from the anniversary of first submission, or sooner if requested by Scottish Government.

3 ASSESSMENT

Phase 1 – 31 January 2025: Business Continuity Planning

The first planning phase was to develop a maintenance-only business continuity plan based on a risk-based assessment of the board's existing infrastructure. The investment plan will aim to mitigate against inherent risks associated with existing infrastructure, meet environmental sustainability standards, and provide the necessary accommodation for service delivery needs. The BCP will cover a 10-year programme and can include:

- Building infrastructure
- Medical equipment
- Sustainability requirements (NHS funded)
- PPP end-of-contract costs
- Digital proposals (capital)
- Building surveys / inspections

In presenting information in support of any funding proposal, the aim will be to be able to demonstrate to both the board and Scottish Government, the need for and importance of the funding proposal to assist in the mitigation of identified infrastructure risks. The accuracy of assessment on need/risk, cost and programme timing will need to be demonstrated.

Scottish Government guidance has indicated for planning purposes only, NHS boards should assume an annual BCP budget which is 1/3 higher than the current capital allocation, with a minimum of £2M per annum for smaller boards. Scottish Government have confirmed that TSH should work to the £2M per annum budget.

The planning cycle for BCP's will be ten years from 2025/26 onwards, with more details presented in the first 5-years of the plan than the second half. A likely presumption, to be confirmed, is that these plans are updated on an annual basis.

For TSH, the initial BCP was prepared and submitted to Scottish Government by the 31 January 2025 deadline.

Phase 2 – Target Date 30 January 2026: Whole System Infrastructure Planning: A Programme Initial Agreement

The second planning phase will be to develop a longer-term service-informed infrastructure investment strategy – referenced as the Preferred Way Forward Option.

The Preferred Way Forward will also need to take account of any regional and national service plans.

The Whole System PIA, which incorporates the Preferred Way Forward Options will need to be submitted by each board.

4 RECOMMENDATION

The Board are invited to note this paper and the attached Business Continuity Planning / Whole System Infrastructure Plan submitted to Scottish Government in January 2025

SCOTTISH CAPITAL INVESTMENT MANUAL

The State Hospitals Board for Scotland

Programme Initial Agreement:

The Do Minimum Option:

Business Continuity & Essential Investment Infrastructure Plans

October 2024

Contents

1 Background to this supplementary SCIM Manual

The Business Continuity & Essential Investment Infrastructure Plan (BCP) is the Do Minimum Option for the Programme Initial Agreement (PIA) for Whole System Infrastructure Plans (WSIP). Its primary focus is to prepare a prioritised investment plan that aims to reduce the likelihood and impact to service continuity from the failure, or insufficiency, of NHSScotland's infrastructure. It is also an opportunity to support environmental sustainability plans where other funding solutions are not available.

BCP's are to be submitted to Scottish Government for review, which will set out each NHS Board's essential investment priorities. These will be constrained by an agreed annual funding threshold to be used for planning purposes only. Scottish Government will review all submitted proposals before confirming back to each NHS Board with which ones can proceed based on funding availability.

2 Introduction and Background to the BCP

2.1 Introduction

The Scottish Government have introduced a new approach to Strategic Infrastructure Planning and Investment across NHSScotland.
This was announced via a Directors' Letter (DL 2024 (02)) that was issued on the 12 February 2024.
It requires each NHS Board to prepare and submit to the Scottish Government, a Programme Initial Agreement (PIA) which sets out a deliverable, whole-system service and infrastructure change plan for the next 20-30 years. Individual capital projects will not be considered for investment by the Scottish Government until a PIA has been approved by the respective NHS Board and the Scottish Government.

NHS Boards will no longer be required to prepare and annually update a Property and Asset Management Strategy, as currently required by CEL35 (2010). The PIA will also constitute the first step in the business case process, thus enabling individual capital investment projects to proceed straight to Outline Business Case stage, once agreed with Scottish Government. This also replaces the requirement for Initial Agreements to be submitted for individual capital investment projects, as currently stipulated by the Scottish Capital Investment Manual. A new Scottish Capital Investment Manual document is available to assist NHS Boards in the preparation of their Programme Initial Agreement.
NHS Boards shall submit their Do Minimum Business Continuity Option to the Scottish Government by 31st January 2025. The whole-system PIA, which incorporates the Preferred Way Forward Option, has a subsequent target date for submission of 31st January 2026. Earlier submissions may be possible, subject to prior agreement with the Scottish Government. The PIA shall then be regularly reviewed by the NHS Board, with any material changes reported to the Scottish Government on an annual basis. The PIA will be updated and resubmitted to Scottish Government for further approval every 5 years from the anniversary of first submission, or sooner if requested by Scottish Government.

2.2 Governance

This risk based, prioritised, planned-maintenance and essential investment programme was required to follow the below governance route:

- Capital Group Approval
- Corporate Management Team Approval
- Board Approval

Scottish Government have indicated that they will accept a relaxation of the governance requirements for the first submission i.e. board approval not required for the January 2025 submission.

Scottish Government also recognise that there will be gaps in information for the first submission, and subsequent discussions can then inform what further detail needs to be worked up.

2.3 Scope of Work

The first planning phase is to develop a maintenance-only business continuity plan based on a risk-based assessment of the board's existing infrastructure. This investment plan aims to mitigate against inherent risks associated with existing infrastructure, meet environmental sustainability standards, and provide the necessary accommodation for service delivery needs. The BCP will cover a 10-year programme and can include:

- Building infrastructure
- Medical equipment
- Sustainability requirements (NHS funded)
- PPP end-of-contract costs
- Digital proposals (capital)
- Building surveys / inspections

Projects scheduled for the first 5 years of the programme should include a more detailed breakdown and explanation of costs, covering:

- An explanation of the basis of costs, to demonstrate their robustness
- Realistic assumptions about the level of risk contingencies and optimism bias to be included
- Project development costs, including professional fees
- Projected inflation and VAT
- Associated revenue costs which require additional funding to deliver the project

The following level of detail is expected for each funding proposal within a Board's BCP:

- In presenting information in support of any funding proposal, the aim will be to be able to demonstrate to both your own board and Scottish Government, the need and importance of the funding proposal to assist in the mitigation of identified infrastructure risks. The accuracy of assessment on need/risk, cost and programme timing will need to be demonstrated.
- For proposals up to £2m (inclusive of all associated costs / charges), a written explanation is required which outlines the proposed investment and expected costs.
- For technically-based proposals (i.e. excluding any service planning element) between £2m-£10m, a shortened Outline Business Case taking the form of an SBAR (Situation, Background, Assessment, Recommendation) will be

required as part of the BCP submission. If this funding proposal is approved, then a Full Business Case (including tender costings) will need to be separately developed and then submitted for approval to Scottish Government.

- Any proposal which includes a service planning element, and/or is above the £10m funding threshold, should form part of the board's WSP, unless expressly agreed otherwise by Scottish Government.

2.4 Funding

For planning purposes only, NHS boards should assume an annual BCP budget which is 1/3 higher than our current capital allocation, with a minimum of £2m per annum for smaller boards. For example, a board with a £9m annual capital allocation should assume an annual BCP budget of £12m.

Following a support meeting in May 2024, confirmation was received from Scottish Government should use the minimum £2M per annum for our planning assumption.

It is important to note that actual allocations from Scottish Government will be made on the basis of need and risk and so may not follow the same distribution as the above planning principles. Also, this planning assumption is double the current expectation for 2025/26 and so boards should expect that not all proposals will be taken forward in the first year.

2.5 Existing Capital Allocation

The work incorporated in The State Hospital BCP investment programme will support the work identified within the existing Capital Allocation. The BCP investment will allow The State Hospital to maintain a good standard of accommodation to support the clinical demand.

Due to the unique security measures at The State Hospital, delivering the identified projects will be challenging due to the requirement to escort all contractors within the secure perimeter of the hospital.

The existing capital allocation budget is managed and distributed by the Capital Group within The State Hospital. The table below indicates the current prediction for the use of the existing capital allocation budget of £269K for 2025/26.

Project	Allocated Budget
IT Hardware (Laptops and Monitors)	£30,000
Leased Vehicles	£34,000
Patient Bank / Digital Inclusion	£75,000
Hosted Digital Platform for Patients	£150,000

3 Assessment of Need

3.1 A risk-based assessment of essential maintenance needs

Each risk has been considered through their probability and impact in the key areas of Business/Financial, Staff/Health & Safety/Injury, Clinical/Service and Reputational/Adverse Publicity/Complaint & Claims.
The next stage was to assess the identified risks as to if, and how, they can be mitigated. Can they be reduced through management of activity, or change of practice, and if they do require capital investment, how can the risks be broken down to mitigate costs?
Risk categorisation has been set as low, medium, high and very high, to remain consistent with other NHSScotland risk tools.

The Impact Key, Likelihood Key and Scoring Key are contained within appendix 5.1 BCP PIA Risk Assessment Guidance Model.

The list of projects have been broken down to the categories of Maintenance, Equipment and Digital. For each category the following information has been provided:

- Description of risk
- How it has been identified
- Why it is a concern
- Proposed mitigation
- Likelihood of failure score
- Impact of failure score

Details for the following list of Projects are contained within appendix 5.2 BCP PIA Risk Assessment – Maintenance.

- ST-MNT-001 Islay External Render / Roofing Repair
- ST-MNT-002 Patient Wander Path Upgrade
- ST-MNT-003 Skye Centre Animal Shed Replacement
- ST-MNT-004 Ground Perimeter Intruder Detection System Replacement
- ST-MNT-005 Perimeter Fence Lighting Columns Replacement
- ST-MNT-006 External Doors Replacement
- ST-MNT-007 Ward Kitchens Replacement
- ST-MNT-008 Ward Upgrade Programme to include Doors / Decoration / Flooring / Isolation Room Blinds
- ST-MNT-009 Building External Lighting Replacement
- ST-MNT-010 Internal Lighting Replacement

Details for the following list of Projects are contained within appendix 5.3 BCP PIA Risk Assessment – Equipment.

- ST-EQP-001 Fire Alarm System Replacement

3.2 Other Essential Infrastructure Priorities

This segment is an opportunity to identify and incorporate other essential infrastructure priorities into the investment proposals. This is to cover essential items of infrastructure which require capital support and cannot be afforded within the existing capital allocation spend, and include the following:

- Medical equipment. – No current requirement. Will be included in future years plans.
- IT / digital infrastructure. – No current requirement. Will be included in future years plans.
- Fleet. – Included within current capital allocation spend
- Estate capacity pressures – relatively small in scale and of immediate necessity. – No current requirement. Will be included in future years plans if identified
- Net-zero policy commitments. – Will be included in future years plans to meet 2038 Net Zero target

In each instance, an evidence-based rationale will be needed to demonstrate why each proposal is regarded as essential, with similar information to list in 3.1

The State Hospitals Board for Scotland are also involved at a National level with Scottish Government to meet the following requirement.

Scotland's Mental Health and Wellbeing Delivery Plan 2023-2025 states that during the lifespan of the Delivery Plan, stakeholders will develop a plan to deliver services in Scotland for women who need high secure care and treatment in the short and long-term (Recommendation Three of the Independent Review of Forensic Mental Health Services, February 2021). The plan to introduce High Secure Services for Women at The State Hospital have been developed in discussion with Scottish Government Ministers, Mental Health Directorate, NHS Chief Executives and the Forensic Network for Scotland.

3.3 Other Financial Commitment Pressures:

These pressures have been categorised as end-of-contract private finance costs, capital coverage for changes to finance rules on leases and GP loans.

The State Hospital currently do not anticipate requiring funding for these types of streams.

4 Prioritised Investment Programme

This section provides a prioritised summary of The State Hospital BCP investment programme, covering all identified items from the assessment of need (as described above). The prioritisation process has a greater emphasis on assessing the basis of the need to preserve service provision and patient care above all other concerns.

Scottish Government have requested that the investment programme will extend up to 10-years in order to illustrate the extent of works required over the next decade, with the focus of allocations being towards the first 3 years of the programme. Hence, more detail has been provided for the highest priority works within the first 3 years of the programme.

Appropriate financial governance arrangements will be followed for each funding decision and allocation. The level of detail described within Table 1 has been completed within this submission for each risk to allow a final decision on funding to be made.

Table 1: Information Required to enable Funding Allocation Approval

Full Value of Funding Request	Information to enable Approval
Up to £2m	A written explanation which outlines the proposed investment and expected costs
£2 - £10m (technical with no service planning)	Shortened OBC or SBAR, followed by a shortened FBC / Tender report.
Above £2m (with a service planning element)	Ordinarily, this should not be the focus of the BCP, unless expressly agreed with Scottish Government.
Above £10m	Ordinarily, This should not be the focus of the BCP, unless expressly agreed with Scottish Government.

To note, whilst a reasonable level of project contingency has been applied to project costs, optimism bias has not been applied as this aspect will be managed by Scottish Government as budget holders.

The purpose of the shortened OBC / SBAR as referenced in Table 1 is to demonstrate a readiness to proceed towards procurement with the projects.

A breakdown of each individual project is included within the following documents:

- BCP PIA Risk Assessment – Maintenance
- BCP PIA Risk Assessment – Equipment
- BCP PIA Risk Assessment – Digital

The prioritised investment programme contained within this BCP aligns with the spreadsheet-based investment programme that has been incorporated as part of the overall submission (see appendix 5.5). Each proposal has a unique reference number that is used in the BCP submission and the accompanying spreadsheet.

5 Appendices

5.1 BCP PIA Risk Assessment Guidance Model

5.2 BCP PIA Risk Assessment – Maintenance

5.3 BCP PIA Risk Assessment – Equipment

5.4 BCP Summary Spreadsheet

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 20
Sponsoring Director:	Acting Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial report and any current issues under consideration by the Project Oversight Board.

2. BACKGROUND

From a governance and oversight perspective, the following schedule of control and interface points between TSH and Securitas UK are in place:

- Twice weekly *(Mon & Wednesday)*: Site operational meeting
- Weekly Technical Review Meeting
- Weekly: 'Look ahead' meeting
- Twice monthly: Strategic Oversight Group
- Monthly: Project Oversight Board

The Project Oversight Board meeting last took place on 20th February 2025; The next Project Oversight Board is scheduled for 20th March 2025. At the meeting of 20th February the Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

The project is in the final stages. All quality targets are being met, the timescale has moved (see 3b for detail) and costs are projected to overspend (see Finance – Project Cost at point 3c below).

b) Project Timescales

The most recent proposed programme has a projected completion of 18th April & this programme is under review.

The installation of technology is complete. Key remaining works are

- Final elements of commissioning
- A quantity of minor works,
- Site Acceptance Testing (SATs) of the installation and the production of documentation

Difficulties in addressing CCTV issues have been the primary cause of recent programme delays, though this issue has reduced in severity and impact.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan, in that the contract with Securitas is due to underspend against budget, including available contingencies. Project management costs and associated contingencies continue to be affected by changes in the project timescale. The project currently has a potential overspend (exclusive of VAT) of approximately £870k. This has increased by approximately £50k since the December 2024 report to the Board. The main components of this increase are Project Advisor costs and Staff costs, both now projected to the end of March 2025.

The key project outline at the end of January 2025 is:

Project Start Date:	April 2020
Planned Completion Date:	April 2025
Contract Completion Date:	May 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin

Total Project Cost Projection (Exc. VAT) at 14/02/25:	£9,661,924
Total costs to date (exc. VAT & retention) at 14/02/25:	£9,581,427
Total costs to end of project (Exc. VAT & retention)	£ 80,497

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget. A letter to Scottish Government was issued week commencing 29 January 2024 as part of the financial planning for 2024 – 2025 outlining the projected spend from April 2024 to anticipated end date and this has been accepted.

A Rounded breakdown of actual spend to date (Exc. VAT) at 14/02/25 is:

Securitas	£ 7.299m
Thomson Gray	£ 1.202m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 0.987m
Miscellaneous	£0.002m
Income	-£ 0.109m
Total	**£ 9.590m**

VAT has been excluded from calculations of amounts paid due to the potential for final adjustments on project completion.

4 RECOMMENDATION

That the Board **note** the current status of the Project.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Update paper on previously approved project
Workforce Implications	N/A
Financial Implications	***The projected overspend is regularly communicated to Scottish Government and is an ongoing action at Project Oversight Board.***
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	***Contract agreement stipulates compliance with Fairer Duty in respect of the remuneration of staff and contractors.***
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ϒ There are privacy implications, but full DPIA not needed ϒ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **ARC(M) 24/04**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 26 September 2024.

This meeting was conducted virtually by way of MS Teams, and commenced at 09.30am.

Chair:

Vice Board Chair	David McConnell

Present:

Employee Director	Allan Connor
Non Executive Director	Stuart Currie
Non Executive Director	Pam Radage

In Attendance:

External Auditor, KPMG	John Blewett
Internal Auditor, RSMUK	Victoria Gould
Acting Director of Security, Estates, and Resilience	Allan Hardy
Internal Auditor, RSMUK	Assam Hussain
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Head of Corporate Governance	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting, and it was noted that there were no formal apologies.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business on the agenda.

3 MINUTES OF THE PREVIOUS MEETING

The Committee approved the Minutes of the previous meeting held on 20 June 2024. Mr McConnell asked if an updated External Audit Annual Report would be circulated for completeness, and this was confirmed.

The Committee:

a) Approved the minutes held on 20 June 2024.

4 MATTERS ARISING – ROLLING ACTION LIST UPDATE

The Committee received the action list and noted progress on the action from the last meeting and agreed that all actions were either closed or on the meeting agenda.

The Committee:

1. Noted the updated Action List.

INTERNAL AUDIT

5 INTERNAL AUDIT REPORTS

The Committee received the Internal Audit Report on the Consultant Discretionary Points Audit, presented by Ms Gould. She outlined the key aspects including the agreed scope of the audit and the outcomes and actions. Ms Gould also informed the Committee that the audit had achieved a partial assurance with one high and three medium actions noted, as detailed in the report. Mr Wallace agreed with the outcome and action points.

Mr Connor asked if there were any available minutes from the Discretionary Panel meeting, and queried the when the Joint Local Negotiating Committee (JLNC) had met. In answer to a further query from Mr Connor on the year being audited, Mr Hussain confirmed that the review focused on 2022/23 but that the calculations for 2023/24 had also been carried out to ensure their validity. Mr Wallace confirmed minutes of the Discretionary Panel would be available, and he would check the position of the JLNC.

Mr Moore advised that he found the audit helpful and raise the issue of whether a Non-Executive Board Member should sit on the panel, given the potential for conflict of interest. Mr Currie added his agreement to this. Ms Gould agreed and referenced the action point from the audit, to review membership of the appeal panel, which was to ensure the same members are not involved in all stages.

Mr Jenkins welcomed the audit and report provided and also agreed that there should not be Non Executive Director involvement until the outcomes of the process are presented to the Remuneration Committee for assurance. It was agreed that the action points outlined in the audit should be taken forward, including review of its terms of reference, and these would be escalated through the Remuneration Committee.

Mr McConnell thanked Ms Gould for the report and welcomed the discussions from members. around this.

The Committee:

a) Noted the Internal Audit Report and remitted the report and findings to the Remuneration Committee.

6 INTERNAL AUDIT

a) AUDIT PROGRESS REPORT

The Committee received the Audit Progress report presented by Mr Hussain who highlighted that the report now shared some of the findings picked up as part the review process. Mr Hussain also noted that the Physical Health Review was due to commence on the 20 October 2024.

b) ACTION TRACKING REPORT

The Committee also received the Action Tracking Report and Mr Hussain provided an overview of the status of each action.

Mr McConnell thanked Mr Hussain for the reports and overview provided.

The Committee:

1. Noted the Audit Progress Report.
2. Noted the Audit Tracking Report.

INTERNAL CONTROL and CORPORATE GOVERNANCE

7 CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register update presented by Mr Hardy who provided an overview of the report and highlighted there were 29 risks on the register which was a reduction of one. He noted that the risk relating to staff trained on soft restraint kits (SRKs) had remained low for over six months and that it had been agreed to move this risk back to the local risk register. Mr Hardy added that 16 risks were within their target level and 13 we are still to achieve target, with two of these progressing well.

Mr Jenkins noted that a new Corporate Management Team (CMT) sub group was being developed which would give greater focus on control and learning taken from Serious Adverse Event Reviews.

The Committee:

1. Approved the Corporate Risk Register

8 FINANCIAL POSITION UPDATE

The Committee received the Financial Position Update presented by Mr McNaught who gave an overview of the report noting the continuation of a small adverse variance at this date with a year-end break even position forecast. He added that meetings continued to be held monthly with each directorate addressing their plans and monitoring progress against achieving savings targets and maintaining a break-even position, and added that costs pressures were communicated to the Scottish Government at a recent meeting. Scottish Government were content with our current position and forecast for the year. Further discussion would take place to discuss specific pressures after the outcomes of quarter two and potentially quarter three. Mr McNaught assured the Committee that known pressures would continue to be monitored on a month to month basis.

Mr Currie asked when a forecast with a reasonable certainty about the year-end financial position could be given, with particular reference to the financial pressures around staffing levels and recruitment. Mr McNaught replied that this was a particular focus within nursing, who worked closely with the finance department to ensure accuracy in this respect. He added that scrutiny was applied to all vacancies to ensure they are essential. Mr McNaught added that known key pressures were factored into projections and costs were spread evenly throughout the year with reasonable certainty usually being achieved at the end of quarter three.

Mr Jenkins added that National Boards have not yet received Agenda for Change pay cost allocations and that this was still being pursued. Mr Jenkins added that the new clinical model had been in place for 12 months and work was progressing in relation to establishing the appropriate staffing model

Mr Moore and Ms Radage welcomed the allocation of funding for substantive posts within eHealth given the importance of this area, and the potential risks. Ms Radage also welcomed the work progressed on nurse recruitment including students. Mr Jenkins thanked Ms Radage for the acknowledgment surrounding recruitment to the nursing service and added that there remained a focus on looking at the data on the direct cause and effect of recruitment and vacancies together with daytime confinement and the clinical model, which would continue to be improved upon.

The Committee:

1. Noted the Financial Position Update.

9 ANCHOR STRATEGY ANNUAL UPDATE

The Committee received the Anchor Strategy Annual update presented by Ms Merson who gave an overview and background surrounding the strategy and noted that as this was the first year of the Anchor Strategy development there had been learning opportunities which she expanded on. She highlighted and summarised the plans for the next year, and stated that the use of metrics to monitor the implementation would be ongoing.

Mr Moore enquired if the guidelines gave guidance on how to define ourselves as a local employer. Ms Merson stated that the guidance does not do this. However, within the strategy, a local employer had been defined as being within the ML11 postcode, and for procurement it would be within the Lanarkshire area.

Mr McConnell asked about the peer learning network, and Ms Merson explained that this was a whole system network for all territorial and national boards. However, it could subdivide into specific themes for smaller groups on specific pieces of work.

Mr Jenkins noted that there had been a lot of learning around the model for the Anchor Strategy, which would continue to be explored, to enable reasonable expectations to be set on deliverables.

The Committee:

1. Noted the Anchor Strategy Annual Update.

10 PROCUREMENT ANNUAL REPORT 2023/24

The Committee received the Procurement Annual Report 2023/24. Mr McNaught presented the key details noting that this report was a statutory requirement. He commended the Procurement Team for the comprehensive summary of their activity. He highlighted that the hospital has been fully compliant in the last year and the team continued to have a strong positive and very proactive involvement in all areas of operation across the various directorates of the hospital.

Mr Moore sought clarity on the high estimated value on some awards and asked if this was based over a number of years rather than an annual value, and this was confirmed. Mr McConnell referred to community benefits and asked if this intertwined with the Anchors Strategy. Mr McNaught confirmed that it did to some level, with some areas of overlap.

Ms Radage asked if Section 4 of the report relating to supported business also related to the Anchors Strategy. Mr McNaught agreed to check this and report back to the Committee.

Action: R Mc Naught

The Committee:

1. Noted the Procurement Annual Report 2023/24.
2. Asked for further information on supported business.

11 LEGAL CLAIMS ANNUAL REPORT 2023/24

The Committee received the Legal Claims Annual Report 2023/24 presented by Ms Smith who provided an overview of activity for the year and highlighted that one claim was settled and closed which was reflected against claims for the two previous years. Ms Smith noted that it was not possible to give much detail in terms of what existing claims relate to as they are live legal issues.

Ms Radage asked for clarity on figures and years quoted with the table on page 1 of the report, which Ms Smith would verify.

Action: M Smith

The Committee:

1. Noted the Legal Claims Annual Report 2023/24.
2. Would provide clarity on the figures and years in Table 1.

12. FRAUD UPDATE / FRAUD ACTION PLAN

The Committee received the Fraud Update and Action Plan presented by Mr McNaught who provided an overview of the reports and added that the Cyber Fraud Service (CFS) virtual sessions continued to be circulated. Alerts received were reviewed and passed on as appropriate within the hospital however there were no matters in the last quarter that required review. He also noted that the Fraud Action Plan was up to date.

Ms Radage noted from the Fraud Update report that the level of sophistication of frauds referenced were similar to previous types and asked if this was the case. Mr McNaught advised that CFS had highlighted that the nature of these frauds were similar. However, the content in some fraudulent emails was becoming more sophisticated.

In relation to the Fraud Action Plan Ms Radage asked for an overview of the six partially met principles. Mr McNaught explained these were in terms of the processes and procedures that were in place; and assured the Committee that the CFS were content with the progress being made. He noted that some aspects may be difficult to achieve due to having a small eHealth team.

There was discussion around the Committee on the developments in the latest technology which were a growing concern, and hence there was a clear need for vigilance.

The Committee:

1. Noted the Fraud Update.
2. Noted the Fraud Action Plan.

13 CYBER CRIME UPDATE

The Committee received Cyber Crime Update presented by Mr McNaught which provided an update on the overall ongoing cyber risks and how risks were being addressing within the hospital.

Mr McNaught spoke to the report, and highlighted the key aspects. In reference to the lessons learned from the Dumfries and Galloway cyber-attack, he assured the Committee that any potential learning had been followed up and shared throughout the organisation, with dedicated reporting to CMT. He added that there continued to be a strong awareness of the current risks, and that systems in place had been successful in detecting and quarantining any threats presented.

Mr Jenkins noted that in terms of cyber security, there was more work to be done and referenced the need to have better shared intelligence across NHS Scotland. Mr Currie concurred with Mr Jenkins and added that there was a need to focus on cyber security, even within the context of a positive outcome on the Network Information Systems (NIS) audit and despite positive feedback from NIS. Mr McNaught assured the Committee that the NIS audit within The State Hospital was not relied upon to give cyber security assurance, but for compliance and systems support.

Ms Radage asked for an overview of the outcomes learned from the recent e-mail phishing exercise. Mr McNaught advised that this had shown some staff in different disciplines in the hospital had failed to recognise a test phishing email. He explained the next steps in this exercise was to focus on learning from this in an encouraging and positive manner.

Mr Hussain noted that the cyber crime report was an insightful update and that it would be useful to know how the number of low and medium rated incidents compared over time.

The Committee:

1. Noted the Cyber Crime Update.

14 POLICY UPDATE

The Committee received the Policy Update presented by Mr McNaught who noted the continued progress in this area. Mr McNaught added that this would continue into the next quarter with policy leads aware of which policies would be due for review. Mr Jenkins welcomed the update and thanked Mr McNaught for the positive progress made.

The Committee:

1. Noted the Policy Update.

15 CLIMATE EMERGENCY and SUSTAINABILITY UPDATE

The Committee received the Climate Emergency and Sustainability update, which was presented by Mr Hardy. He provided an overview of the report and highlighted that it was currently Climate Awareness Week with various activities planned throughout the hospital. Mr Hardy noted that the current risk remained at medium and work was on-going with NHS Assure to look at options to move the Net Zero Route Map forward to identify other areas for improvement. He assured the Committee that progress was taking place as much as possible in relation to the three actions that remain outstanding.

Mr McConnell asked if availability of funding affected vehicle replacements. Mr Hardy confirmed that this fell within the existing capital budget, and was managed through the Capital Group. However, a new electric vehicle had been purchased for use within the hospital. He further explained that due to the distance some journeys covered, especially for patient transfer, it was not possible to have an all-electric fleet of vehicles.

The Committee:

1. Noted the Climate Emergency and Sustainability Update.

EXTERNAL AUDIT

16 AUDIT PROGRESS UPDATE.

The Committee received the External Audit Progress Update. Mr Blewett provided an overview and noted that following a planning meeting in October 2024, work on the planning and risk assessment would shortly take place. The External Audit Plan would then be presented at the next Audit and Risk Committee meeting.

The Committee:

1. Noted the Audit Progress Update.

INTERNAL UPDATES FOR INFORMATION

17 REVIEW of EFFECTIVENESS of AUDIT and RISK COMMITEE

The Committee received the report on the Review of Effectiveness of Audit and Risk Committee. Ms Smith provided a summary of the responses received from the questionnaires given to members, each of whom had responded. Ms Smith summarised key points raised under each heading for discussion by the committee:

- Membership Induction and Training - it was noted that members of the Committee may sit on or chair other Committees and Ms Smith noted that this point had been raised previously. She added that given the size of the Board, it was unavoidable but noted this could also bring a benefit in terms of members having a wider view across all the areas of governance in terms of internal control;
- Internal Control - an improved position was noted in coordinating with the other Committees and also a greater focus on counter fraud;
- The Role of Risk Management - a query was raised in terms of how well the Committee is made aware of the role of Risk Management, particularly in the preparation of the Internal Audit Plan, and clarity was required on the cooperation between internal and external audit;
- Financial Reporting – it was noted that the external auditors' report is presented in a timely way however, there was discussion around the procedures undertaken by management to prepare the annual accounts and how these are reported;
- Administration - whilst there is a specific resource to support all Committees this function was being undertaken throughout the team presently;
- Training and Induction for new members – in the sense that there should be preparatory work in anticipation of new Committee members joining.

Ms Smith highlighted that overall the responses received were positive and added there was agreement that the Committee contributed effectively to the overall control environment.

Mr Currie commented on whether it was practical to ensure the independence of Committee members in such a small board like the State Hospital. Ms Radage agreed and added that it was useful that members were part of other Committees. She noted that this could bring a richness and depth of understanding. Ms Radage also noted the need for succession planning for Committee members. Mr McConnell agreed with Ms Radage on this point, adding that advance planning should be considered as early as possible. Mr Jenkins agreed with Ms Radage and Mr McConnell's points and noted the responsibility of Scottish Government for Non Executive appointments.

In relation to Non-Executive Directors being members of a range of committees, Mr Jenkins gave the view that this offered a more robust process by having members who could transfer issues over to other Committees to consider. Mr Jenkins also highlighted the wealth of experience and backgrounds that the Non-Executives Directors had which was of great benefit.

Mr Hussain remarked on comments made on Internal Audit, and underlined that the Committee Chair was able to hold private discussions with the head of internal audit, with regular meetings held so that any emerging issue could be raised. He assured the Committee that the internal and external auditors co-operated with each other and that internal auditors complete work set out by the external auditors which they report on as part of the External Auditors Annual Audit Report. He highlighted that all work planned and carried out was shared in the progress report along with any changes to previous planned work. He also advised that the plan included an internal charter setting out roles and objectives – so this related to the question around definition of responsibilities and authority. Lastly, he advised that auditors aligned their work with key areas identified on the Risk Register as well as giving management the opportunity to direct the auditors to other challenging areas.

Mr Blewett agreed with Mr Hussain around the cooperation of the Internal and External auditors.

Mr McConnell welcomed the discussion and noted the positive assessment of the effectiveness of the Audit and Risk Committee.

<u>The Committee:</u>

1. Noted the Review of Effectiveness of Audit and Risk Committee.

18 FINANCE, eHEALTH and AUDIT GROUP UPDATE

The Committee received the Finance, eHealth and Audit Group Update presented by Mr McNaught who confirmed that there are no matters requiring escalation to the Audit and Risk Committee.

The Committee:

1. Noted the Finance, eHealth and Audit Group Update.

19 SECURITY, RESLILIENCE, HEALTH and SAFETY OVERSIGHT GROUP

The Committee received the Security Resilience, Health and Safety Oversight Group presented by Mr Hardy who confirmed that there are no matters requiring escalation to the Audit and Risk Committee.

The Committee:

1. Noted the Security, Resilience, Health and Safety Oversight Group Update.

20 DRAFT AUDIT and RISK COMMITTEE WORKPLAN 2025

The Committee received and noted the draft Audit and Risk Committee Workplan for 2025 presented by Ms Smith who asked for amendments or additions required.

Mr McConnell thanked Ms Smith for the draft workplan and advised that no changes were required.

The Committee:

1. Approved the Draft Audit and Risk Committee Workplan 2025.

21 ANY RELEVANT ISSUES TO BE SHARED WITH GOVERNANCE COMMITTIEES

Mr McConnell suggested the following issues be shared:

- Staff Governance Committee and Remuneration Committee to be made aware of the internal audit into Consultants Discretionary Points.
- Clinical Governance Committee to be made aware of the upcoming Physical Health Internal Audit.

Mr Currie suggested that the Staff Governance Committee also be made aware of the need and responsibility of staff to report second jobs.

22 ANY OTHER BUSINESS

There was no other business raised by members.

23 DATE AND TIME OF NEXT MEETING

The next meeting will take place on Thursday 30 January 2025 at 9.30am via MS Teams.

The meeting ended at 12 noon.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 February 2025
Agenda Reference:	Item No: 21b
Report Author:	Head of Corporate Governance
Title of Report:	Audit and Risk Committee – Highlight Report
Purpose of Report:	For Noting

This report provides the Board with an update on the key points arising from the Audit and Risk Committee meeting that took place on 30 January 2025.

1	Internal Audit	The Committee received progress reporting on audit activity, including a review of the outstanding actions from previous audit reporting, and future planned audits. One finalised audit was received relating to Statutory and Mandatory Assurance with reasonable assurance. The Committee discussed the findings and learnings to be taken from the audit, and that this would be shared with the Staff Governance Committee.
2	External Audit	The External Auditors advised progress on work relating to the audit for the current financial year, including planning and risk assessments and process walkthroughs. This was noted by the Committee.
3	Corporate Risk Register	The Committee received a report on the position on the Corporate Risk Register, focused on the three risks currently rated as high. There were no new risks to be considered. Progress of work to develop the register further was also reviewed, especially around how to demonstrate movement of the risks over time, supported through mitigations, and it was agreed that this should be considered further.
4	Finance	The Committee received an update on the financial position noting that there was continued expectation of a breakeven position for 2024/25 albeit this was challenging in the current national landscape. Capital funding received in December 2024 had been allocated for upgrade works required.
5	Audit Scotland National Reports	The Committee considered the report, as a useful and well expressed tool for the position across NHSScotland as a whole, especially around the financial position and identification of savings.

5	Counter Fraud	The Committee received a quarterly summary of alerts received from Counter Fraud Services (CFS) and noted this. The Committee Chair will link with the Finance and eHealth Director on allegations received, and how to demonstrate the robustness of the investigative process.
6	Cyber Crime Report	The Committee received an update, noting no major or local risks reported in the past quarter.
7	Internal Updates	The Committee received updates from the Finance eHealth and Audit Group, and the Security, Resilience, Health and Safety Group.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minute will be presented, once approved by the Committee.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP / Corporate Objectives	As part of corporate governance arrangements, to ensure committee business is reported timeously to the Board.
Workforce Implications	None through reporting – information update
Financial Implications	None through reporting – information update
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested, pending approval of formal minutes
Risk Assessment (Outline any significant risks and associated mitigation)	Committee update only as part of governance process – no specific risks to be considered unless raised by committee chair/members for Board attention.
Assessment of Impact on Stakeholder Experience	No assessment required as part of reporting
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included