THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 19 JUNE 2025
at 12.30pm
Hybrid Meeting: in Boardroom and on MS Teams

A G E N D A

12.30pm			
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 24 April 2025	For Approval	TSH(M)25/03
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 25/44
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**Project Update for the National High Secure Forensic Healthcare Services for Women in Scotland** Report(s) by the Programme Director	For Noting	Paper No. 25/45
1.10pm	**RISK AND RESILIENCE**		
8.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 25/46
9.	**Annual Report 2024/25: Risk and Resilience** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 25/47
10.	**Finance Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 25/48
11.	**Bed Capacity Report:** **The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 25/49
1.45pm	**CLINICAL GOVERNANCE**		
12.	**Annual Report 2024/25:** **Clinical Governance Committee** Led by the Committee Chair	For Decision	Paper No. 25/50
13.	**Quality Assurance and Quality Improvement**	For Noting	Paper No. 25/51

	Report by the Head of Planning, Performance and Quality		
14.	**Clinical Governance Committee:** - Approved Minutes 13 February 2025 - Report of Meeting 8 May 2025	For Noting	 CGC(M)25/01 Paper No. 25/52
2.05	**BREAK**		
2.20pm	**STAFF GOVERNANCE**		
15.	**Annual Report 2024/25: Staff Governance Committee** Led by the Committee Chair	For Decision	Paper No. 25/53
16.	**Annual Report 2024/25: Remuneration Committee** Led by the Committee Chair	For Decision	Paper No. 25/54
17.	**Organisational Development and Wellbeing Strategy** Report by the Director of Workforce	For Decision	Paper No. 25/55
18.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 25/56
19.	**Protecting Vulnerable Groups (PVG) – Update** Report by the Director of Workforce	For Noting	Paper No. 25/57
20.	**Staff Governance Committee:** - Approved Minutes 20 February 2025 - Report of Meeting 15 May 2024	For Noting	 SGC(M)25/01 Paper No. 25/58
3pm	**CORPORATE GOVERNANCE**		
21.	**Annual Report 2024/25 – Audit and Risk Committee** Led by the Committee Chair	For Decision	Paper No. 25/59
22.	**Report on the Annual Accounts 2024/25** Report by the Director of Finance and eHealth	For Decision	Paper No. 25/60
23.	**Patients' Funds Accounts** Report by the Director of Finance and eHealth	For Decision	Paper No. 25/61
24.	**Annual and Medium-Term Plans: Scottish Government Approval** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/62
25.	**Performance Report 2024/25 and Annual Comparative Figures** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/63
26.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 25/64
27.	**Audit and Risk Committee:** - Draft Minutes 27 March 2025	For Noting	 ARC(M) 25/02

- Verbal Update Meeting 19 June 2025

28.	**Any Other Business**		Verbal
29.	**Date of next meeting:** 9.30am on 28 August 2025		Verbal
30.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
31.	**Close of Session**		Verbal

Estimated end at 3.45pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 25/03**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 24 April 2025.

This meeting took place by way of MS Teams and commenced at 9.30am

Chair:	Brian Moore
Present:	
Employee Director	Allan Connor
Non- Executive Director	Stuart Currie
Non- Executive Director	Cathy Fallon
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:	
Skye Centre Manager	Jacqueline Garrity [Item 7]
Acting Director of Security, Estates & Resilience	Allan Hardy
Head of Communications	Caroline McCarron
Social Work Mental Health Manager	David Hamilton
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minutes]
Programme Director	David Walker [Item 8]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone and noted that there were no apologies for the meeting.

He acknowledged that a member of the public had joined the meeting by way of teams, to observe the meeting.

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 minutes of the previous meeting held on 27 February 2025 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 19 December 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 progress on Action No. 3, Excellence in Care Walkrounds was discussed with Mrs McCaffrey advising that the planned visit from colleagues on NHS Forth Valley had to be cancelled at short notice due to lack of availability, but had been re-scheduled for 15 May. In addition, the Associate Nurse Director was in contact with colleagues from other NHS Boards for support in this area.

It was also noted that the Board would have the opportunity after today's meeting to consider the approach to linking papers to Corporate Objectives as set out in Action No. 17.

The Board:

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

5 CHAIR'S REPORT

Mr Moore opened his update by describing the Celebration of Achievement Awards for patients, which he had attended. It had been a great opportunity to listen to patient stories, and reflect on the progress individuals had made. In particular, the Koestler Award had been presented to a worthy recipient. There had been carers at the ceremony as well as a performance by the Patients Choir which had added to the positive atmosphere. The Chair reflected that this occasion had demonstrated the range of opportunities available to patients in the State Hospital (TSH).

Mr Moore advised that he had attended a meeting of the NHS Board Chairs Group, and that the key focus there had been on the Nursing and Midwifery Taskforce Report which encompassed different aspects including work life balance, workload, and safe staffing levels, as well as education. He noted that some papers at today's meeting were relevant to these issues. Ms McCaffrey added that she would be attending a Scottish Executive Nurse Directors (SEND) meeting later today, and would be in a position to feedback on this, saying that the key themes in the report were similar across different fields of expertise.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided a summary of his activities since the last Board meeting, beginning with events within the hospital. He had attended communal meetings with both patients and staff within the Transitions Service, and was planning to visit other services across the hospital. He noted that Mr David Walker, Programme Manager, had also attended to provide an update on the progress being made by the Project Team for the High Secure Women's Service. Mr Jenkins had also attended the Intellectual Disability (ID) Development Day, and he commented on how helpful this had been with reflection on the direction for the service and how it linked to strategic planning through the TSH Annual Delivery and Medium Term Delivery Plans.

The Chief Executive provided feedback to the Board about the second Leadership Development Day which took place on 1 April. This session followed on from the initial session which had taken place on 31 October 2024 as part of engagement across the organisation in the development of strategic

planning. This session had included focus on organisational health, in terms of culture and had been well attended and received. A third session in this series was planned for late summer.

Mr Jenkins noted the progress made in key workstreams including resilience, nursing resourcing and the Perimeter Security Project, and that updates would be provided at this meeting. A fully detailed paper was included on today's agenda in relation to the Women's Service Project. He advised that there had been a high level of activity around attendance management and the challenges faced in this respect, and this was also part of today's agenda. He said that he had been pleased to see the improvements made on PDPR compliance in the past two months. He also noted the work undertaken by colleagues in Finance during this period, for end of year with a positive position being predicted. For Board awareness, he confirmed that the continuation of the Service Level Agreement with NHS Lothian for pharmacy services had been agreed and signed off.

He noted that today's agenda included Health Board Collaboration and Leadership, reflecting the priority of NHS Reform across NHSScotland, and the work progressing for example around centralised business systems.

More widely, Mr Jenkins provided an update on his work with Healthcare in Custody, and the challenges outlined by the relevant Minister, Ms Jenny Minto, in the courts and tribunal service.

He also advised that the Board Chief Executives (BCE) Group strategy session on mental health had taken place on 12 March, and that he had hosted this along with the Director of Mental Health, Mr Stephen Gallacher. Professor Thomson had also attended in her role as Director of the Forensic Network. Mr Moore queried about if had presented during this session, to discuss key issues for forensic mental health. Mr Jenkins said that the session had been well attended with all NHS Board Mental Health Leads having been invited. It had been a deep dive into the Mental Health and Wellbeing Strategy, with consideration of a refresh of strategy and a cross system discussion arising from this. He noted that the meeting had included discussion of a pilot model being tested within NHS Lanarkshire currently which linked to Police Scotland, women's services as well as the Forensic Network's action plans and guidance. Further, adolescent services as well as services for children and young people in the context of a recent BBC documentary in this area were also discussed.

The Board:

1. Noted the update from the Chief Executive.

7 VOLUNTEER STORY: VOLUNTEER EXPERIENCE WITHIN THE STATE HOSPITAL

Ms McCaffrey introduced this agenda item which was a video made with a recent volunteer in TSH about her experience. Ms McCaffrey highlighted that this helped to show some of the potential benefits of the volunteer scheme for patients as well as for the volunteers themselves, and how this brought a positive impact for the hospital as a whole.

Ms Garrity joined the meeting and provided some further background about the volunteer service, saying that four new volunteers had been recruited recently. This video was from an individual who was completing an undergraduate degree in psychology, and had volunteered at the hospital to gain experience of a forensic healthcare setting.

The Board watched the video presentation The volunteer told her story, beginning with being nervous and hesitant with patients at first, but that she had managed to overcome this with support from TSH staff. She felt that this had enhanced her communication skills and provided coping mechanisms for stressful situations. She reflected that this experience at TSH had helped her to develop further in her chosen career within psychology. During her time at TSH, she had appreciated the positive feedback she had from both patients and staff, with support available from different staff groups to help her in her volunteer role. This had meant that she had been able to keep the patients' interests at the heart of the work that she had done. She had felt that she was making a difference to the patient experience. It had been a unique experience given the nature of the service that TSH provided, and she would recommend to others to consider fulfilling a volunteer role.

At the conclusion of the video, Mr Moore opened up the discussion commenting firstly that it was excellent to see the volunteer service attracting new recruits.

Ms Fallon said that she had found the video to be heartwarming, with such a positive story about TSH. This was an important contrast to some of the media focus on forensic mental healthcare and TSH in particular. She asked whether the patient group had been able to see the video and hear this feedback. Ms Garrity confirmed that this had been arranged, and that patients had made a card to thank the volunteer and wish her well for the future.

Mr Currie made the suggestion that the video would be a positive addition to the staff induction programme, and reflected on the positive benefit to TSH from volunteers. There was a raw honesty to the video which added to its value. He asked whether there was linkage to the Patients' Advocacy Service (PAS) in terms of recruiting and supporting the volunteer role, and Ms Garrity confirmed that this was the case with shared learning being found in this way. Ms Radage commented on the positive way this video could be used to promote the work of TSH, especially as it helped to break down some of the myths about high secure forensic care. She also said it had become clear when attending the Patient Partnership Group (PPG) that volunteers play an important role in patients' lives.

Ms McCaffrey thought that the video helped to showcase TSH and could be a valuable tool in recruitment across different areas – staff may find a forensic high secure setting to be unfamiliar at first, but this showed the ability to build confidence and skills, and even to consider working in forensic care in the future. Professor Thomson agreed, and said it was clear that this had brought positive benefits for the individual volunteer as well as for patients. She noted that it may be helpful to consider linking to universities to attract volunteers as part of career development opportunities. Ms Garrity confirmed that this was being considered further at present, referring to the volunteer management system led by Health Improvement Scotland (HIS). Mr Wallace added that this would fit well with the Workforce Pan 2025/28 which was under development especially in growing links with further education bodies.

Mr Moore summarised the discussion for the Board, noting that it had been very helpful, and showed that the volunteer strategy was being put into action. He noted that the Board would be interested in hearing about further developments underway for the recruitment of volunteers a well as linking to universities and colleges. He offered thanks from the Board to the volunteer for her contribution to TSH as well as for taking the time to make this video, which had been very impressive.

The Board:

1. Noted this content of this presentation, and the potential further opportunities it had highlighted.

8 HIGH SECURE FORENSIC HEALTHCARE SERVICE FOR WOMEN

The Board received a paper (Paper No. 25/22) from the Chief Executive Officer, on the progress of this service. Mr Walker joined the meeting at this stage in order to present the key aspects of the report for the Board. He confirmed that the Women's Project Oversight Board had met twice, chaired by Mr Currie who was the Non-Executive Director Lead. The amended terms of reference had been agreed at the last meeting and would be submitted to the TSH Board in due course. The Core Project Team (CPT) had also been established, and this was chaired by Mr Walker, meeting weekly.

Mr Walker summarised the current position in terms of each phase of the project. Within Phase 1, for the Interim and Outreach Service, there had been a workshop on 1 April attended by representatives from medium secure services and the prison service, and these links would continue with meetings on a quarterly basis. Mr Walker also highlighted the work being developed on clinical guidance, as well as admission criteria. Further, he asked the Board to note progress in terms of recruitment to the new service within the timescale set, and the risks associated with this as well as the need for delivery of training in order to meet the target opening date for the service of 21 July 2025.

Moving on to Phase 2, Mr Walker confirmed that the feasibility study had been completed and was

presented to the OMT on 11 April. It would be submitted to the Corporate Management Team on 7 May, and then to the Women's Project Oversight Board. Subject to endorsement, it would be submitted to the TSH Board at its June meeting seeking decision-making at this point.

Mr Walker outlined the key aspects of funding, asking the Board to note that the additional funding of £100k had been received in month 12 of 2024/25, and had been allocated to the work required to adapt Mull 3. He confirmed that a risk register had been established for this project, and did not have any further issues to escalate to the TSH Board at this stage. He summarised the work ongoing on stakeholder engagement and communication planning.

Mr Currie provided an update as Chair of the Women's Project Oversight Board, saying that this work was moving forward as a fast pace and that the project team were demonstrating skill in delivering this. It was an inclusive process with stakeholders, with each having the opportunity to contribute. He was mindful of the need for transparency and an appropriate level of scrutiny by the full TSH Board especially given the need for accountability for public funds.

Mr Moore picked up this final point, and underlined the need for the TSH Board to have assurance. Ms Fallon agreed and said that she had found the report very helpful in its level of detail. She asked about the specific skills that staff may need to deliver care to female patients, and how this would be made available. Further, she queried the potential impact on the additional nursing posts that the TSH Board had recently agreed, and whether recruitment to the female service would have an unintended consequence on the plan to eliminate daytime confinement. She also noted that the TSH Board had agreed that this project and the development of a high secure service should be added to the Corporate Risk Register as part of the Board's role to scrutinise any arising risk as the service developed.

Mr Jenkins referred to Item 12 on today's agenda relating to nurse resourcing, which linked to this discussion, and as a means to demonstrate the focus on how this additional resource was being utilised especially around elimination of daytime confinement. On training, the spoke of the need to be cognisant of the different presentation of female patients to males, and of the learning taken from Rampton Hospital to ensure that TSH staff were trained appropriately. He accepted the point on the Corporate Risk Register, confirming that this would be completed.

Action – Mr Hardy

Mr McConnell noted that there were risks outlined in terms of recruitment albeit that the process was developing well, and asked if it was anticipated that recruitment of staff would be sufficient to meet the demands of Phase 2, once the time came to move to that. He also asked to what extent disciplines such as Allied Health Professionals or Psychology attached to the female service, would be utilised across the whole hospital should it be the case that there was lower demand experienced within the female service itself. Mr Jenkins outlined the setup of an anchor ward or area for staff who were allocated to the female service, where they would be attached in the event of less demand within the female service. In terms of Phase 2, the staff already in place would continue into the later phase and so there would be less immediate pressure. He said that there was a 36 month period planned to lead up to Phase 2 which would allow for any arising issues to be resolved before moving to a full service.

Professor Thomson advised that for the consultant psychiatrist posts, these would be available across the body of the hospital. She also noted the crucial differences in caring for male and female patients particularly around trauma informed practice, and the need to ensure staff were trained appropriately. She raised a potential logistical issue on the opening date for the interim service in July as it was during the summer holiday season, and this may impact on delivery of training. Ms McCaffrey spoke about the way in which new staff would be inducted and trained as well as being anchored to other areas. She thought that this would involve the balancing of core essential skills for all staff, along with the development of new skills as required for different patient cohorts.

Ms Radage welcomed the report, considering this to be comprehensive and that it reflected the fast pace of this project. She asked about the newly recruited staff to the female service, and what the key attraction was for them to this new area for the hospital. Ms McCaffrey described the variety of reasons for this, including previous experience or alternatively the desire to develop new skills. She noted that a

new service could have the potential to inspire and motivate those involved in its development, and bring opportunities to contribute to the way that the service is developed.

Mr Moore summarised for the Board, thanking everyone for a detailed and constructive discussion, and commenting positively on the major achievements of the POB for the pace of delivery. There was discussion on how reporting should be brought to the TSH Board as whilst it was now a standing item for bi-monthly meeting, there would be a need for oversight in the intervening periods. There was agreement around the table that a summary of the key discussions and areas of focus of each Women's Project Oversight Board should be produced after each of its meetings, and circulated electronically to the TSH Board.

Action – Mr Walker

It was also noted that this project should formally be added to the Corporate Risk Register as indicated in today's meeting.

The Board:

1. Noted the full update within reporting.
2. Requested that the project be added to the Corporate Risk Register.
3. Requested monthly reporting following each Women's Project Oversight Board, in the month between each TSH Board meeting.

9 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 25/23) from the Acting Director of Security, Resilience and Estates to provide an update on the Corporate Risk Register. Mr Hardy provided an overview of the content of the report, and asked the Board to note the inclusion of timelines for each directorate area, showing risk movement. He outlined the proposal to include new risks for staff absence, the implementation of the Reduced Working Week, as well as any potential delay to completion of Protecting Vulnerable Groups PVG) checks in line with updated guidance. He provided a brief summary of the risks within each directorate, noting those which were at a High/Very High grading.

Mr Moore noted that the Board found the report helpful, and noted the work being taken forward on Risk MD30 – Failure to Prevent/Mitigate Obesity, and that the Board would welcome reports on progress. The recommendations of the report were accepted by agreement around the table.

The Board:

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

10 FINANCE REPORT TO 31 MARCH 2025

The Board received a paper (Paper No. 25/24) from the Director of Finance and eHealth, reporting on the financial position to 31 March 2025 (Month 12). Mr McNaught summarised the position for the Board, noting that this was a draft outturn at this stage for year end, and confirming that it was anticipated that a break-even position would be achieved. There would be a small underspend, estimated to be £188k. He also advised that Scottish Government had confirmed that they were satisfied with this, as well as with the forecast for 2025/26.

He advised that directorate budget meetings continued to be held each month, to support implementation of the savings plan for the current year with any expected increases in pay and non-pay elements factored in. Mr McNaught confirmed that the capital budget was fully utilised during 2024/25, including the additional funding allocation received in Month 11. Capital demands were now being prioritised for the coming year, with advice awaited from Scottish Government as to the potential

availability of additional funding following review of all NHS Boards Business Continuity Plans.

Mr Currie spoke positively about the amount of work this represented, and asked about how to ensure that departments across the organisation were taking a risk based approach to spending prior to any decision-making commit funding. This would require staff to be considering value for money up front, and developing the skills to be able to recognise this. He also asked about any impact that demonstration of efficiencies now may have on confidence from government to allocate additional funding in the future. Mr McNaught thought that TSH was in a good place, and noted that positive relationships existed with Scottish Government colleagues. At the same time, any additional allocation for TSH would be judged against need in other NHS Boards. The typically lower nature of requirement from TSH as a small organisation may be helpful in this context. He also said that internally, there was greater awareness which helped to harness understanding and efforts towards savings requirements. Mr McNaught also reflected that in terms of recurring savings, for smaller teams the vast majority of their budget was for staff pay meaning that it may not be possible to make savings at the set target level.

Mr McConnell was pleased to note the emerging financial position for 2024/25 as reported, which represented a good result with a small underspend. Mr Jenkins echoed this, noting for information that £188k represented approximately one and half day's operational costs for the hospital. Mr McConnell asked about the audit process for the annual accounts, in terms of key themes at a national level for public bodies, and Mr McNaught indicated that there were no particular issues to be aware of presently.

Ms Fallon asked about the required increase in costs for instances of clinical acuity in individual patients within TSH as well as the cost of supporting those who required to attend general hospital for treatment. She also asked if there was a need to factor in additional costs for specific training needs for staff for the female service. Mr McNaught advised that there was no specific additional training cost indicated at present, and Mr Jenkins noted that this would be built into the revenue stream for the women's service. For the unexpected increases in costs due to clinical acuity, Mr McNaught said that these had been absorbed within existing budgets for 2024/25. Ms McCaffrey agreed with this point, noting that the costs of an additional ward would not continue as this was not currently required.

Ms Radage asked about capital funding, as the table in Section 5 appeared to indicate an overspend given the differential between year to date spending, and the planned outlay. Mr McNaught provided assurance that this was due to a timing issue on reporting with there being no capital overspend.

Mr Moore noted the position as outlined, with a break-even position being forecasted. It was positive to see the ownership of the financial position being spread across the organisation, with staff being aware of their responsibilities in this regard. He noted thanks to Mr McNaught and his team for their detailed work in this area.

<u>The Board:</u>

1. Noted the content of the report.

11 BED CAPACITY REPORT

The Board received a paper (Paper No. 25/25) from the Medical Director, which outlined bed capacity within TSH for the two month period to 31 March 2025. Professor Thomson summarised the content of the report in terms of the key aspects including patient flow within TSH and the wider position in the forensic estate.

Ms Fallon asked about the Orchard Clinic and the continued reduction in capacity, as well as further detail on patient flow within TSH, She thought it would be helpful to be able to take a deeper dive into this area to gain an understanding of how patients experienced movement across services in the TSH, prior to transfer from the hospital. She thought it would be beneficial to consider further how this was evidenced within TSH. Professor Thomson advised that the Orchard Clinic had required to carry out structural refurbishments, with works commencing in August 2024 with completion expected in August

2026. This represented a reduction of seven beds. However, there had been an improving picture in

terms of patients being able to transfer from TSH to lower levels of security.

She went on to advise that within TSH, there had been pressure on beds generally within Major Mental Illness. In view of this, efforts were being made to optimise the use of bed capacity within the Transitions Service, with a change in the referral criteria which made it possible to make transfers at an earlier stage. This in turn would free up capacity within Treatment and Recovery. Within the Admissions and Assessment, there were patients who had not been able to move on to Treatment and Recovery due to the lack of availability of beds, despite meeting the time limits set within clinical guidelines. She advised that work was ongoing presently which encompassed consideration of changing structures, and the impact on patent flow with Treatment & Recovery sitting at 100% occupancy.

Mr Moore indicated that it was helpful to have identified the blockage in patient flow, and that this was being considered within the overall framework of the clinical model. Ms Fallon was in agreement, and said that this was an area that would benefit from further scrutiny and discussion in the Clinical Governance Committee and should be added to its agenda.

Action – Ms Smith/ L Thomson

Ms Radage asked if bed capacity for the female service would be added to reporting, and this was agreed for future reporting once the service opened.

The Board:

1. Noted the content of report.

12 NURSE RESOURCING

The Board received a paper from the Director of Nursing and Operations (Paper No. 25/26) to provide the Board with an overview of the Nurse Resourcing Strategy for 2025/26, in the context of a number of internal and external factors. Ms McCaffrey provided a summary of the background to this in terms of the health and care staffing legislation and reporting requirements, e-rostering, and the reduced working week.

She confirming that recruitment progressed well for additional nursing AfC Band 3 posts, following the Board agreement for this in December 2024: with 9.4 whole time equivalent (WTE) staff commencing employment in March 2025 on a fixed term basis. She then explained that with the fast pace of development for the female service, this meant that these staff were entitled to be considered for any permanent posts that became available. All of these staff wished to do so, and it was agreed that any appointable staff who had not been successful in securing a permanent post, would be offered a 12 month fixed term position. Ms McCaffrey acknowledged the need to ensure that the impact of this recruitment should continue to be measured, especially in respect of the elimination of daytime confinement. She also underlined the need to offer sustained support for these cohorts of new staff coming to TSH, including an integrated approach with existing staff, supervision, and mentoring. She said that the paper also outlined the way in which staff within the female service would be anchored to other services in the hospital, to take into account period of lower demand as well as maintaining skill sets.

She focused in particular on daytime confinement, and the need to progress towards elimination of this. Ms McCaffrey outlined the steps taken to streamline reporting and governance in this area. This enabled decision-making led by the data which had shown that the Transitions Service was being impacted disproportionately by daytime confinement. Therefore, a decision was made that eight of the ten WTE additional staff would be allocated to this service. The remaining staff would be allocated to target Admissions and Assessment, and Treatment and Recovery Services.

Lastly, Ms McCaffery emphasised the need for a reduction in sickness absence, recognising the impact that the high level of absence within nursing overall was having. She outlined the timeline for the

strategy, towards its end date in April 2026. This included the elimination of daytime confinement by October 2025.

Mr Jenkins added his support, highlighting the usefulness of this as a strategic overview of the direction of travel, and key aims. Professor Thomson added her support, providing assurance that the Clinical Governance Group were closely monitoring this to see the effects of the additional staffing on daytime confinement as a key clinical issue. She also agreed with the learning to be taken from other high secure hospitals, as outlined in the report.

Ms Fallon welcomed the target date of October 2025 to eliminate daytime confinement, but sought additional assurance on how the steps being taken now would be significantly different from previous efforts. Ms McCaffrey thought that the key change now lay in the detailed preparatory work which had focused on establishing the strands of work required, and this gave additional confidence in setting a realistic target. Mr Jenkins noted the key changes of the past 18 months including in the clinical model, as well as in detailed analysis of how baseline staffing resources were being deployed, and the impact of additional resourcing for clinical acuity and/or outboarding of patients. This meant that there was now clear data during this period to underpin decision-making. He thought that between March and June of this year; the impact of additional staff should be demonstrable. This was prior to the opening of the female service, and allocation of staff to that.

Mr Moore summed up the discussion saying that the progress made, and learning taken in this area were appreciated. He wished to make it very clear that the TSH Board's expectation was that daytime confinement would become a never event, and that the target date of October 2025 would be met. The TSH Board wished to deliver this, and this was underlined emphatically. Reporting should be brought back to provide updates on how this was moving forward.

Action – K McCaffrey/ M Smith

<u>The Board:</u>

1. Noted the content of the report.
2. Set clear expectation that daytime confinement would be eliminated by the target date set.
3. Requested progress reporting in this regard.

13 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 25/27) which outlined quality assurance and improvement activities during the past two months. Ms Merson provided an overview of this report including the details in relating to clinical audit work completed, and the master sheet to summarise local performance. She also noted the improved data evidence within the Variance Analysis Tool (VAT).

She highlighted that TSH3030 had been launched for 2025, and that this had elicited a very positive response so far with 20 teams registered to take part. This would support the development of quality assurance across difference areas of the hospital, with mentoring and support sessions being delivered through the QI Forum. It was a competitive event, and this also lent to the enthusiastic participation of both staff and patients. Ms Merson also asked the Board to note the continued progress in Realistic Medicine, as well as in the evaluation matrix which documented the work completed regarding evidence for quality, including analysis of the national and local guidance and standards recently released and pertinent to TSH.

Ms Fallon complimented the good compliance shown by the master audit sheet, showcasing improvements made. She asked about how many staff were trained in QI, and how the organisation derived benefit from this. Ms Merson confirmed that almost 30 staff were trained nationally including the Scottish Improvement Leaders Programme (ScIL) and that 18 staff members had undertaken QI Essentials in the last three years. She said that TSH benefitted from this in a range of ways to ensure that QI approached were embedded in TSH, with this expertise being coordinated through the QI Forum.

Ms Fallon asked for clarification as to why two different asthma guidelines were under review, and Professor Thomson advised that the screening team within Clinical Quality would have found differences within each guideline meaning that separate reviews would be required. She added that this may have been due to asthma being assessed at a mild or moderate level, compared to a more chronic condition.

Mr Moore noted that the Board could take positive assurance through the clinical audit work, as well as the improvement in VAT form completion with medical completion increasing from 54% to 94%. He welcomed the TSH3030 initiative, and the planned “Oscars” event scheduled for 24 June, saying that this would be a good opportunity for Non-Executives to get involved in the event. This was agreed around the table.

Action – Ms Smith/ Ms Merson

The Board:

1. Noted the content of the report.

14 TSH CARERS TRAVEL SCHEME

The Board received a paper from the Acting Head of Security, Resilience and Estates (Paper No, 25/28) which outlined the issues involved in carer travel to the hospital for in person visits. Mr Hardy described the background to this as well as possible options for consideration.

This was focused on three main areas in terms of carer need, as well as the level of resourcing and logistics involved in provision of a dedicated transport service. This had included close liaison with the Person Centred Improvement Team (PCIT) so as to assess the level of need within the carer cohort – this had established that there were now in place good arrangements between this group and the PCIT to pre-plan visits. This included any exceptional circumstances should patient or carer need change over time.
Therefore, the result of the assess meant that setting up a new dedicated transport service was not required at present, but this could be re-visited in the future if appropriate.

Ms Fallon was in agreement with this recommendation, but thought that this issue had arisen due to one carer’s difficulties in getting to the hospital, and wished to know whether this had been resolved. Ms McCaffrey was able to confirm that this was the case, and that this was based on them having to make a long journey across the country, and having some difficulty for the last stage of the journey to the hospital. The individual was supported in this by the PCIT and was content with the arrangements made. She reflected that this could be the case where individual journeys may throw up some logistical issues, and that these could be addressed as they arose, rather than a new transport service being required more generally.

Mr McConnell thought that this was reasonable, noting that the position could be re-visited in the future if necessary. He reflected on the context of the opening of a high secure female service within TSH, based upon ease of access and that this may be a focus going forward.

Mr Jenkins agreed with this and gave assurance that access for carers would be at the forefront of consideration of this issue in the future.

Mr Moore summarised the Board’s agreement that a new transport service was not assessed to be required presently, and that future consideration of this this would fall within the remit of the Carers Strategy, and its related action plan which was now being implemented.

The Board:

1. Approved the recommendation as set out in the report.

15 HEALTH AND CARE STAFFING REPORT

The Board received a report from the Director of Nursing and Operations (Paper No. 25/29) which provided assurance to the Board on the work progressed towards compliance with the requirements of the Health and Care (Staffing) (Scotland) (2019) Act. Further, to review the first annual update report for 2024/25 endorsing this for submission to Healthcare Improvement Scotland (HIS).

Ms McCaffrey summarised the content of the report, noting that positive feedback had been received throughout the year, relating to the quarterly reports submitted. The report summarised the outcome of the self-assessment undertaken across each area indicated and which had resulted in substantial assurance in nine of the ten standards which were applicable to TSH, and reasonable assurance on Training and Consultation of staff. Staff needs had been identified and included within the Corporate Training Plan for 2025/26. She advised that work was continuing with HIS in relation to a revised workload tool which would be fit for purpose within forensic healthcare environments. Finally, that work was progressing within TSH to fully realise the benefits of e-rostering.

Ms Fallon congratulated Ms McCaffrey and her team for the very positive position for TSH. Mr Moore agreed with this, saying that this work had been completed well within TSH. He noted that the evidence statements required for reporting were general, and he commented on how this supported escalation of risk, and confidence in robust processes. He asked about the availability of real time data, and escalation routes including clinical in the context of the recent report by HIS into emergency care with questions raised on the deliverability of the statutory requirements for safe staffing. He thought that there may be further questions on the reliability and effectiveness of the standards. Ms McCaffrey noted that reporting was accurate in terms of the current position within TSH. Professor Thomson noted that there were recognised difficulties for medical staff, which were being experienced across NHS Boards.

Mr Jenkins added that the legislative requirements had been fulfilled, and served the purpose of outlining the systems and process that were in place. At the same time, there were wider issues that need to be considered from an operational standpoint.

The Board:

1. Approved the content of the annual report for 2024/25 onward submission to HIS.

16 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 25/30) which provided updates on workforce performance to 31 March 2025, across a range of metrics. Mr Wallace provided further background in key areas, focused most particularly on staff absence levels and the actions in place to improve this position.

In March 2025, the sickness absence rate had increased slightly, with a related increase in the short term absence rate. However, the long term absence rate had reduced during this same time period. He advised that absence rates within the nursing cohort remained the major challenge for TSH. He confirmed the ongoing review of the approach to maximising attendance, with dedicated reporting in this respect being submitted to the TSH Staff Governance Committee who took detailed oversight of this area. This approach had identified the key areas for improvement as set out in the report, including how to develop impactful communication to staff about the impacts of high levels of absence on service delivery, and the overall costs to the organisation. There was a need to find a balance between highlighting this, whilst also recognising the person centred, supportive approach to managing absence within NHSScotland policy. As part of this approach, there would be a continued review of pathways to ensure that staff had the right support as quickly as possible; as well as ongoing evaluation of this to seek evidence that the approach was working.

Mr Currie agreed that it would be helpful to link absences to the financial costs involved, and to the requirements of the Health and Care (Staffing) (Scotland) (2019) Act. He said that considering all of the

activity and work being conducted in this area, it was disappointing to see continued high levels of sickness absence. He raised the question of what else could be done to reduce absence, especially in the context of the continuing costs of overtime. Mr Radage agreed with this, and thought that the report outlined the key issues very clearly. She asked about how messaging was communicated to staff, and the potential impact that could have. Mr Wallace commented that this was an approach that had been used more widely in NHSScotland, and that it was important to be thoughtful about this. It was about ensuring that there was a strengthening the role line managers played in developing a relationship with staff so that any such messaging could be within that context. At the same time, more general communication methods like posters could risk the unintended consequence of alienating staff with good attendance records. Overall, it was essential to find a means through which to highlight that the high levels of sickness absence being experienced within TSH were not sustainable.

Mr Moore noted that some areas had sickness levels of up to 19% which was very concerning and would have a huge impact on the quality of the service being offered. Mr Jenkins added that performance across different areas of the hospital was variable, and there was a need to understand why this was the case more fully, so that appropriate actions could be put in place. There was a concern about wider cultural issues playing a role, and he recognised that this had to be addressed.

Professor Thomson noted that although it was the role of line managers to manage staff absence, further support delivered through Human Resources to enable them to do so had been impactful in the past. She was concerned about the way in which high levels of absence may impact patient care, and the ability to eliminate daytime confinement of patients. Mr Wallace concurred, but raised the risk of short term impact being achieved only, and that longer term change would come from line managers being empowered to act, as well as accountable for performance in their teams. He thought that the key to improvement would lie within building this capacity within managers who were best placed to build relationships within their teams, and have lasting impact on the culture of the organisation.

Mr Jenkins underlined the way in which this issue was of key focus across directorates, and that it would be helpful for the Staff Governance Committee to be able to take a deeper dive into the causes, as well as the possible solutions to this challenge.

Mr Moore summarised the view of the Board, emphasising that the Board were concerned about the high levels of sickness absence evidenced, and the impacts being experienced including the financial costs, delivery of patient care, and also on staff as a whole within the hospital. This was not moving in the right direction, and required urgent focus for improvement. The Board would continue to monitor this closely, seeking improved performance.

<u>The Board:</u>

1. Noted the content of the report.
2. Expressed concern about the continued high levels of sickness absence, and the impacts on the organisation.

17 WHISTLEBLOWING ANNUAL REPORTING 2024/25

The Board received a paper (Paper No. 25/31) from the Director of Workforce which included the TSH Annual Whistleblowing Report for the year 2024/25.

Mr Wallace detailed the content of the report, confirming that TSH had not received any new cases to be considered under the standards for this year. The Annual Report outlined the approach taken within TSH and followed on from the submission made by to the Cabinet Secretary for Health and Social Care, by Ms Shalinay in her role as Whistleblowing Champion, and which had been considered and endorsed at the last meeting of the Board.

The Board were content with the report, and agreed that it should be submitted to the Independent National Whistleblowing Officer (INWO) on this basis.

The Board:

1. Approved the content of reporting for onward submission to the INWO.

18 PROTECTING VULNERABLE GROUPS (PVG) REPORT

The Board received a paper (Paper No. 25/32) from the Director of Workforce to provide an update on the changes being made by Disclosure Scotland, relating to the Disclosure (Scotland) Act 2020, as of 1 April 2025.

Mr Wallace highlighted the changes, and the way in which this would impact all NHS Boards including TSH. The protecting Vulnerable Groups (PVG) had become a legal requirement with changes made to the disclosure levels. Further, PVG membership had become mandatory for all regulatory roles, and the definition of such roles had been revised. This meant that within TSH, all roles had to be reviewed, and an assessment made that these changes meant that almost all employee roles within TSH would fall within this definition. Mr Wallace asked the Board to note the required timescale for this work to be completed, as well as the costs involved both financially as well as in resourcing. There would be ongoing impacts as renewals would arise within each year to ensure continuing compliance.

Ms Fallon asked about how the costs were being met, and Mr Wallace confirmed that these were being met by TSH, rather than asking staff to meet these directly. Ms Fallon also asked for clarification in terms of Non-Executive Directors, and Mr Wallace noted that Scottish Government had provided this, to the effect that this role would be included within the definition. Ms Radage asked whether Disclosure Scotland had raised any concerns about their ability to process the resultant increase in applications. Mr McConnell noted the operational risk should Disclosure Scotland not be able to process applications timeously. Mr Wallace advised that no specific concerns had been raised to date, and thought the risk in these terms would be delays in completing recruitment of new staff. It would be helpful if Disclosure Scotland were able to focus on new applicants, and confirm a grace period for retrospective applications.

Mr Moore noted that the Board was content with this update, and that further reporting should return to provide a report on any emerging issues or resultant risks.

The Board

The Board:

1. Noted the content of reporting.
2. Requested further reporting on any emerging issues or resultant risks.

19 HEALTH BOARD COLLABORATION AND LEADERSHIP

The Board received a paper from the Chief Executive Officer (Paper No. 25/33) which contained nationally agreed content relating to the reform agenda across NHSScotland as set out by the First Minister in his statement on 27 January 2025.

Mr Jenkins outlined the key concepts including the establishment of new governance arrangements through the NHS Scotland Executive Group, and the need for all NHS Boards to ensure a systematic approach to the delivery of care at a local level as well as in the delivery of planned care to meet the needs of larger populations. He noted the refreshed approach in patient access to care, with three products to be published in the first half of this year, Following the Operational Improvement Plan, there would be the Population Health Framework and the Health and Care Service Reform Framework.

In parallel to this there was also renewed focus on efficiency and productivity, especially around

business systems to ensure that all opportunities for service efficiency were explored.

Mr Jenkins noted the ask of NHS Boards to be cognisant of the reform agenda, and the requirement to refresh the approach to the NHS Board performance framework, and related Executive personal objectives as set out by Ms Caroline Lamb, Chief Executive of NHSScotland and Director General for Health and Social Care, in her letter to all NHS Chairs and Chief Executives dated 2 February 2025.

Mr Moore said that this was of key importance and would be explored further in the Board Development Session scheduled for 1 May. There was agreement to acknowledge and endorse the recommendations as set out in the paper.

The Board:

1. Noted and endorsed the recommendations set out in this paper.

20 ANNUAL REVIEW OF STANDING DOCUMENTATION

a) Scheme of Delegation and Standing Financial Instructions
b) Standing Orders and Members Code of Conduct

The Board received a paper (Paper No. 25/34) from the Director of Finance and eHealth which included the Scheme of Delegation and the Standing Financial Instructions. Mr McNaught confirmed that there had been no significant changes in the year, and the Audit and Risk Committee had approved these documents, recommending that they be submitted to the Board for its approval.

The Board received a paper (Paper No. 25/35) from the Head of Corporate Governance, encompassing a review of the Board Standing Orders and Members Code of Conduct. Ms Smith highlighted that there were no proposed amendments to the Standing Orders. In relation to the Code of Conduct, she noted that some slight adjustments had been made in terms of wording and layout to be in keeping with the model code from the Standards Commission. Further, the section on Training and Development had been removed based on the commission's advice in relation to the need to delineate clearly between performance issues and the code of conduct. This report had also been submitted to the Audit and Risk Committee, who approved these for onward submission to the Board.

The Board:

1. Approved the Scheme of Delegation and the Standing Financial Instructions, as set out.
1. Approved the Board Standing Orders and Members Code of Conduct, as submitted.

21 BOARD IMPROVEMENT PLAN

The Board received a paper from the Head of Corporate Governance (Paper No. 25/36) to provide a six monthly update on the plan which had been developed following self-assessment, with the focus being on continuous improvement.

Ms Smith outlined the key aspects which related to the continued refresh of risk management approach, as well as the development of a Stakeholder mapping to support engagement and the interdependencies and links to other workstreams. It was noted that a comprehensive Organisational Development Strategy would be reviewed at the Staff Governance Committee in May, and would be key to progress in this area. Finally, that work was progressing in a key area of risk relating to succession planning, especially for Heads of Service. Lastly, she noted that a further progress report would return in six months' time.

Mr Moore commented on the importance of the Board being alert to the actions contained within the plan, and the work being progressed as evidence of effectiveness. He noted that that the Board wished to appoint a Non-Executive Equalities Champion, and this was noted as Ms Raghavan. Finally, that there was expectation that a further self-assessment exercise for Board would be rolled out nationally in the first half of 2026.

The Board:

1. Noted the content of the report, and that a further update would return in six months.

22 COMMUNCATIONS ANNUAL REPORT 2024/25

The Board received a paper from the Head of Communications (Paper No. 25/36) which covered performance during this year. Ms McCarron advised that the report provided a full summary of the department, giving a wide ranging comprehensive communications service to stakeholders. She welcomed the Board's feedback on the content and format of reporting.

Ms Radage noted the work completed on website accessibility, with a small resource within the department. Ms Fallon echoed that and asked that a further update be brought back to the Board on the progress in that areas especially related to resourcing within the Communications Team.

Mr Currie was mindful of the need to demonstrate professionalism when managing media interactions. He reflected on the upcoming changes for the Board, most notably the female service, and any opportunities that this may bring to help to inform communications. He also spoke about the need to develop a communications approach with staff on attendance management, as discussed at today's meeting. Ms McCarron confirmed that she would be linking in with Scottish Government colleagues on the development of the communications approach.

Mr Moore added that it would be helpful to give further consideration to the aspects discussed, as well as to the wider approach, for example to staff bulletins in the context of staff feedback. He also noted that the Board would welcome discussion of management of media enquiries within the Board Development Session schedule.

Action(s) – Ms McCarron

The Board:

1. Noted the content of reporting.
2. Requested an update on website accessibility workstream and resourcing.
3. Requested Communications approach be part of Board Development schedule.

23 NETWORK AND INFORMATION SYSTEMS (NIS) UPDATE

The Board received a paper from the Director of Finance and eHealth (Paper No. 25/38) which set out the outcome of the assessment made in October 2024, following the previous review in October 2023. This confirmed an overall assessment rate of 78% which was a very positive assessment. Mr McNaught also advised that the Key Performance Indicator (KPI) compliance of 60/60/40 had been achieved. The team were now focusing on reviewing the remaining areas for development, making any improvements prior to the next review in 2026.

The Board were content with the update presented within reporting.

The Board:

1. Noted the 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. 25/39) to confirm the updated position.

Mr Jenkins asked the Board to note the key points within reporting, in terms of the general project update

and the projected completion date. In particular, Site Acceptance Testing (SATs) had confirmed that there were minor points to be resolved in this respect prior to Practical Completion. He also confirmed that since the date of reporting, the £108k additional funding had been received and allocated for project team expenditure.

Board Members noted this position, and that the project was nearing completion date.

The Board:

1. Noted this update in relation to the Perimeter Security and Enhanced Internal Security Systems Project and recognised that this was also an item for the Private Session of the Board Meeting.

25 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 30 January 2025; as well as a summary report (Paper No 25/40) on the key areas of reporting and discussion at the meeting, which had taken place on 27 March 2025.

Mr McConnell, as Committee Chair, highlighted that at its last meeting the Committee had reviewed two internal audits including an audit on e-rostering which had achieved only partial assurance. This was being shared with the Staff Governance Committee, and would be an area for repeat audit to ensure improvement in this area. He also noted that the Committee had reviewed a draft of the annual governance statement which was a helpful process at this stage of the year prior to finalisation.

The Board:

1. Noted the content of the approved minutes 30 January 2025
2. Noted the update from the meeting held on 27 March 2025.

22 ANY OTHER BUSINESS

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

23 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 12.30pm on Thursday 19 June 2025.

24 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.

25 CLOSE OF MEETING

Mr Moore brought the session to a close, thanking everyone for their contributions.

The meeting ended at 1.10pm

ADOPTED BY THE BOARD _____

CHAIR _____

Approved as an Accurate Record

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	August 2025	**October Update:** Review and align to governance arrangements for committees, and bring back to the Board. **February Update:** Scheduled for Board Development Session on 1 May, alongside wider review of governance. **June Update**: Refreshed approach agreed at Board Development Session around agenda setting Review of report template linked to website accessibility workstream – pilot of papers through CMT in July and then take forward for Board and Committees, pending learning taken.
2	August 24	Carers Story	Travel scheme to TSH – for carers	A Hardy	April 2025	**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. **April Update:** Report on agenda: Item 14 June Update: Board reviewed reporting and agreed to continue extant position. **CLOSED**

3	August 24	Quality of Care	- Quality of Care Reviews implementation	K McCaffrey	April 2025	**December Update:** Associate Nurse Director progressed through Patient Safety Forum, and first Quality of Care 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. At meeting, Board noted update and agreed that work with other Boards to be helpful. **April Update:** March visit was re-scheduled to 23 April due to availability. Feedback following this visit can be provided verbally at board meeting. Noted at meeting that visit had to be re-scheduled due to availability issues. **June Update:** First formal visit to Mull 1 took place on 14 May. Report now received and discussed at Patient Safety Group on 10 June 2025. Overall positive report with one recommendation pertaining to DTC, which is already being addressed. Governance going forward will be through Patient Safety Group with reporting in the 6-month and 12-month Patient Safety reports the Clinical Governance Committee. Consider closing action in this context.
5	October 24	Corporate Risk Register	-Consider Risk SD51 in context of project finalisation – and post completion period and how to re-frame risk	A Hardy	May/June 25	**December Update:** This will be reviewed fully on completion of the project to understand risk/ requirements to mitigate system failure. To return to Board in June. **June Update:** Project Update on agenda, with expectation of final reporting in August 2025.

			-Review Workforce Risks and potential to add to CRR – e.g. absence - Update on progress of improvement work on management of SAERs			**December Update:** This is under review and will return to the Board. Reviewed at Staff Governance Committee in February 25. **February Update:** To return to Board in June. **June Update:** On Agenda (Item 8) **December Update:** Work remains ongoing to improve SAER process. Risk team will complete this work in the fourth quarter, once all outstanding SAER's are complete. **February Update:** Discussed and agreed to add to Board Development Session agenda. Arranged for 1 May 2025. **June Update:** CMT agreed governance group to take oversight of SAERs at its meeting in June. This will now be implemented.
7	February 2025	Matters Arising	To check that Patients' Advocacy Service have allocated space within Skye Centre	G Jenkins	June 2025	**April Update:** Review is underway with PCIT/Skye Centre Manger as well as PAS to identify needs and ensure that appropriate space can be made available to meet the needs of patients. **June Update:** Confirmed that PAS do have access to spaces within Sky if they have a request from patient to meet with them e.g. Sports office/pac room. Further consideration to dedicated space for "drop in" service.

8	February 2025	Matter Arising	To plan presentation regarding Non-Executive role for PPG	M Smith	July 2025	**April Update:** Discussed and agreed with PCIT, who have also discussed with members of PPG to see if this would be helpful. There is agreement on this from the patients and it has been scheduled for PPG in July 25. **CLOSED**
9	February 2025	Chair's Update	TSH3030 – update to Board on this year's event	M Merson	April 2025	**April Update:** on agenda as part of reporting: Item 13. **June Update**. Board noted update at April meeting and have been invited to the "Oscars" event taking place on 24 June. **CLOSED**
12	February 2025	CEO Update	Provide an update to Board on roll out and impacts of Digital Inclusion Made Purple Pilot	R McNaught	October 2025	**April Update:** Work in progress, and update to next Board meeting. **June Update:** Confirmation that groundwork for pilot progressed well with clinical and security staff having access, and patients being consulted with on future content e.g. music, shopping, education. Focus on connectivity of devices by September 25. Update to return to Board in October, with eHealth annual reporting.
13	February 2025	Female Service	Reporting to Board including governance arrangements and terms of reference for agreement	D Walker	April 2025	**April Update:** Reporting on agenda: Item 8 **June Update:** Reporting now standing item for Board, including interim reports so that monthly updates can be provided from Project Oversight Board. **CLOSED**
14	February 2025	Staff Governance Report	Provide financial analysis aligned to staff absence to demonstrate impacts, and which areas most impacted for care delivery	S Wallace/	April 2025	**April Update:** Reporting on agenda: Item 16 Board noted progress and detailed oversight through Staff Governance Committee. **June Update:** Maximising Attendance reporting routed through Staff Governance Committee in May and performance will be tracked and update

						to be provided in August meeting.
16	February 2025	Whistleblowing	Capture the routes through which concerns can be raised, and how made accessible to Staff i.e. business as usual and place whistleblowing route within that overall context, as well as whether meaningful data can be provided.	S Wallace	August 2025	**April Update:** Work in progress, and update to return to Board. **June Update:** Work is progressing, and reporting will return to the August Board Meeting
17	February 2025	Corporate Objectives	-Circulate refreshed and approved version to Board, and for website. -Request Authors link their papers directly to the Corporate Objectives, each of which now had identifier reference.	M Smith/ All Directors	August 2025	**April Update:** Action completed to revise the Corporate Objectives and publish. All Directors asked to ensure that reports include direct link to Corporate Objectives, prior to submission to Board for April meeting. All reports on agenda should be compliant. **June Update:** Consider any further Board feedback and align to work on refreshing reporting templates.

18	April 2025	High Secure Female Service	Risk to be added to the Corporate Risk Register	A Hardy/ D Walker	June 2025	**June Update:** On agenda (Item 8)
19	April 2025	High Secure Female Service	Dedicated Reporting to be provided to TSH Board, following each Project Oversight Board to support oversight in intervening period between TSH Boards.	D Walker	May 2025	**June Update:** Interim report was circulated in May following the Project Oversight Board meeting., This will now be provided as part of routine governance. **CLOSED**
20	April 2025	Bed Capacity	Following discussion on patient flow between services within TSH – noted benefit of further review and remitted to Clinical Governance Committee who also receive this reporting. Addition of female capacity once interim service open in July 2025	L Thomson/ M Smith	August 2025	**June Update:** Bed Capacity Report is on agenda for Clinical Governance Committee in August. CGC workplan will note requirement to add reporting on female capacity once interim service is operational in July. **CLOSED**
21	April 2025	PVG Update Report	Update noted, and request to bring back further update on progress at next Board, and CMT to escalate any issues in intervening period	S Wallace	June 2025	**June Update:** On agenda (Item 19)

	April 2025	Communications Annual report	Discussion on website accessibility work, and wider resourcing with request that returns to the Board. Further discussion on communication with staff on key issues such as attendance management, and wider approach to media enquiries. Noted to be on planner for Board Development Sessions, to be arranged.	C McCarron/ M Smith	October 2025	**June Update:** Scheduled for Board Development Day in October 2025, and confirmed with Communications.

Last updated – 12.06.25 M Smith

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 7
Sponsoring Director:	Chief Executive Officer
Author(s):	Programme Director
Title of Report:	Project Update for the National High Secure Forensic Healthcare Services for Women in Scotland
Purpose of Report:	For Noting

1. SITUATION

This paper provides an update on the new development of National High Secure Forensic Healthcare Services for Women in The State Hospital (TSH).

2. BACKGROUND

TSH has been asked by Scottish Government to implement a proposal to deliver High Secure Services for Women in Scotland at TSH.
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'.
The proposal is being developed in two phases:

i. develop and implement an **interim women's service model**,
ii. develop and implement an **outreach service model.**

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. Progress the planning for a medium – longer term service model.

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 creating a central 'treatment hub' at TSH. In January 2025, funding was confirmed by Scottish Government to progress both Phase 1 and 2, thereafter a Core Project Team (CPT) has been established to take forward planning.

3. ASSESSMENT

3.1 GOVERNANCE

The establishment of a Women's Project Oversight Board (WPOB) is supported and agreed though the Corporate Management Team and The State Hospitals Board for Scotland. The WPOB is chaired by Mr. Stuart Currie, Non – Executive Director and meets monthly. The last meeting was held on 22 May 2025.

The CPT meets on a weekly basis and is chaired by the Programme Director.

The latest updates on progress of both phases are as follows:

3.2 PHASE 1 UPDATE – INTERIM AND OUTREACH SERVICE

Clinical Governance

Referral and Admission Criteria:
The referral criteria and admission process has been agreed. Referrals will be managed through the Patient Pathway Group with a lead Psychiatrist allocated to commence the assessment. Full details of the process are within the clinical guidance and describe the specific needs of patients who, for example, may be under 18, have Intellectual Disabilities, or involved in conflict resolution over their required level of security.

Clinical Guidance:
The clinical team has established a weekly meeting to develop Clinical Guidance. The Clinical Guidance document will be presented to the WPOB on 26 June for final approval having been endorsed by the Clinical Governance Group.

Ward Adaptations:
Works have commenced on the adaptations required for the service and all elements are currently on track to be completed by the go live date of 21 July. The ward will be subject to a formal 'Ligature Risk' assessment and 'Control Book' inspection once the works have been completed.

Safeguarding:
Social Work Department team members have been liaising with Scottish Prison Service and Health colleagues. The Chief Social Work Officer for South Lanarkshire Council and the local MAPPA Operational Group which encompasses health, housing, police and social work colleagues have been briefed on the planned service and recommended further engagement with the 'Violence Against Women and Girls' lead.
The Adult Support and Protection, Keeping Children Safe and Appropriate Adult policies have been reviewed for the interim service and remain fit for purpose. A wider review of the Keeping Children Safe policy is ongoing and will incorporate guidance around pregnancy. Additional training for the TSH social work team is ongoing and will be completed in advance of the service opening in July.

Staff Governance

As outlined previously, the following positions have been appointed to:

- Consultant Psychiatrist
- Senior Charge Nurse
- Clinical Security Liaison Manager

In addition, the Specialist Occupational Therapist (OT) and Housekeeper are on track to start for the target date of 23rd June 2025.

The Consultant Psychologist and Psychologist roles have been appointed to and start dates are planned for September, due to notice periods and qualification dates. However, the Women's service will be covered by the existing team in the interim.

The OT Support Workers and Rehabilitation Instructors posts have been appointed to from existing staff and recruitment 'backfill' has commenced.

Nursing positions - External recruitment has progressed in line with the timeline set:

- Charge Nurses (3wte) - all ready to start for 23rd June 2025
- Registered Nurses (12.5wte) - 6 new employees ready to start on 23rd June 2025 and 6 internal staff wished to move their base ward to the Women's service
- Healthcare Support Workers (HCSWs) (11wte) - 10 ready to start on 23rd June, at time of writing report.

Currently, the 'patient ready' date remains on target for 21 July 2025. Further updates will be provided in due course regarding the progress.

Training Plan:
A formal training plan has been developed for staff recruited to the interim service. Training will take place over a four week period commencing 23rd June 2025 and will include:

- Statutory/Mandatory training
- PMVA
- Trauma informed practice/Clinical Model
- High Secure orientation.

On successful completion the Interim Service will be 'patient ready'.

Organisational Development Plan:
The CPT in conjunction with Organisational Development have submitted a proposal which outlines a multi-phase approach to team development for the newly established Women's Service. The four phase programme is designed to support a psychologically safe, trauma-informed and collaborative culture from the outset, ensuring the team is equipped to deliver compassionate and effective care.

The phases are as follows:
1. Foundations Phase (Before Opening or Early Days)
2. Relational & Reflective Phase (First 3 Months)
3. Skill-Building & Problem-Solving Phase (3–6 Months)
4. Ongoing Culture and Growth (6 Months Onwards)

This team development plan is designed to evolve with the service and adapt to the dynamic needs of the staff and patients.

Project Timeline:
An overall project timeline has been established and each element of service delivery contains further details of components and timescales towards 'the 'patient ready' date of 21July 2025. The project timeline was reviewed by the WPOG at its meeting on 22 May and remains on track.

3.3 PHASE 2 UPDATE

The feasibility study for Phase 2 was completed in April 2025 and within budget. The report provided by Thomson Gray outlines the work undertaken to assess the options contained within the 'High Level Information Pack'. Thomson Gray have identified a preferred location option for the medium to long term development of High Secure Services for Women in TSH. The findings from the report were present to the WPOB, Medical Advisory Committee and the Partnership Forum since the last TSH Board meeting in April.

A presentation on the report and findings will be delivered at the private session of the Board on 19 June 2025.

3.4 FINANCIAL UPDATE

Phase 1
Funding for Phase 1 has been committed by the Mental Health Directorate in year 2025/26. Verbal confirmation of recurring funding has also been given by Scottish Government with confirmation is writing anticipated as part of budget setting for 2026/27. This enabled the recruitment of a permanent staff group for the Women's service. A further £100k has been allocated for capital adaptations to Mull 3.

Spend to date is within budget for both revenue and capital.

Phase 2
The allocation of £223,975k in 2024/5 for the Feasibility Study (Phase 2) includes:

Revenue Allocation: £73k (spend £59k)
Capital Allocation: £150k (spend £89k)

The remaining allocation of £76k has been carried over into 2025/6.

3.5 RISK REGISTER

A risk register has been developed jointly by the CPT and Risk department. Identified risks have been divided into the following themes:

- Workforce
- Finance
- Governance
- Clinical
- Environmental

Each risk is assessed weekly by the CPT and a report provided monthly to the WPOB. This process aligns itself to the TSH Risk Management Strategy and allows for the WPOB to escalate any risk to the Corporate Risk Register if required. Currently, there are seven 'High' Risks (previously eight) being managed through the WPOB process, none of which require further escalation. The High Risk in relation to 'Funding for development of service is withdrawn' was reduced from High to Medium.

3.6 STAKEHOLDER MAPPING AND COMMUNICATIONS PLAN

A comprehensive stakeholder mapping exercise and communications plan have been established by the CPT. These were endorsed by the WPOB in March and engagement with internal and external stakeholders is ongoing. Recent engagement has been with the following organisations:

HMP Stirling
Forensic Network for Scotland – Womens Services Planning Group
The Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment – CPT
Patient Advocacy Service - Board meeting.

3.7 DATA PROTECTION IMPACT ASSESSMENTS (DPIA)

DPIA:
When TSH undertakes a project or makes changes to its services or changes the use of personal data it is required to consider privacy 'by design and by default'. A DPIA is being

developing in conjunction with the Information Governance and Data Security Officer and will be submitted to the June WPOB for approval.

4. RECOMMENDATION

The Board is invited to note the status and progress of the project to deliver National High Secure Forensic Healthcare Services for Women in Scotland.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP	This paper outlines the strategic direction, as led through Scottish Government and being taken forward by the State Hospital's Board. The Corporate Objectives 2025/26 proposed include this as a key focus of work.
Corporate Objectives Please note which objective is linked to this paper	**1 Better Care** 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.
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 detail within the paper, representing additional revenue and capital out with existing budget.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Project Oversight Board to TSH Board (both public and private sessions).
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 has been developed by the Project Team and endorsed 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	Equality Impact Assessments are in place for both phases of the project. Planned linkage with NHS Central Legal Office ensures 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	The development of the service will reduce current inequalities and gaps in service provision.

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 ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No. 25/46

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 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
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 updated status on the current Corporate Risk Register.

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

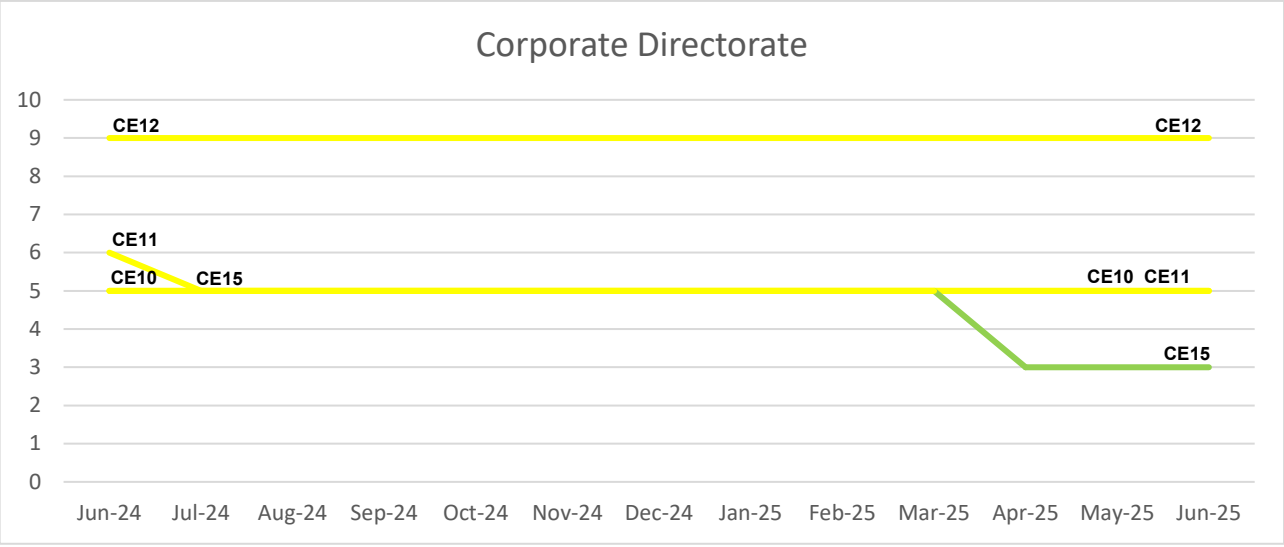
All risks are in date.

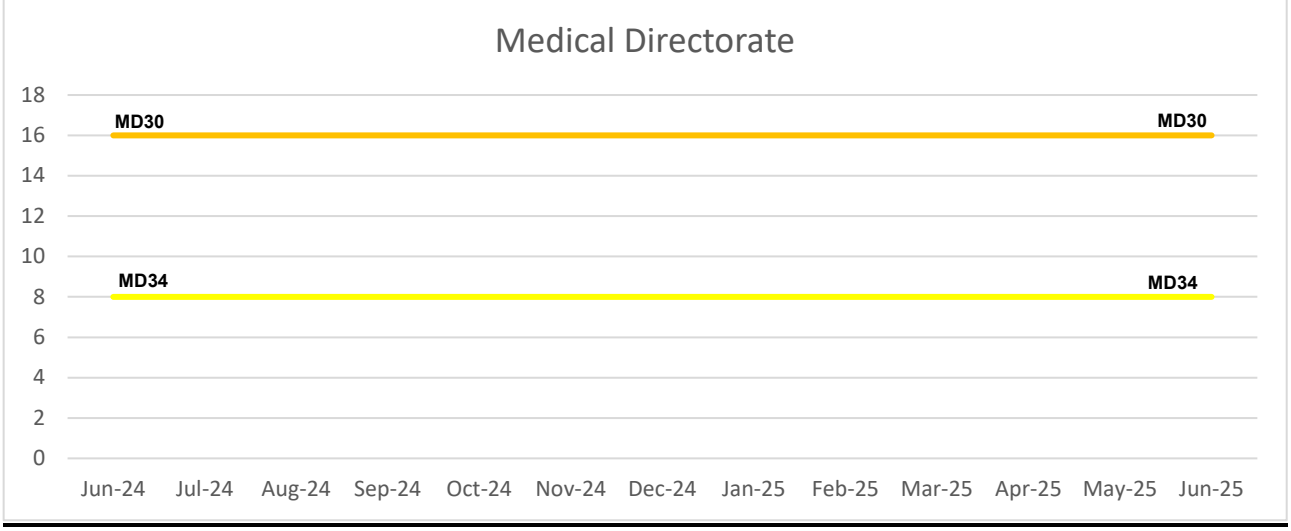
3.3 Risk 12 Month Movement

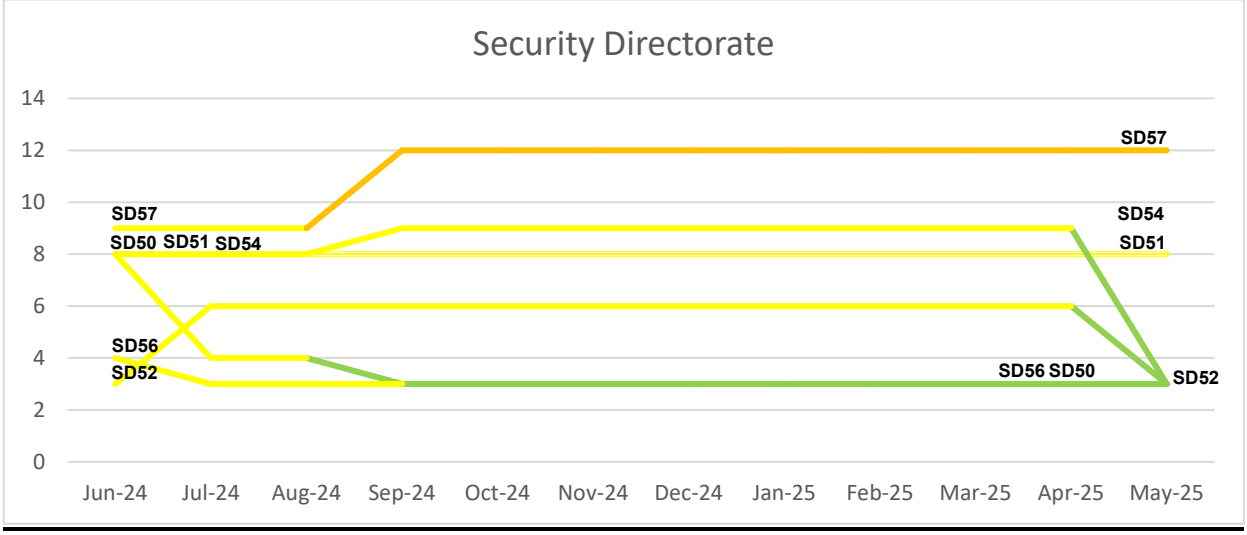
The following charts show the longitudinal movement of risk over a twelve-month period

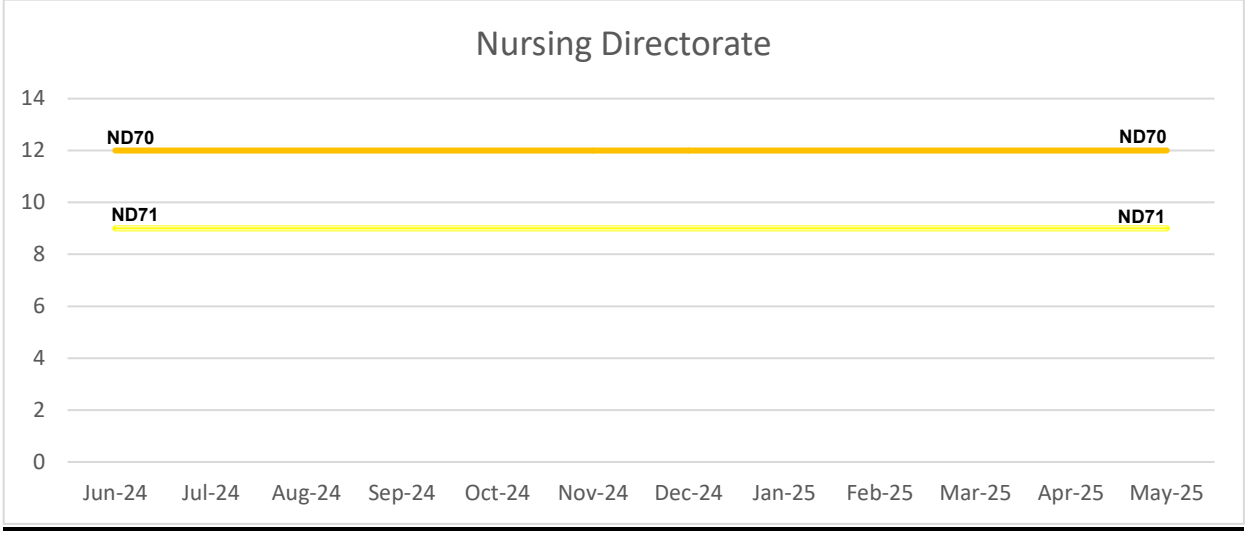
Likelihood	Impact/Consequences				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	Medium (5)	High (10)	High (15)	V High (20)	V High (25)
Likely (4)	Medium (4)	Medium (8)	High (12)	High (16)	V High (20)
Possible (3)	Low (3)	Medium (6)	Medium (9)	High (12)	High (15)
Unlikely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

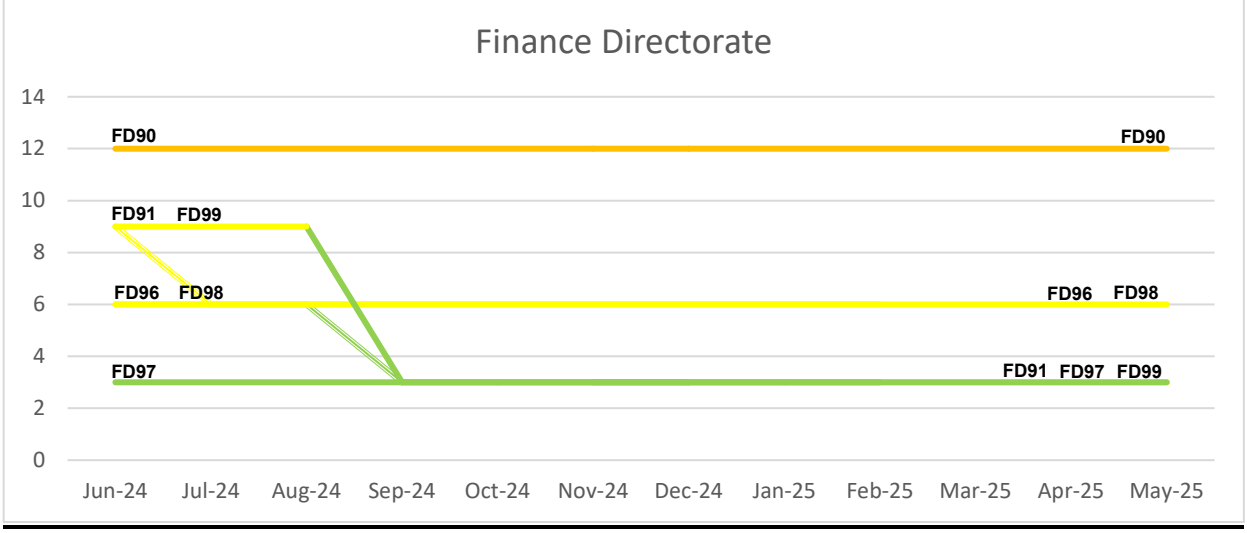
- Very High 17 -25
- High 10 - 16
- Medium 4 - 9
- Low 1 - 3

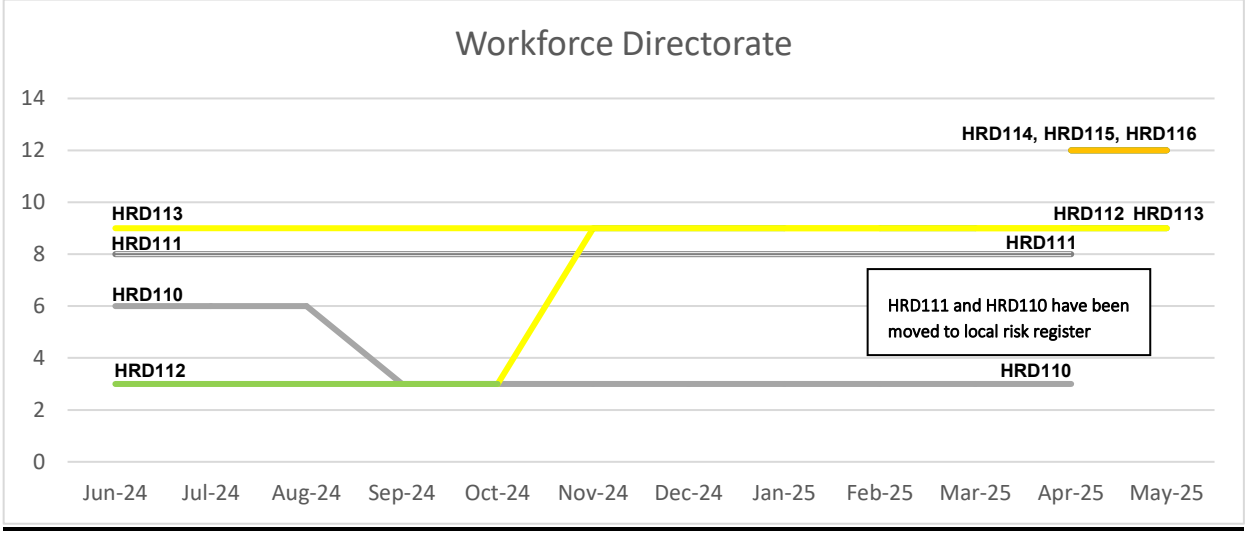





Security Directorate
14
12
10
8
6
4
2
0
SD57
SD50 SD51 SD54
SD56
SD52
SD57
SD54
SD51
SD56 SD50
SD52
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25


Nursing Directorate
14
12
10
8
6
4
2
0
ND70
ND71
ND70
ND71
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25


Finance Directorate
14
12
10
8
6
4
2
0
FD90
FD91 FD99
FD96 FD98
FD97
FD90
FD96 FD98
FD91 FD97 FD99
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Apr-25
May-25



3.4 Update on Proposed Risks for inclusion on Corporate Risk Register

The Corporate Management Team has requested that a Corporate Risk be developed and added to the register in relation to the ongoing development of the Female Service within TSH. This risk is currently under development in collaboration with the Project Lead and the Acting Director of Security, Estates and Resilience. A full project risk register is managed and reviewed by the Female Project Oversight Board. Once overall risk is defined this will be ratified at CMT before presentation to the Board.

3.5 Corporate Risk Register Updates

Workforce

Additional risks were accepted at CMT in June 25 and have been added to the Corporate Risk Register.

HRD114 – Impact of Reduced Working Week

NHS Scotland is in the process of implementing a reduction in the standard working week from **37 hours to 36 hours** by **1st of April 2026**. There is a working group exploring how this change can be implemented locally.

The implementation may present several risks, including:

- Increased strain on the workforce
- Potential impact on patient care
- Financial implications for the organisation

This risk is currently graded as **High (Major × Possible)** and will be monitored by the HR Director and Head of HR, with updates provided by the Reduced Working Week Sub-Group.
Full Risk Assessment available in Appendix 2.

HRD115 – Sickness Absence within TSH Increases Above Acceptable Levels

The target is **5%**, whilst in April 2025 absence is **7.86%**.
Maximising attendance remains a key priority for the Board. Sustained high absence levels pose several risks, including:

- Increased pressure on remaining staff
- Lower staff morale
- Financial strain
- Negative impact on patient care
- Reputational damage
- The risk also considers potential non-compliance with the Working Time Directive.

This risk is currently graded as **High (Major × Likely)** and will be monitored by the HR Director and Head of HR, with updates provided by the Workforce Governance Group to CMT then onto the Staff Governance Committee.

Full Risk Assessment available in Appendix 3.

HRD116 – PVG Checks

Recent changes introduced by Disclosure Scotland now require all staff to complete a Protecting Vulnerable Groups (PVG) check, along with mandatory five-yearly rechecks. This change in governance is expected to result in a significant backlog and delays in PVG processing, which may impact recruitment and onboarding timelines.
The new legislation is projected to increase the number of PVG checks requested by TSH by 300% in the current year, with an ongoing 200% annual increase thereafter. Although this risk is not yet formally recognised, it is anticipated that the volume of checks could potentially lead to operational challenges.

Additional potential hazards include:
- Breach of legislative requirements
- Risk of unlawful employment of staff without appropriate clearance
- Reputational damage to the organisation

The risk is currently graded as **High (Major × Likely)** and will be monitored by the HR Director and Head of HR. Updates will be provided through the Workforce Governance Group to CMT then onto the Board.

Monthly updates on progress of all above risks will go to CMT from July 2025.

Full Risk Assessment is available in Appendix 4.

Risks Moving to Local Risk Register
CMT agreed that the below risks would move to the Local Risk Register and be managed by the HR Department. As per policy if the risk moves to High they will be brought back to the Corporate Risk Register.

HRD110 Failure to Implement and Continue to Development the Workforce Plan

This risk is currently rated as low and is at target level. Following the development of the 2025 Workforce Plan this risk has been moved to the Local Risk Register

HRD112 Deliberate Leaks of Data

The risk is currently at its target level and cannot be reduced further, as adequate control measures are in place to inform staff of their responsibilities regarding Information Governance. While the risk remains, any deliberate data breaches fall outside the direct control of TSH. The risk will continue to be recorded on the **Local Risk Register** to ensure that training and communication efforts related to information governance are maintained and adhered to.

Corporate

CE15 Impact of Covid Statutory Inquiry – Following review risk was decreased to low, accepting that the control measures in place are adequate to manage the risk.

SD57 Failure to Complete Adverse Reviews Timeously will be combined with CE12 Failure to Utilise Appropriate Systems to Learn from Adverse Events both externally and internally due to similarities in content, part of this review will also look at what directorate the risk is appropriately monitored and managed..

CE11 Risk of Patient Injury will be relocated to the Director of Security, Estates and Resilience who has oversight of Health and Safety.

Security

SD52 – Resilience Arrangements Not Fit for Purpose
The risk rating has been reduced to Moderate × Rare (Low) following several updates to the organisation's resilience plans. All plans are now current and considered fit for purpose within the existing operational model. The appointment of a permanent Resilience Officer has further strengthened resilience processes through ongoing plan development, testing, and engagement with external partners.

SD54 – Implementing Sustainable Development in Response to the Global Climate Emergency
This risk has also been reduced to Moderate × Rare (Low), based on the organisation's progress in exceeding set targets and ensuring that current initiatives are on track within required timescales. The risk will continue to be monitored and updated, with the potential for escalation should any concerns be raised through the Climate Change and Sustainability Group.

3.6 High and Very High Risk – Monthly Update

The State Hospital currently has **7** 'High' graded risks, 3 risks have just been added to the CRR and are detailed in the previous section, the other 'High' risks are detailed below:

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

The risk has been reviewed following several meetings with the Lead Dietitian and Clinical Quality Facilitator. Available data has also been assessed, and the development of a Tableau dashboard, which will support risk evaluation, is nearing completion. The dashboard is currently in its final stages and will help inform the overall risk level.
A meeting was held with the Medical Director CEO and Risk to clearly define a way forward with a deadline for completion of the 30th of July.
A meeting was also scheduled for 10 June 2025 with the Medical Director and relevant stakeholders to discuss the future approach to reviewing this risk.

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

Monthly Update:

Risk ND70 remains under development. Progress continues on the creation of a **staff resource dashboard**, which is intended to support future risk assessments by providing relevant data insights. The dashboard is currently in the testing phase and is expected to go live next month.
A meeting was recently held with the Chief Executive, Security Director, Nursing Director, and the Risk Management Team Leader to discuss the risk. Some final actions were identified during the meeting to complete the risk update and finalise its assessment.
Security Director SD57- Failure to complete Category 1 and 2 Reviews on Time

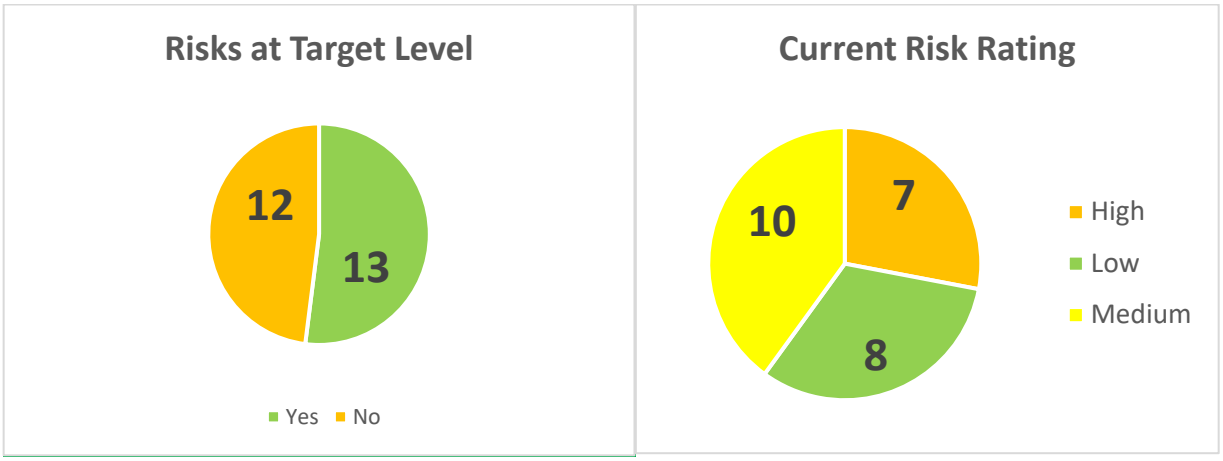
Monthly Update:

Risk SD57 was elevated to **'High'** following a review in October 2024. The Risk and Resilience Team identified an increased likelihood that adverse event reviews and their associated actions may not be completed within required timeframes, due to recent operational pressures within the team. In response, the Corporate Management Team (CMT) has approved the establishment of a **Serious Adverse Event Review (SAER) Group**. This group will be responsible for commissioning, monitoring, and reviewing all Category 1 and Category 2 SAERs. Its formation is intended to strengthen operational ownership and focus on the review process, serving as a key control measure to help reduce the risk rating from High.

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

Risk FD90 has been revised to reflect the national financial pressures highlighted in Scottish Government communications issued in January and February 2024 to Chairs, Chief Executives, and Directors of Finance. These communications outlined anticipated funding shortfalls and significant budget constraints for the 2024/2025 financial year. As a result, the risk rating remains at **'High'** and will continue to do so until national funding reaches a level that allows annual savings requirements to be reduced to a manageable and recurring level.

3.6 Risk Distribution



Currently 13 Corporate Risks have achieved their target grading, with 12 currently not at target level.

As outlined in the TSH Risk Management Strategy, **low and medium risks are considered tolerable** within the organisation's defined risk appetite. While some corporate risks have not yet reached their target levels, they remain within the agreed risk parameters. The Risk Manager is continuing efforts to reduce these risks to their target levels through ongoing review and timely updates to ensure effective risk management.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70, SD57	MD30, HRD114, HRD115, HRD116	
Possible	FD91		CE12, HRD113, ND71, HRD112	FD90	
Unlikely			FD96, FD98,	MD34, SD51,	
Rare			FD97, SD56, FD99, SD50, SD54, CE15, SD52		CE10, CE11

Review Periods:

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

3.7 CRR Development

The Risk Management Team continues to review and enhance the risk management process. The Corporate Risk Register is being regularly updated in close collaboration with directors across all services.
A replacement for the Datix Incident Management System, called **InPhase**, has been sourced and purchased. This new platform, which includes a dedicated risk register module, will be rolled out progressively throughout the year and is expected to be fully implemented by the end of March 2026. The InPhase system will be used to manage all risks going forward.

4 RECOMMENDATION

The Board are asked to endorse the current Corporate Risk Register as an accurate representation of the organisation's risk profile.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	**Better Care** • Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk. • Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. • Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system. **Better Workforce** • Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation.
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	Audit committee/ CMT
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

Appendix 1

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	July 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	July 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 & Performance Director	July 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	July 25	Security, Risk and Resilience Oversight Group	Monthly	-
Workforce HRD114	Workforce	Impact of reduced working week	Major X Possible	Major x Possble	Moderate x Unlikely	Director of Workforce	Head of HR	July 25	Workforce Governance Group	Monthly	New
Workforce HRD115	Workforce	Sickness absence levels increase above acceptable levels	Major X Possible	Major x Possble	Moderate x Possible	Director of Workforce	Head of HR	July 25	Workforce Governance Group	Monthly	New
Workforce HRD116	Workforce	Delay in completion of PVG checks from Disclosure Scotland	Major X Possible	Major x Possble	Moderate x Unlikely	Director of Workforce	Head of HR	July 25	Workforce Governance Group	Monthly	New

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	Major x Rare	Major Rare	Chief Executive	Board Secretary	Sept 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	Sept 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	Sept 25	Security, Risk and Resilience Oversight Group	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	Sept 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	Sept 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	Sept 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	Sept 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	Sept 25	Information Governance Committee	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	Sept 25	Clinical Governance Group	Quarterly	-
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	Sept 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 CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	Oct-25	Covid Inquiry SLWG	6 Monthly	↓
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	6 Monthly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Security Director	Sept 25	Security, Risk and Resilience Oversight Group	6 Monthly	↓
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Sept 25	Security, Risk and Resilience Oversight Group	6 Monthly	↓
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	Oct 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	Oct 25	Information Governance Committee	6 Monthly	-

Appendix 2

Impact of Reduced Working Week Ref: HRD114

Corporate Objective	**Better Care**	**Risk Owner**	Director of Workforce	**Action Officer**	Head of HR?

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
NHS Scotland are in the process of implementing a reduction from a 37 hour working to a 36 hour working week. The implementation of this could result in strain on the workforce, impact patient care and have financial implications.	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☒	
Objectives/ Project	☐	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☐	
Staffing and Competence	☒	
Financial (inc damage, loss or fraud)	☒	
Inspection/ Audit	☐	
Adverse Publicity/ Reputation	☐	
Physical Security	☐	
Other (Specify)		

Hazards	Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
- Increased workload for staff (perceived or real) due to the reduction in hours but the workload requirements remaining static. - Could exacerbate staff shortages due to the numbers of available hours from staff being reduced. - Patient day could be impacted due to the reduction in hours available. This could potentially affect service hours and the number of activity slots available. - Patient care could be impacted with a reduction in service hours and availability of appointments with medical staff. - If the service is not implemented within timescales it could affect staff morale and have financial implications if staff are required to be paid overtime. - There could be further financial implications if service hours cannot be modified and additional staff are required, contributing to more budget restraints. - There could be an impact on the flexibility of the workforce with less hours available.	

Individuals or group exposed	Patients and Staff	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
- Compliance with PCS(AFC)2024/2 - Reduced financial impact once implemented and in a business as usual model - Increased staff morale by reducing working week of NHS staff. - Increased staff Wellbeing/Worklife Balance	

Existing Control Measures	List any existing measures in place to mitigate this risk.
- RWW SubGroup, co chaired by Director of Workforce and Employee Director to lead change process and provide oversight, reporting directly to the Partnership Forum. - Direct support from the Workforce Directorate to each service to ensure that they fully consider the implications of their proposed changes. - Process agreed which requires consultation with Staff and Staff side to agree new working patterns.	

Likelihood	**Impact/Consequence**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Descriptor	**Rare** (1 in 1000)	**Unlikely** (1 in 100)	**Possible** (1 in 20/Month)	**Likely** (1 in 7 days)	**Almost Certain** (1 daily)
Probability Look at available data where possible to work out likelihood from information sources such as Datix.	Can't believe this event would happen – will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists – unlikely to occur.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	This is expected to occur frequently / in most circumstances – more likely to occur than not.

For impact descriptors please refer to the NES Risk Matrix on the TSH Intranet:

http://adsp02/Departments/RiskandClinicalEffectiveness/RiskManagement/Documents/A4%20Incident%20Categories%20Matrix%20Sep%2021.doc

Review Periods:

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

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	Major	Possible	High
Target Movement Movement since last review	-	-	-
Target Risk Rating	Moderate	Unlikely	Medium
Current Risk Rating	Major	Possible	High

Further Control Measures Required	Include any additional controls identified to
- Comprehensive service plans need to be developed based on the hours available to provide the service - Consideration of Service Provision and whether change to operating models are required to align with future hours - Consideration of Patient Day and new Nursing Shift Roster are also key for other services to align to.	

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external) Detail any existing KPIs that would link to risk and show performance against risk
Notification to SG by: - **1st October: to confirm plans in place** - **1st April 2025: to implement plans fully**	

Date Added	26/03/2025
Completed by	Stephen Wallace/ Stewart Dick
Date Reviewed	26/03/2025
Next Review	Click or tap to enter a date.

Risk Register	Corporate Risk Register
Directorate	Human Resources and Workforce
Group/Committee Monitoring Risk	Workforce Governance Group

Appendix 3

Sickness Absence Levels within TSH increase above acceptable levels Ref: HRD115

Corporate Objective	**Better Workforce**	**Risk Owner**	Director of Workforce	**Action Officer**	Head of HR?

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
Sickness levels within TSH increase above acceptable levels of 5%	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☐	
Objectives/ Project	☐	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☐	
Staffing and Competence	☐	
Financial (inc damage, loss or fraud)	☐	
Inspection/ Audit	☐	
Adverse Publicity/ Reputation	☐	
Physical Security	☐	
Other (Specify)		

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
- Increased workload and pressure for staff in affected departments - Low morale for staff - Impact on service to patients ie. reduced activity and increased time in rooms. - Increased breach of WTD - Increase in DTC - Potential cancellation of outings ,visits. - Financial implications – overtime, additional staff, delayed projects. - Reputational damage relating to the above issues		
Individuals or group exposed	Staff and Patients	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk

Ensuring absence levels remain within acceptable levels should allow the hospital to operate at the intended level, support staff to do their roles and ensure excellent patient care is delivered. Will help to promote Staff Health and Wellbeing.	being mitigated. (e.g. cost savings)

Existing Control Measures	List any existing measures in place to mitigate this risk.

- Extensive Policy and Guidance from NHS Scotland
- Policy and Awareness Training for Managers
- Support from HR team in management of absence.
- Proactive Wellbeing Support
- Support through Occupational health, Physiotherapy and Psychological Support
- Regular reporting, and commissioning of support through Governance framework.
 	
- Regular Review Meetings across all services, purpose of these meetings is to:
 	
  - Review long-term sickness absence cases and persistent short-term absences
  - Consider number of staff within the department requiring sickness absence
  - Evaluate progress of individuals previously identified as having concerning patterns from the five-year data produced by the Head of Learning & OD.
  - Review those who become absent shortly after formal monitoring has expired.
  - Consider improvement requirements within the department and additional support required from HR, OD or OH.	

Likelihood	**Impact/Consequence**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Descriptor	**Rare** (1 in 1000)	**Unlikely** (1 in 100)	**Possible** (1 in 20/Month)	**Likely** (1 in 7 days)	**Almost Certain** (1 daily)
Probability					

Look at available data where possible to work out likelihood from information sources such as Datix.	Can't believe this event would happen – will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists – unlikely to occur.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	This is expected to occur frequently / in most circumstances – more likely to occur than not.

For impact descriptors please refer to the NES Risk Matrix on the TSH Intranet:

http://adsp02/Departments/RiskandClinicalEffectiveness/RiskManagement/Documents/A4%20Incident%20Categories%20Matrix%20Sep%2021.doc

Review Periods:

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

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	Major	Likely	High
Target Movement Movement since last review	-	-	-
Target Risk Rating	Moderate	Possible	Medium
Current Risk Rating	Major	Likely	High

Further Control Measures Required	Include any additional controls identified to
- Greater focus on long term sickness (with clear pathway from initial contact to conclusion). (Long term absence is currently greater than absence target) - Greater flexibility of workforce: increased resource in the SSR would allow flex to accommodate/mitigate short term spike in absence to limit service impact, but continue to look to address problem long term	

Date Added	26/03/2025
Completed by	Stephen Wallace/ Stewart Dick
Date Reviewed	26/03/2025
Next Review	Click or tap to enter a date.

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external) Detail any existing KPIs that would link to risk and show performance against risk
April 2025 Figures are 7.86%, above target for 5%	

Risk Register	Corporate Risk Register
Directorate	Human Resources and Workforce
Group/Committee Monitoring Risk	Workforce Governance Group

Appendix 4

PVG Checks – Disclosure Scotland Ref: HRD115

Corporate Objective	**Better Workforce**	**Risk Owner**	Director of Workforce	**Action Officer**	Head of HR?

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
New changes introduced by Disclosure Scotland in terms of requirement of retrospective checks, 5 yearly checks are likely to see a backlog and delay in processing of PVGS, which may also impact on Recruitment and onboarding.	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☒	
Objectives/ Project	☐	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☒	
Staffing and Competence	☒	
Financial (inc damage, loss or fraud)	☐	
Inspection/ Audit	☐	
Adverse Publicity/ Reputation	☒	
Physical Security	☐	
Other (Specify)		

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
- Increased workload and pressure for Workforce Team to process checks (Additional 200 this year (increase of 300%) and Additional 120 annually (Increase of 200%) - Other work required to be reprioritised and delayed to address PVG Updates. - Legislative breaches if appropriate people are not checked timeously - Reputational Damage if checks are not completed appropriately - Potential delays in processing, which may impact onboarding for womens services and in general		
Individuals or group exposed	Staff and Patients	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk

Safer environment and more consistent guidance from PVG (once fully complete)	being mitigated. (e.g. cost savings)

Existing Control Measures	List any existing measures in place to mitigate this risk.
- Action Plan developed by Workforce Team - Milestones and areas of action identified	

Likelihood	**Impact/Consequence**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Descriptor	**Rare** (1 in 1000)	**Unlikely** (1 in 100)	**Possible** (1 in 20/Month)	**Likely** (1 in 7 days)	**Almost Certain** (1 daily)
Probability Look at available data where possible to work out likelihood from information sources such as Datix.	Can't believe this event would happen – will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists – unlikely to occur.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	This is expected to occur frequently / in most circumstances – more likely to occur than not.

For impact descriptors please refer to the NES Risk Matrix on the TSH Intranet:

http://adsp02/Departments/RiskandClinicalEffectiveness/RiskManagement/Documents/A4%20Incident%20Categories%20Matrix%20Sep%2021.doc

Review Periods:

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

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	Major	Likely	High

Target Movement Movement since last review	-	-	-
Target Risk Rating	Moderate	Unlikely	Medium
Current Risk Rating	Major	Likely	High

Further Control Measures Required	Include any additional controls identified to
- Appropriate Measures in place for retrospective checks - Increased Resource to support - No further mitigation to mitigate delays at Disclosure Scotland	

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external) Detail any existing KPIs that would link to risk and show performance against risk
Recruitment Time to Fill KPIs (Monitored on ongoing basis)	

Date Added	26/03/2025
Completed by	Stephen Wallace/ Stewart Dick
Date Reviewed	26/03/2025
Next Review	Click or tap to enter a date.

Risk Register	Corporate Risk Register
Directorate	Human Resources and Workforce
Group/Committee Monitoring Risk	Workforce Governance Group

Paper No. 25/47

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 9
Sponsoring Director:	Acting Director of Security, Estates and Resilience
Author(s):	Risk Management Team Leader
Title of Report:	Risk and Resilience Annual Report 2024/25
Purpose of Report:	For Noting

1 SITUATION

The Risk and Resilience Annual Report provides The Board with details of the activity undertaken within the Risk and Resilience department over period 1 April 2024 until 31 March 2025.

2 BACKGROUND

The Risk and Resilience Department, part of the Security Directorate, is involved in a range of functions including:

- The development and maintenance of Local and Corporate Risk Registers
- Risk assessments for identified risks
- Development and review of Resilience Plans,
- Incident Reporting and Enhanced Reviews (Cat 1 & 2)
- Health & Safety
- Duty of Candour
- Administration of Datix System
- Training

The Audit Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures. Report is provided to The Board each year prior to publication.

3 ASSESSMENT

This report is presented to The Board for noting.

4 RECOMMENDATION

The Board is asked to note the Risk and Resilience Annual Report for 2024/25.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Better Care • Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. • Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system. • Work with stakeholders and Scottish Government representatives to enhance the reputation and healthcare 'profile' of the State Hospital. Better Workforce • Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation. • Continue to support training and development for all staff at every level across the organisation.
Workforce Implications	None identified as part of reporting
Financial Implications	None identified as part of reporting
Route To Board Which groups were involved in contributing to the paper and recommendations	Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	No impact identified
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 impacts 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

Risk and Resilience Annual Report

2024-25

Prepared by: Risk Management Team Leader and Acting Director of Security, Estates and Resilience

Approved by: Acting Director of Security, Estates and Resilience

Contents

1. Risk Management Department

1.1 Introduction

The Risk and Resilience Department, situated within the Security Directorate, plays a pivotal role in safeguarding the organisation's operational integrity and ensuring preparedness across a range of critical domains. The department's core functions include:

- **Strategic Risk Management**: Development and ongoing maintenance of both Local and Corporate Risk Registers to ensure alignment with organisational objectives and regulatory requirements.
- **Risk Assessment**: Systematic evaluation of identified risks to inform mitigation strategies and support decision-making at all levels.
- **Resilience Planning**: Design, implementation, and periodic review of Resilience Plans to enhance the organisation's capability to respond to and recover from disruptive incidents.
- **Incident Management**: Oversight of incident reporting processes and facilitation of Enhanced Reviews for Category 1 and 2 incidents, ensuring lessons learned are captured and acted upon.
- **Health and Safety Governance**: Promotion and monitoring of health and safety standards across the organisation, in line with statutory obligations and best practice.
- **Duty of Candour Compliance**: Ensuring transparency and accountability through the effective application of Duty of Candour principles.
- **Datix System Administration**: Management of the Datix incident reporting system to support accurate data capture, analysis, and reporting.
- **Training and Capacity Building**: Delivery of targeted training programmes to embed a culture of risk awareness, resilience, and continuous improvement.

This department's work underpins the organisation's commitment to proactive risk management, regulatory compliance, and operational resilience.

1.2 Aims and Objectives

The Risk and Resilience Department continues to play a vital role in supporting The State Hospital's (TSH) commitment to safety, quality, and operational continuity. Key areas of focus include:

- **Policy and Procedure Governance**: Development, implementation, and regular review of comprehensive Risk and Resilience policies and procedures to ensure alignment with best practice and regulatory standards.
- **Proactive Risk Identification and Management**: Early identification of emerging risks that may impact TSH, followed by structured management using recognised risk management tools and methodologies.
- **Incident Review and Organisational Learning**: Implementation of robust incident review processes to ensure that significant adverse events are thoroughly investigated. Action Plans are developed to address root causes and promote continuous learning across the organisation.
- **Fostering a Quality Culture**: Supporting the development of a quality-driven culture by enhancing staff competencies and embedding effective risk management practices throughout TSH.
- **Crisis Preparedness and Resilience**: Ensuring the hospital remains resilient and capable of operating beyond normal parameters during times of crisis, through the development and maintenance of comprehensive response frameworks.
- **Partnership and Collaboration**: Building and sustaining strong relationships with partner agencies to foster shared understanding, coordinated responses, and mutual learning opportunities.

2. Governance

2.1 Committees/Groups

The Audit Committee holds overarching responsibility for evaluating the effectiveness of the organisation's internal control systems and corporate governance framework. This includes oversight of the Risk Management Strategy and its associated policies and procedures.

Risk management is fully embedded within The State Hospital's (TSH) governance structure. Members of the Risk and Resilience team actively participate in the majority of hospital committees and groups, ensuring that risk considerations are integrated into decision-making processes at all levels.

Regular reporting is provided to these groups, covering key areas such as:

- Risk activity and emerging threats
- Incident trends and analysis
- Progress on adverse event action plans
- Updates to local and corporate risk registers
- Operational stability and resilience

Key Committees and Groups Receiving Risk and Resilience Reports:

- Health and Safety Committee
- Security and Resilience Group
- Climate Change and Sustainability Group
- Security, Risk & Resilience, Health & Safety Oversight Group
- Audit and Risk Committee
- Organisational Management Team
- Clinical Governance Group
- Clinical Governance Committee
- Corporate Management Team
- Patient Safety Group

In addition to these core groups, the Risk and Resilience team maintains a presence across a range of other hospital forums, including:

- Infection Control
- Information Governance
- Corporate Governance
- *And other operational and strategic groups as required*

This integrated approach ensures that risk awareness, resilience planning, and safety culture are consistently reinforced across the organisation.

3. Key Work Activities (2024-2025)

3.1 Risk and Resilience

3.1.1 Changes within Department

In 2024/25, the team underwent structural changes due to retirements, which created opportunities for staff to take on temporary 'acting up' roles.

- The Head of Risk and Resilience position is currently vacant, with the previous postholder temporarily acting as Director of Security, Risk and Resilience.
- The Risk Manager role from 2023/24 is also vacant. The postholder is currently acting as Risk Management Team Leader, overseeing the team and reporting directly to the Director of Security, Estates and Facilities.

In 2025/26, the team's structure will be reviewed and finalised, with a permanent organisational framework put in place.

Current Model as of March 2025, note that this structure is temporary.

3.1.2 Corporate Risk Register (Appendix 1)

A corporate risk is defined as a potential or actual event that:

- Interferes with the achievement of a corporate objective or target.
- Would have an extreme impact if effective controls were not in place; or
- Is operational in nature but cannot be mitigated to an acceptable level of risk.

Appendix A contains the current Corporate Risk Register, which now includes 25 risks distributed across the six Directorates. Risks are reviewed regularly throughout the year, with updates provided to the Corporate Management Team (CMT) and the Board. Four of the risks are currently graded as High, with the remainder classified as Medium or Low.

As part of a planned project, a comprehensive refresh of all corporate risks was undertaken last year. Each Directorate was reviewed individually. During this process, some risks were redefined, updated, merged with others, or moved to the Local Risk Register. Additional risks were also added to reflect emerging concerns and evolving priorities.

3.1.3 Department/Local Risk Registers

Departmental or Local Risk Registers capture risks specific to individual departments. These are risks that fall within the scope and capability of local managers to manage and are monitored and reviewed by the Head of Service. All departments are expected to maintain a Local Risk Register, supported by relevant risk assessments and action plans where necessary.

The Head of Department is responsible for informing the relevant Executive Director of any departmental risks. They must also identify risks that warrant escalation—particularly those graded as Very High or High—for potential inclusion in the Corporate Risk Register. Additionally, the Head

of Department is accountable for the ongoing development, review, and updating of the Local Risk Register.

The Risk Manager continues to oversee the Local Risk Register process. Each department within the hospital maintains an active register, which is reviewed regularly and evolves in response to changes in the hospital environment. This process is supported by members of the Organisational Management Team.

The Corporate Management Team (CMT) is kept informed of progress through updates provided by the Director of Security, Estates and Resilience.

3.2 Resilience

The Director of Security, Estates and Resilience holds overall responsibility for the management of Resilience within TSH. The Director also chairs both the Security, Risk and Resilience, Health and Safety Oversight Group and the Security and Resilience Group.

The Risk and Resilience Department supports these functions by producing an Annual Report for the Board's Audit Committee, as well as providing regular Resilience Reports to the relevant oversight groups.

3.2.1 Resilience Plans

Level 2 Plans

Level 2 Plans primarily address Loss of Service scenarios and are managed internally by operational teams. In most cases, services are restored quickly, and recovery is handled within standard operational procedures.

Currently, all Level 2 Plans are up to date. Each plan is subject to a three-year review cycle, during which it will be tested to ensure it remains fit for purpose. This process is coordinated by the Resilience Officer.

All Level 2 Plans are formally approved by the Security and Resilience Group.

Level 3 Plans

Our current Level 3 Plans remain fit for purpose, and all partner agencies are satisfied with the existing arrangements. These plans are based on a multi-agency joint working model, involving collaboration with Police Scotland, Scottish Fire and Rescue Service, Scottish Ambulance Service, South Lanarkshire Council, and the West of Scotland Regional Resilience Partnership.

Work is ongoing to redevelop the Level 3 Plans. A first draft has been shared with partner agencies for feedback.

Over the past year, the following documents have been completed and approved:

- Multi-Agency Incident Response Guide (MAIRG)
- MAIRG Contingency Plans
- TSH Roles and Responsibilities

The final document, outlining action plans, is scheduled for completion by September 2025.

3.2.2 Resilience Related Incidents

In line with the approved Resilience Framework, all resilience related incidents are reported via Datix, with Level 2 and 3 incidents being reviewed directly by the Security, Risk and Resilience, Health and Safety Oversight Group.

The Incident levels are defined within the Resilience Framework as follows:

Level 1: Incidents which cause minor service disruption with one area/department affected which can be contained and managed within the local resources

Level 2: Incidents which cause significant service disruption, interruption to hospital routine, special deployment of resources and affect multiple areas/departments.

Level 3: A major/emergency situation which seriously disrupts the service and causes immediate threat to life or safety. These incidents will require the involvement of the Emergency Services

Over the year April 24 – March 25, there have been two incidents managed at Level 3 and one Level 2 incidents out with the staffing issues recorded.

	2020/21	2021/22	2022/23	2023/24	2024/25
Level 2	0	19	8 (+ 3106 staffing resource)	0 (278, All staffing resource, only full closure)	1 (23 full closure incidents were recorded)
Level 3	4	0	0	1	2

One Level 2 incident was recorded this year. The incident occurred in response to a Red Category Storm Warning, which subsequently led to power supply issues within TSH.

Other incidents that were recorded were in relation to full ward closures due to staffing resource issues. No other incidents within TSH met the criteria for Level 2 classification; all other events were effectively managed within standard service operations.

Two Level 3 incidents were recorded during the year, and both involved the activation of Incident Command.

3.2.3 Training and Exercising

Risk Management Training

Datix training was delivered to all new staff during induction and also to 10 staff members in management roles, along with additional personnel supporting the Risk and Resilience Team. The training is designed to:

- Teach staff how to navigate and use the Datix system effectively
- Ensure quality assurance of all Datix entries
- Support thorough investigation of incidents recorded in Datix
- Enable staff to extract and analyse data from the system

Training is delivered on a continuous basis by the Risk Manager, and in future, will also be supported by the Risk Project Support Officer.

Resilience Training

Resilience training is a key component of our strategy to develop and maintain high resilience standards across the organisation. Over the past year, we have continued to strengthen our capabilities through a series of targeted training events, including:

- Completion of Level 3 PPE refresher and accreditation training
- Delivery of Critical Incident Communicator (CIC) CPD events for The State Hospital CICs
- One CIC attended the full Negotiator Course at Tulliallan Police College
- One CIC attended the Negotiator Coordinator (Neg CO) Course at Tulliallan
- Delivery of Mental Health Awareness sessions to Police Scotland Negotiator Unit and, more recently, the Scottish Prison Service
- Golden Hour training for Operational Managers
- Induction training for new nurses (First on the Scene)
- A cyberattack simulation exercise conducted in collaboration with eHealth and an external contractor, involving multiple Heads of Service

3.2.4 Partner Agency Working

Maintaining and developing strong relationships with our partner agencies is a key component of our resilience strategy, particularly during times of crisis. Our key partners include:

Police Scotland

Our relationship with Police Scotland remains strong. Over the past twelve months, the following milestones have been achieved:

- Continued support from a dedicated Police Scotland response team for the hospital, with close liaison with the Security Department
- Operational site visits for all new response inspectors and sergeants for familiarisation and situational awareness.
- Joint development of our Level 3 and Multi-Agency Incident Response Plans
- Participation in the Emergency Services Mobile Communications Programme survey of the hospital, involving all emergency services

Scottish Fire and Rescue Service

- TSH has continued to work closely with Scottish Fire and Rescue through the Local Resilience Partnership (LRP) over the past year. Operational site visits continue for all relevant visiting crews. Continued work with operational intelligence (OI) for fire crews and also yearly fire safety visits.

Scottish Ambulance Service

Key milestones achieved in collaboration with the Scottish Ambulance Service include:

- Operational familiarisation visits to the hospital with key departments
- Development of flow navigation pathways to support patient care
- Creation of support resources for alternative care options

South Lanarkshire Council

As part of the local LRP, we maintain a close working relationship with South Lanarkshire Council. We have facilitated familiarisation visits for new staff to help them understand hospital operations and foster shared learning. This collaborative work will continue.

Critical National Infrastructure

The hospital is actively engaged in the Four Nations Critical National Infrastructure database through the Emergency Preparedness, Resilience and Response (EPRR) framework.

3.2.5 Business Continuity Arrangements

Our Business Continuity Policy was revised and approved by PAG in January 2025

3.3 Health & Safety

3.3.1 Control Book Audits

Health & Safety Electronic Control Books (eCBs) provide the framework for managing Health & Safety arrangements across TSH. The hospital currently operates approximately 30 eCBs, each audited within a two-year cycle to ensure compliance with both organisational and local policies and procedures.

In the 2024/25 period, eight Control Books were audited. A new approach has been introduced whereby the Health & Safety Advisor conducts a pre-audit review of documentation and provides feedback to the Control Book holder before the full audit. This proactive method fosters collaboration, reduces conflict, and has been positively received by staff. It also supports the development of teamwork, confidence, and competence in Health & Safety practices.

During the audit process, an opportunity for improvement was identified in the consistency of Control Book documentation and the application of risk assessments. Staff have welcomed the proposal to standardise and update generic documentation. A comprehensive review is currently underway, led by the Health & Safety Advisor.

All audited areas achieved green scores (above 80%), providing assurance that Health & Safety standards across the hospital remain high. These areas continue to be actively managed by staff and will be formally re-audited in two years, with full engagement from both staff and senior management.

3.3.2 2024/25 Training Plan

Staff Training remains a key priority for the Risk Management team. Since taking up the role in February 2024, the Health & Safety Advisor, supported by the Risk Manager, has focused on engaging with and developing the electronic Control Book holders and their deputies.

This initiative has had a highly positive impact, enhanced staff support and development while significantly increasing confidence and competence in managing the Control Book and its contents.

Looking ahead, the team aims to expand training opportunities across the State Hospital to further strengthen Health & Safety knowledge and awareness among all staff.

3.3.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR requires employers to report incidents that arise out of or in connection with work, including:

- The death of any person
- Specified injuries to employees or hospital treatment for non-employees
- Employee injuries resulting in more than seven consecutive days of absence
- Dangerous occurrences
- Certain occupational diseases

In 2024/25, there was an increase of 26 reported RIDDOR incidents compared to the previous year (2023/24). This rise highlights the need for continued focus on incident prevention, staff training, and robust risk assessment practices.

	Q1	Q2	Q3	Q4	2022/23	2023/24	2024/25
'Specified' Injuries*	2	4	1	1	**1**	**2**	**8**
Over 7 day lost time Injury	5	11	6	10	**7**	**12**	**32**
Total	7	15	7	11	**8**	**14**	**40**

All RIDDOR incidents were reported to the Health and Safety Executive (HSE) as required. However, during the year, several incidents were not communicated to the Risk and Resilience Team within appropriate timescales. This highlighted a gap in training and internal reporting processes.

To address this, improvement work has been underway and is scheduled for completion in June 2025. The aim is to strengthen internal reporting procedures and ensure timely escalation of incidents.

All individual RIDDOR incidents continue to be monitored and reviewed by the Health and Safety Committee. Following each report, relevant risk assessments are updated to reflect any new findings or required controls.

3.4 Fire

During the year, five fire alarm activations occurred at The State Hospital, all of which received a response from the Scottish Fire & Rescue Service. Importantly, no actual fires were identified.
Of the five incidents:

- Three were due to faults within the fire alarm system.
- Two were triggered by smoke caused by bread overheating in toasters.

These events highlight the importance of ongoing maintenance and staff awareness to minimise false alarms and ensure effective emergency response.

3.5 Incident Reporting

Datix is the hospital's electronic incident reporting system, accessible to all staff via the intranet and through a desktop shortcut on every hospital computer.

Each reported incident is investigated locally to ensure that appropriate remedial and preventative actions are taken. The system also supports the identification of incident trends and significant individual events through well-defined processes.
Datix classifies incidents into seven overarching types:

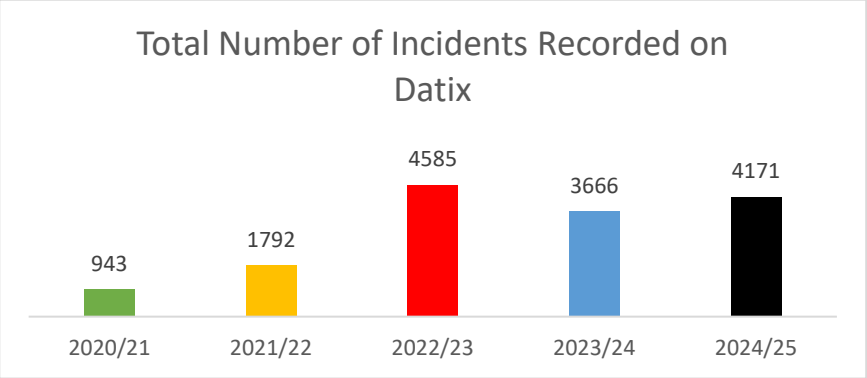
1. Health and Safety
2. Security
3. Direct Patient Care
4. Equipment, Facilities & Property
5. Communication / Information Governance
6. Infection Control
7. Other

This classification helps ensure that incidents are appropriately categorised and addressed, supporting continuous improvement in safety and service delivery.

3.5.1 Datix Incidents

4171 incident reports were finally approved during 2024/25; a significant increase in the number of incidents finally approved in 2023/24 (3666). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years.

Please note Staff Resource Incidents were not recorded on Datix until 2022/23 onwards



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2020/21	2021/22	2022/23	2023/24	2024/25
Staffing Resource	X**	X**	3192	**2296**	**2264**
Health & Safety	413	461	660	**554**	**886**
Security	93	139	277	**297**	**348**
Direct Patient Care	142	146	206	**232**	**386**
Equipment/Facilities/Property	78	75	105	**135**	**171**
Infection Control	55	60	77	**53**	**18**
Communication/Information Governance	48	65	51	**94**	**88**
Other	115	846	11	**5**	**10**
Totals	943	1792	4585	**3666**	**4171**
*Average Patient Population	114	115	110	102	101

**Based on bed compliment at end of each quarter/4*

Incidents are monitored by relevant groups who are responsible for taking forward any additional actions.

3.5.3 Risk Assessment

The process of risk assessment at The State Hospital (TSH) involves evaluating two key factors:

- **Likelihood** of an event occurring (e.g. rare, unlikely, possible)
- **Impact** or consequence of the event on the organisation (e.g. financial, reputational, operational, regulatory)

The table and chart below illustrate the number of incidents graded as **High** and **Very High** risk from 2020/21 to 2024/25. These figures have substantially decreased from last year, primarily due to a reduction in reported Staff Resource Incidents.

The significant drop in 2024/25 reflects improvements in how staffing is detailed and managed across the hospital, resulting in fewer high-severity incidents and demonstrating the positive impact of proactive workforce planning and risk mitigation strategies.

Likelihood	Potential Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very high	Very high
Likely	Medium	Medium	High	High	Very high

Year	No. of “High” or “Very High”Graded Risk Incidents
2020/21	0
2021/22	628
2022/23	684
2023/24	2026
2024/25	305

3.5.4 Duty of Candour

The Organisational Duty of Candour is a legal obligation that outlines how healthcare organisations must respond when an unintended or unexpected incident results in harm or death.
Under this duty, organisations are required to:

- Inform those affected that such an incident has occurred
- Offer a sincere apology
- Involve the individual or their family meaningfully in a review of what happened

This process ensures transparency, accountability, and a commitment to learning and improvement in the delivery of care.

Duty of Candour Incidents	2021/22	2022/23	2023/24	2024/25
Considered	**103**	**115**	**54**	**170**
Investigated	**1**	**0**	**2**	**4**

- There was a sharp increase in incidents considered in 2024/25, rising to 170 from just 54 the previous year.
- Despite the increase in cases considered, the number of incidents formally investigated remained low across all years, peaking at only 4 in 2024/25.
- This trend may reflect improved identification and reporting processes, while maintaining a high threshold for formal investigation.

In 2024/25, a total o**f four** Duty of Candour incidents were formally recorded at The State Hospital.

All four incidents involved serious injuries sustained by patients during the course of their care. Each case was thoroughly investigated through the appropriate internal review processes, in line with statutory Duty of Candour requirements.

Further details and analysis can be found in the Duty of Candour Annual Report 2024/25.

3.6 Serious Adverse Event Reviews (SAER)

SAERs are conducted to identify the contributing factors of an incident, with the aim of reducing the likelihood and/or impact of similar events in the future. The level of review is proportionate to the severity of the incident:

- **Category 1 Reviews** are the most rigorous and involve a full Root Cause Analysis. These are used for the most serious incidents to ensure comprehensive organisational learning.

- **Category 2 Reviews** are used for less serious incidents that still require an in-depth investigation to identify learning points and reduce the risk of recurrence.

SAERs are typically commissioned by the Corporate Management Team (CMT), following notification from the Risk and Resilience Department, who monitor Datix for incidents that meet the criteria.

SAERs Commissioned in 2024/25

- Category 1 Review
    - Cat 1 24-01
- Category 2 Reviews
    - Cat 2 24/01
    - Cat 2 24/02
    - Cat 2 24/03
    - Cat 2 24/04

3.7 Freedom of Information (FOI) Responses

During 2024/25 the Risk Management Team received 4 FOI requests totalling 18 questions. The team provided data for all of them where it was held by our department.

The Risk and Resilience Team also received 1 Subject Access Request

4. Summary

4.1 Areas of Good Practice

In addition to the positive outcomes highlighted throughout this report, several areas of good practice have been identified across the hospital in relation to risk management:

Hospital-Wide Practices

- Effective monitoring of risk information by relevant groups and committees.
- Regular review of patient-specific risks by clinical teams.
- Strong evidence of learning from incidents, with local actions implemented to minimise recurrence.

Risk Management Department Initiatives

- Continued development of the Corporate Risk Register in collaboration with risk owners, resulting in a streamlined and up-to-date register for 2024/25.
- Delivery of resilience training programmes across the hospital, including:
    - Incident Command
    - Golden Hour Training
    - Level 2 Plan Exercises
- Redevelopment of the Learning from Events process, enabling the collation, monitoring, and implementation of learning from multiple sources.
- Ongoing work to enhance the SAER process, ensuring a more robust system for commissioning, monitoring, and approvals.
- Updates to the RIDDOR process to ensure full compliance with Health and Safety legislation.
- Review and relaunch of the Health and Safety Management System, including:
    - Staff training
    - Continuation of audits in 2024/25
    - Development of an updated Control Book process
- Continued internal development of the Datix Incident Reporting System throughout 2024/25.
- Increased team capability through acting-up opportunities, enhancing experience and resilience.
- Agreement of the InPhase contract, with implementation scheduled for 2025/26.

4.2 Identified Issues and Potential Service Developments

1. Capacity Challenges in Managing SAERs

During 2024/25, the Risk and Resilience Team experienced difficulties managing the volume of Category 1 and 2 Significant Adverse Event Reviews (SAERs), particularly when multiple reviews were commissioned simultaneously. This issue was raised throughout the year, as only one team member was available to act as an investigator, creating a capacity bottleneck.
To address this, future plans include involving hospital managers more directly in the SAER process. This will be supported by the establishment of a dedicated SAER Group, currently in development, which will oversee commissioning, monitoring, and support for investigations.

2. Delays in RIDDOR Reporting

In 2024/25, several RIDDOR incidents were not reported to the Risk and Resilience Team within the required timescales, resulting in multiple late submissions and breaches of Health and Safety regulations.
In response, the reporting process was reviewed, and reminders were issued to relevant staff to ensure timely and compliant reporting going forward. These changes aim to strengthen internal communication and reinforce accountability across departments.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in June 2026.

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	May 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	May 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 & Performance Director	May 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	May 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	Major x Rare	Major 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 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	Quarterly	-
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 CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	May 25	Covid Inquiry SLWG	6 Monthly	-

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	6 Monthly	-
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	Oct 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	Oct 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	Oct 25	HR and Wellbeing Group	6 Monthly	-

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	19 June 2025
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Senior Management Accountant
Title of Report:	Finance Report – to 31 May 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 2025/26 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 Enhanced Security Project is noted to have a delayed end date, as reported directly to the Board and notified to SG finance – being anticipated to complete in the first quarter of 2025.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £50.271m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and additional allocations as anticipated.

The State Hospital Annual Budget	£'000
Total Budget	50,271

The current budget comprises of the following allocations, these funding allocations are anticipated to be received from Scottish Government in due course:

- Baseline budget - £47,570k
- Recurring 24/25 baseline - £101k
- Forensic Network - £335k
- Additional capital charges re perimeter project - £1,246k
- E-health Strategic Funding - £192k
- Additional National Insurance costs – employers costs - £267k
- Female Services (currently in post) - £558k

The year-to-date position is £20k overspent, the improvement in the position is a combination of the non-recurrent budget allocations being added and also the reduced overtime spend within ward nursing.
Ward nursing costs have reduced by £130k since last month as a result of reduced overtime being utilised, this is impacted by the closure of the additional ward and the recruitment into additional unregistered nurses to replace overtime.

3.2 2025/26 Budget

The 3-year plan required by SG includes savings requirements of £1.9m (approx.3.8%) to ensure a breakeven position. Current plans have been set for £1.8m and further work will be completed to identify the remaining gap, with achieved savings to be reported monthly.

The formula Capital budget for 2025/26 has been set at £282k, with an additional £380k non-recurring capital allocated for the patient wander path, Skye centre animal shed repair and Islay roof repair, in response to the Board's submission in December 2024 of estate pressures.

3.3 Year-to-date position 2025/26 – allocated by Board Function / Directorate

Directorate	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance	Budget WTE	Actual WTE	Comments
Cap Charges	4,477	746	746	1			Capital charges have increased as a result of the capatilisation of the security project. SG have agreed the increased depreciation charges will be fully funded
Central Reserves	556	0	0	0			RRL phased to period 12 and released as required, additional RRL will be added as further allocations are agreed.
Chief Exec	2,586	457	459	(2)	27.07	24.97	Social Work budget has been uplifted to reflect additional costs set out in the SLA
Finance	2,668	468	461	6	33.18	32.48	E-Health strategic RRL funding has been assumed in the budget, this is a non recurring allocation and as a result will not be uplifted in line with pay awards, which is creating an underlying pressure. Costs for M365 are currently being funded from reserves, the annual cost is anticipated to be £180k.
Human Resources Directorate	1,179	197	188	10	16.03	15.79	Underspend in training and vacancies across the directorate
Medical	3,662	724	726	(1)	20.66	20.32	Pharmacy budget has been uplifted to reflect the current SLA prices
Misc Income	(100)	(17)	(58)	42	0.00		Income benefit from current ECP patient
Nursing And Ahp's	26,329	4,299	4,448	(148)	410.25	412.43	see below for detailed narrative from nursing directorate
Security And Facilities	8,915	1,491	1,418	73	124.29	115.98	Vacancies across the directorate are contributing to underspend, utilities pressures have been funded from reserves
	50,271	**8,366**	**8,386**	**(20)**	**631.48**	**621.97**	

Nursing & AHPs (as provided from Nursing Directorate)

In keeping with previous submission reports, the main contributors to nursing overtime are increases to the daily operating model because of clinical acuity (including boarding patients for physical healthcare requirements), vacancies and sickness absence. Between July 2024 and March 2025, the hospital was also operating with one additional ward to care for a patient with specific risk and clinical needs which caused added financial pressures. However this ward has now closed (closed at end of March 2025).

As noted in previous updates, pro-active-recruit campaigns to manage the Band 5 nursing vacancy gap have demonstrated success and following Board approval work was undertaken in January 2025 to employ an additional ten Healthcare Support Workers. This recruitment campaign resulted in additional onboarding mid-March 2025. A recruitment event was also undertaken in March 2025 with a focus on recruitment to the interim women's service at the hospital. Interviews for this have now concluded and work is underway to allocate staffing to this service. Further Band 5 adverts are live with interviews expected in June.

Robust attendance management processes and regular reviews of employee relation cases remain in place. Likewise, monthly Senior Charge Nurse (SCN) performance reviews are scheduled for the coming financial year. These meetings enable supportive discussions with SCNs around effective roster management, effective use of allocated funding, and robust oversight of non-pay related spending. These meetings were recommenced in June following a temporarily pause between March-May to allow focus on year-end requirements within the Finance Department.

The Director and Associate Director of Nursing continue to meet monthly with the Head of Finance to ensure the Nursing Directorate remain on track to meet all financial savings and requirements.

3.4 Financial pressures / potential benefits.

Pressures:

Ward Nursing

- Overtime has reduced significantly in M2, the overall pay cost in ward nursing has reduced by £130k when compared to last month. Decreased levels of overtime remain to cover sickness absence and registered nursing vacancies. The year-to-date pressure is mainly a result of the high level of overspend witnessed in M1.
- Budget has been added to cover the increased NI costs.

M365

- M365 is unfunded and remains as a current pressure, reserves are being used to cover this pressure.

Energy and Inflation Increases

- Utilities remain a pressure, it is anticipated there will be a £400k reduction against last year's costs in utilities, however an underlying pressure will remain. The annual pressure is anticipated to be £200k, it is intended this will be fully funded from reserves.

AFC Reform

- The reduction in 37.5 hour working week– underway by ½ hour for full-time (pro rata for part time staff) will be reduced down to 36 hours by April 2026.
- A provision has been raised against future costs that may occur as a result of the band 5 – band 6 changes.
- Training – protection is in place against these costs as per national guidance.

NIC – Employers Costs

- 60% of the increased costs will be allocated by the SG with the remaining gap covered in 2025/26 by a non-recurring sustainability funding.

PAIAW – (payment as if at work)

- Funding continues to be held as a reserve to cover any remaining historical costs that may arise.

Women's Services

- An allocation from SG has been agreed to cover the cost of the staffing for women's services. Budget will be allocated as the individuals are recruited into post.

Capital Charges

- The total annual costs for depreciation of the hospitals assets in 2025/26 is forecast at £4,400k. This is an increase of £1.2m from 2024/25, due to the enhanced security project capitalisation. Scottish Government have confirmed we will receive an additional allocation to cover the full costs.

Benefits:

Travel & Training

- Less spend has continued to be required following covid, with most meetings and some training online.

4 ASSESSMENT – SAVINGS

Savings targets of £1,780k have been identified, further work will be done to meet the current gap in savings.
Savings are over-achieved to date against the current target set as demonstrated in the table below:

Directorate	Annual Target £k	YTD Target £k	Savings Achieved £k	Suplus/ (Shortfall) £k
Chief Exec	70	12	11	(1)
Finance	78	13	12	(1)
Human Resources Directorate	37	6	13	7
Medical	113	19	15	(4)
Nursing And Ahp's	822	137	180	43
Security And Facilities	660	110	111	1
	1,780	**297**	**342**	**45**

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

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation has increased by 5% to £282k, capital priorities are currently being planned and agreed through the Capital Group and will be updated on this report when finalised.

Additional non-recurring capital budget of £380k has been granted by SG for 25/26 for the following projects:

- Islay Exterior Render/Roofing Repair - £0.08m
- Patient Wander Path Upgrade - £0.25m
- Skye Centre Animal Shed Replacement - £0.05m

The Enhanced Security Project has been capitalised it is anticipated to be fully completed in June 2025. The additional capital charges against this project will start to be incurred now as previously discussed in this report.

6 RECOMMENDATION

The Board is asked to note the content of the report – highlighting the following position and forecast –

Revenue
The forecasted year-end position is breakeven. Overtime within ward nursing, utilities, M365 and the non-recurring funding are currently the highest risk factors this financial year.

Capital
Capital projects and plans will be agreed through the Capital Group, and the budget will be fully committed for the year.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	Monitoring of financial position
Corporate Objectives	**3. Better Value** – a) Meet the key finance targets set for the organisation and in line with Standard Financial Instructions. 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.
Workforce Implications	No workforce implications – for information only
Financial Implications	Reporting on financial outturn and budgetary compliance
Route to Board Which groups were involved in contributing to the paper and recommendations.	Senior Management Accountant CMT Partnership Forum Audit and Risk Committee
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:	19 June 2025
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Associate Medical Director PA to Medical Director & Associate 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 1st April 2025 until 31st May 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	20	48	22	12 + 2 ID surge	104
Admissions	4 (external) 0 (internal)	0 (external) 6 (internal)	0 (external) 4 (internal)	0 (external) 1 (internal)	4 (external) 11 (internal)
Discharges/Transfers	0 (external) 6 (internal)	2 (external) 4 (internal)	2 (external) 0 (internal)	0 (external) 1 (internal)	4 (external) 11 (internal)
Bed occupancy as at 31/05/2025	83.3%	100%	91.7%	116.7% (ID beds)	86.7% (available beds) 74.3% (all beds)

Please note that in total there were 104 patients as of 31 May 2025. Within this number, 14 patients are under the care of the Intellectual Disability Service (the service is currently 2 patients in excess of their 12 patient allocation).

Table 2 – Time between referral and admission

Date	6 weeks or less	More than 6 weeks	Total Number
01/04/2025 – 31/05/2025	3	1	**4**

Three patients were admitted within 6 weeks of referral, with one patient not admitted due to doctors wanting to trial him in prison for an additional 2 weeks, a decision was made to bring the patient in following this review.

There are 8 patients identified for transfer (7 MMI and 1 ID), 4 of whom have been fully accepted. No patient has been waiting longer than 12 months. There has been one excessive security appeal 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

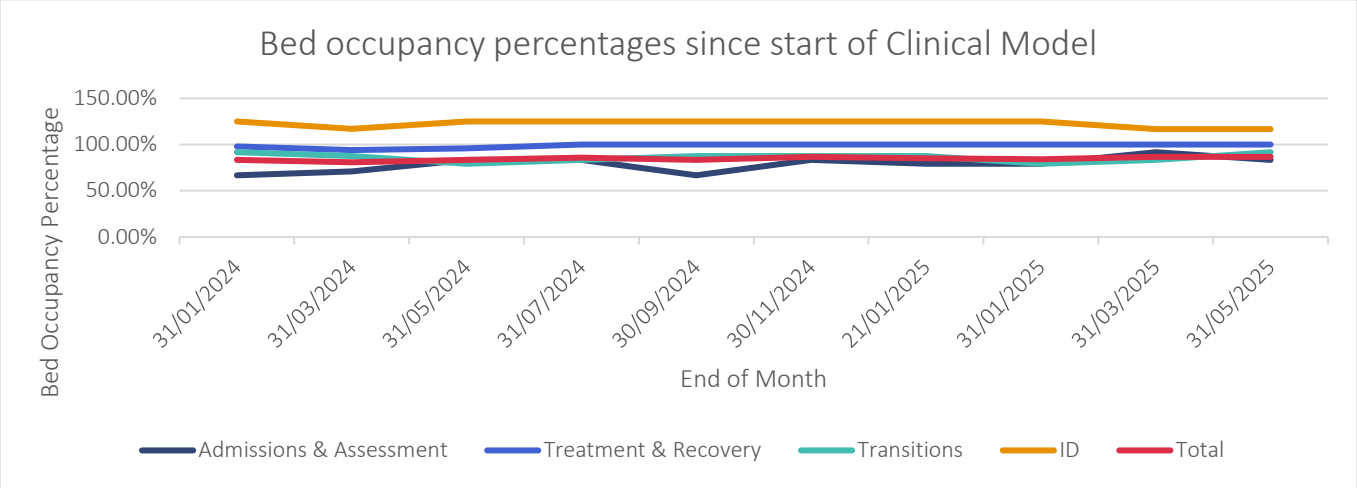


Table 3 Bed Occupancy by Service and in Total

Service	31/01/24	31/03/24	31/05/24	31/07/24	30/09/24	30/11/24	31/01/25	31/03/25	31/05/25
Admissions & Assessment	66.70%	71%	83.30%	83.30%	66.7%	83.30%	79.2%	91.7%	83.30%
Treatment & Recovery	97.90%	94%	95.80%	100%	100%	100%	100%	100%	100%
Transitions	91.60%	87.50%	79.20%	83.30%	87.5%	87.5%	79.2%	83.3%	91.70%
ID	125%	117%	125%	125%	125%	125%	125%	116.7%	116.7%
Total	**83.3%**	**80.8%**	**83.30%**	**85.8%**	**83.3%**	**86.7%**	**84.2%**	**86.7%**	**86.7%**

Table 3 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. 3 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, but due to influx of patients, may be implemented sooner than expected.

d) Forensic Network Capacity

We receive a weekly forensic estate update report from the Forensic Network to aid patient flow (Appendix 1). The Orchard Clinic has temporarily reduced its capacity for over one year by 7 beds for urgent repairs.

Please note as of the 2 June 2025 there are two available male beds in medium security (3 female), three male beds in low security (2 female) and two ID low secure regional beds.

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 invited to note the content of the report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	The report supports strategy within the hospital, and all associated assurance reporting.
Corporate Objectives Please note which objective is linked to this paper	1b - Tailor the Clinical Model to better reflect the graduated clinical and security steps for patient progression on their care and treatment pathway. 1i Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. 1p - Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment. 1r - Support the development of a national framework for collaborative working in the delivery of forensic mental health services across NHSScotland. 2f - 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.
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

Paper No. 25/50

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 12
Sponsoring Director:	Committee Chair
Author(s):	Head of Clinical Quality
Title of Report:	Clinical Governance Committee Annual Report 2024/25
Purpose of Report:	For Decision

1 SITUATION

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2024/25. The stock take also includes the Committee's Terms of Reference.

2 BACKGROUND

Each year the committee undertakes a review of clinical governance arrangements, consisting of:

- A review of reporting structures within the hospital.
- A review of the committee's terms of reference.
- An annual report summarising the work of the groups and departments that report to the Clinical Governance Committee.

3 ASSESSMENT

Terms of Reference
The Committee's Terms of Reference are subject to annual review.

Clinical Governance Committee Annual Report
The report summarises the work of the Clinical Governance Committee and highlights particular areas of good practice along with matters of concern that have been discussed throughout the year.

4 RECOMMENDATION

The Board is asked to note and agree the Clinical Governance Committee Annual Report 2024/25.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	To give assurance to the Board that governance structures and processes are fit for purpose. It also supports the Quality Strategy within the hospital.
Corporate Objectives Please note which objective is linked to this paper	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. Tailor the Clinical Model to better reflect the graduated clinical and security steps for patient progression on their care and treatment pathway. Eliminate the use of Day Time Confinement to all but very exceptional circumstances. Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk. Ensure the principles of the rehabilitative care are applied optimising opportunities for meaningful patient activities, educational development and occupational development across all service areas. 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. 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. Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system. Deliver a programme of Infection Control related activity in line with all national policy objectives. 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. Be accessible to patients, their family and visitors ensuring their views and experiences are reflected in service improvements, implementing the Carer Strategy 2025/28.

	Embed the principles of Realistic Medicine, through the Realistic Action Plan for 2025/26. Work with stakeholders and Scottish Government representatives to enhance the reputation and healthcare 'profile' of the State Hospital. Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment. Take forward national collaboration and interface work with the Healthcare in Custody Network. Support the development of a national framework for collaborative working in the delivery of forensic mental health services across NHSScotland. Tackle and address the challenge of obesity, through delivery of the Supporting Healthy Choices programme. Continued improvement of the physical health opportunities for patients. Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient. Address the overall social wellbeing issues for patients undergoing treatment. Utilise connections with other health care systems to ensure patients receive a full range of healthcare support. 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. Ensure the organisation is aligned to the values and objectives of the wider mental health strategy and framework for NHSScotland.
Workforce Implications	The various reports throughout the year would include any issues
Financial Implications	The various reports throughout the year would include any issues
Route to Board Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Group for noting Clinical Governance Committee for noting Risk and Audit Committee for decision
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2024 – 31 March 2025

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical quality have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 and subsequently through the NHS Healthcare Improvement Scotland *Making Care Better – Better Quality Health and Social Care for Everyone in Scotland 2017-2022.* The 5 main strategic priorities are:

1) Enable people to make informed decisions about their own care and treatment.
2) Help health and social care organisations to redesign and continuously improve services.
3) Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve.
4) Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve.
5) Make best use of all resources.

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2023/24 and examples of good practice and matters of concern. CGC reports follow a standard format to ensure consistency and ease of reference between reports. The headings are:

- Core Purpose of Service/Committee
- Current Resource Commitment
- Summary of Core Activity for the last 12 months
- Comparison with Last Year's Planned QA/QI Activity
- Performance against Key Performance Indicators
- Quality Assurance Activity
- Quality Improvement Activity
- Stakeholder Experience
- Planned Quality Assurance/Quality Improvement for the next year

2. Committee Chair, Committee Members and Attendees

Committee Chair
Cathy Fallon, Non-Executive Director

Committee Members
Stuart Currie
David McConnell
Shalinay Raghavan

Attendees
Brian Moore, Chair of The State Hospitals Board for Scotland
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director (Lead Director for Clinical Governance)
Elizabeth Flynn, Head of Psychological Services
Monica Merson, Head of Corporate Planning and Business Support

Karen McCaffrey, Director of Nursing and Operations
Robin McNaught, Director of Finance & eHealth
Dr Khuram Khan, Chair, Medical Advisory Committee (until August 2024)
Dr Gordon Skilling, Chair, Medical Advisory Committee (from November 2024)
Sheila Smith, Head of Clinical Quality
Margaret Smith, Board Secretary

The Committee can decide to invite the Board Chair to sit as a member of the Committee for a meeting, should this be required for quorate decision-making.

3. Meetings during 2024/25

During 2024/25 the Clinical Governance Committee met on four occasions, in line with its terms of reference. Meetings were held on:

- 23 May 2024
- 8 August 2024
- 14 November 2024
- 13 February 2025

Attendance of members at the meetings can be found in appendix 1.

4. Reports Considered by the Committee During the Year

4.1 12 Monthly Internal Governance Reports

May
Infection Control
This report covered the period 1 April 2023 - 31 March 2024. .
Updates on the 9 Standards within the HIS Infection Control Standards (2022) were included within the report along with the work plan for the next 12 months.

Medicines Committee
This report covered the period 1 April 2022 - 31 March 2023.
The Committee received and approved the key activities and commended the service for being able to work within budget.

Patient Learning Annual Report
This report covered the period 1 January 2023 - 31 December 2023.
The Committee noted the progress that had been made and acknowledged the planned future developments that were detailed within the report. The report noted that a key focus for 2023 had been to maintain delivery of established patient learning programmes within the Skye Centre and that positive progress had been made in a number of areas of patient learning within the State Hospital.

August
Research Committee/Research Governance and Funding
This report covered the period 1 April 2023 - 31 March 2024. The main areas of focus was the range of research activity and its dissemination undertaken by the State Hospital staff, and the mechanisms and roles in place to support research across the organisation. In total, there were 14 study proposal reviews with 24 study progress reports and 4 final reports

Duty of Candour
This report covered the period 1 April 2023 - 31 March 2024. The report covered information on the policy, training that had been implemented across the site as well as the governance and monitoring arrangements. Of the 54 incidents considered by the Duty of Candour Group two of the incidents fulfilled the criteria for Duty of Candour.

Patient Safety
This report covered the period 1 July 2023 - 30 June 2024. The four principles remained: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. All these work streams had been considered within the report with key priorities for 2024/25 being discussed and agreed at the meeting.

Rehabilitation Therapies Service
This report covered the period 1 July 2023 – 30 June 2024 and provided a summary of the key areas of work and the committee endorsed the future areas of work and service developments contained within it.

Mental Health Practice Steering Group
This report covered the period 1st April 2023 – 31 March 2024. The Committee approved the activities carried out and the areas of work the Mental Health Practice Steering Group intend to focus on over the next 12 months.

November
Pre-Transfer CPA/MAPPA
This report covered the period 1 October 2023 - 30 September 2024. The report identified a number of key areas and areas of good practice.

Child and Adult Protection
This report covered the period 1 October 2023 - 30 September 2024. The report highlighted key areas of work and the Committee commended the planned activity for the next 12 months.

Physical Health Steering Group
This report covered the period 1 October 2023 - 30 September 2024. The report noted the developments and progress made in the five key strands for which the Physical Health Steering Group had responsibility. 2025 will see the PHSG working towards the target of patients gaining no more that 5% of their admission weight within the first 12 months and continuing to progress the Supporting Health Choices Improvement Programme.

Supporting Healthy Choices
The report contained information on how the team have focused on establishing strong foundations for work moving ahead, with the establishment of clear governance and reporting structures, and establishing a comprehensive data management plan to evaluate change and intervention effectiveness. Alongside this, improvement activity has been initiated and implemented.

Person Centred Improvement Service
This report covered the period 1 October 2023 – 30 September 2024 and key areas of work were presented.

February
Clinical Governance Group
This report covered the period 1 January 2024 - 31 December 2024. The report provided a summary of the work of the Clinical Governance Group over the past 12 months and outlined the areas of future work.

Psychological Therapies
This report covered the period 1 January 2024 - 31 December 2024 and highlighted a number of positive areas as well as outlining key pieces of work for 2025-2026.

Activity Oversight Group
This report covered the period 1st January – 31st December 2024 and highlighted some key achievements and areas of future work over the next 12 months.

4.2 Standing Items Considered by the Clinical Governance Committee during the Year

May
Patient Movement Statistical Information
This report covered the reporting period up until 31 March 2024. It was agreed that this report would be replaced by a quarterly bed capacity report, starting from the August meeting.

August
Bed Capacity
The Committee received and noted the first bed capacity report at its August meeting, and quarterly thereafter. The reports highlighted continued problems with capacity across the Forensic Network; bed occupancy within the State Hospital (across the 4 main Services) and details on surge bed contingency planning that has been implemented through the Clinical Model Oversight Group.

Reports at All Meetings

Learning from Complaints
The quarterly Learning from Complaints & Feedback report was considered and noted and actions arising from all complaints are included within the report to share the learning which enables the organisation to develop services which take cognisance of complaint outcomes.

Incident Reporting and Patient Restrictions Report
The report showed the type and number of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. This was the first full year of the Committee only getting the clinical data that was relevant to them.

Nurse Resource Report
These reports included updates on staffing; clinical resourcing; use of daytime confinement; resource incidents as well as updates on our compliance with the Health Care Staffing Act (HCSA).

Corporate Risk Register – Clinical Update
The most recent paper at the February 2025 meeting showed that all clinical risk assessments were within their review date; Two high/very high risks remain within the hospital, MD30 – Failure to prevent/mitigate obesity and ND70 – Failure to utilise our resources to optimise excellent patient care and experience. This risk will be updated to read “Failure to Meet Agreed Patient Care Standards due to Staff Resourcing. There are a number of areas being worked on to reduce these risks.

4.3 Other Items discussed During the Year

Quality Strategy
The Committee received and approved the Quality Strategy at their meeting in August 2024. The Strategy covers the period 2024/2029The Committee were content with the wide range of

consultation and approved the Strategy to be presented at the Board meeting for final approval. They agreed that evaluation of the Strategy will sit with Clinical Governance Group.

Carers Strategy
The Carers Strategy was presented to the November meeting of the Committee. The Carers Strategy identified 4 priority areas for development. A detailed delivery plan with at least three improvement activities under each of the priority areas will be developed. The Committee approved the Strategy with the proviso that the Family Centre visiting experience is added prior to it going to the Board for final approval.

5. Presentation Items During the Year

New Clinical Care Policy
The May 2024 meeting saw a presentation that provided an overview of the preparation that had gone into the successful implementation of the new Clinical Care Policy. The Clinical Care Policy replaces the PMVA Observation Policy and is in response to the 'From Observation to Intervention' (a proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health) published by Healthcare Improvement Scotland in 2019. The presentation gave key updates on:

- the background into the policy and what it involved;
- why the policy was being introduced;
- the effective date of the policy (1st May 2024)

The committee were content with the comprehensive information surrounding the policy. They commended the team for bringing this piece of work forward and the proactive involvement of the MWC.

Clinical Model Evaluation and Internal Audit Report
This presentation gave details on the internal audit report that had been carried out on the implementation of the Clinical Model, as well as progress made since formal handover from the project implementation team in July 2023. It was noted that the report provided reasonable assurance to the organisation.

The presentation gave the Committee the history of the development around the new clinical model, the aims of tailored security based on risk and clinical presentation, and a sense of progression for patients through supporting physical health, therapeutic activities and treatment goals as well as information on the implementation of the model, and the careful management of this.

The presentation concluded by offering assurance that the model was delivering on the key aspects that it had set out to so.

The Committee were content with the assurances that were given and asked for the slides to be sent round the Committee.

Trauma Informed Care
The Head of Psychology led the Committee through a presentation on 'A Trauma Informed TSH' at the Meeting in November 2024. The Committee were given the background to the context of the National Trauma Transformation Programme, and the related Roadmap.

The current agenda within this workstream was summarised including the appointment of a Trauma Champion, and the delivery of training and the use of reflective practice. Lastly, the

presentation set out future planning including a trauma Roadmap Self-Assessment and further analysis of patient needs.

The Committee found the presentation to be helpful and informative and asked that this approach be considered further in a Board Development session in six months' time.

People with Lived Experience
At the February 2025 meeting, the Forensic Network Manager presented a paper that she had written and submitted to the Forensic Network Advisory Board and the Scottish Government around 'people with lived experiences' (PLE).

The Committee found the presentation to be very helpful and thought provoking and requested that this item be brought back to the Committee once it has been progressed further with the wider team and PCIT.

6. Special Topics/Items for Approval

Clinical Governance Annual Stock Take
At its May 2024 meeting, the Committee received and noted:

- The Clinical Governance Reporting Structures 2023/24;
- Programme of Work for 2024/25 subsequent to any changes that may arise at future meetings;
- Clinical Governance Committee Terms of Reference
- Clinical Governance Annual Report 2023-2024.

7. Areas of Good Practice Identified by the Committee

- Daily medicines report for the non-administration of medication and the e-learning module on the Safe Use of Medicines.
- A member of staff had maintained contact with a patient who had moved on to enable them to continue with their degree.
- Good practice in relation to the linking complaints training to NHS Values and Behaviours within Corporate Induction.
- Activity boxes for hard to reach patients within ward areas
- The introduction of the hard to reach cafes
- Complaints Officer attending the Patient Partnership Group on a regular basis
- The positive steps in relation to infection control embedding itself across the organisation.

8. Matters of Concern to the Committee

There was one area of concern noted at the February 2025 meeting that was around the structure, format and process for risk assessment and the impact on transfers due to information sharing issues.

9. Conclusion

From the review of the performance of the Clinical Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Clinical Governance arrangements were in place throughout the year.

Attendance at meetings (members)

	23 May 2024	8 August 2024	*14 November 2024	8 February 2023
Cathy Fallon	X	X		X
Stuart Currie	X	X		X
David McConnell	X	X	X	X
Shalinay Raghavan				X

X denotes attendance
** Pam Radage attended to allow the meeting to be quorate*
*** Dr Skilling replaced Dr Khan as Chair of the Medical Advisory Committee*

Appendix 2

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Clinical Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that clinical governance mechanisms are in place and effective within the State Hospital.

2 COMPOSITION

2.1 Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair.

Members:

- Stuart Currie
- David McConnell
- Shalinay Raghavan
- Cathy Fallon (Chair of the Clinical Governance Committee)

In Attendance:

- Brian Moore, Chair of The State Hospitals Board for Scotland
- Gary Jenkins, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- Dr Liz Flynn, Head of Psychological Services
- Monica Merson, Head of Planning, Performance and Quality
- Karen McCaffrey, Director of Nursing and Operations
- Robin McNaught, Director of Finance & eHealth
- Dr Gordon Skilling, Chair, Medical Advisory Committee
- Sheila Smith, Head of Clinical Quality
- Margaret Smith, Head of Corporate Governance/Board Secretary

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at a meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members, the Chair of the Medical Advisory Committee and the Chair of the Research Committee, will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via

the minute secretary at least 2 working days prior to the meeting unless an exceptional event prevents this level of notice.

Where a member who is due to present a paper is not able to attend, they should ensure that another person is suitably briefed in order to deal with this item. The arrangement made should be discussed and approved by the Committee Chair.

To fulfil its remit, the group may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings. If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

Others may attend the Committee on the approval of the Committee Chair.

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting. The Chair of the Committee may convene additional meetings as necessary.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least three full working days in advance to allow time for consideration of issues.

The lead Executive for co-ordinating agendas and papers is the Medical Director.

All papers will clearly state the agenda reference, the author, and the purpose of the paper, together with the action to be taken. Cover papers should be prepared in the format set out in Corporate Document Standards, to draw out the main issues for the Committee, and will be subject to document control.

The secretariat for this Committee will maintain a master file of documents, in line with Policy for Management, Retention and Disposal of Administrative Records.

3.3 Quorum

In the event of the Committee making decisions, two members need to be in attendance to be quorate.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Board Secretary is responsible for minute taking arrangements. The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive (Medical Director) prior to approval by the Committee and notification to the Board.

Following approval, minutes will be submitted to the Board and then published on the hospital's website.

4 REMIT

4.1 Objectives

The main objectives of the Clinical Governance Committee are to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital; and that the principles of clinical governance are applied to the health improvement activities of the Board.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with clinical standards, in delivery of improved services for patients, and ultimately in improved outcomes for patients as evidenced through the clinical key performance indicators reported in the Annual Delivery Plan.

4.2 Systems and Accountability

- To ensure that appropriate clinical governance mechanisms are in place throughout the hospital in line with national standards.
- To ensure that clinical risks are managed in accordance with the corporate risk management strategy, policies and procedures.
- To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed through clinical governance mechanisms.
- To ensure that systems are in place to meet information governance standards.
- To ensure that systems are in place to meet research governance standards.

4.3 Safe and Effective Care

To provide assurance to the Board in respect of clinical risk management arrangements, that:

- Structures are in place to minimise potential problems such as effective risk assessment and management, incident reporting, critical incident reviews, and complaint procedures.
- Lessons are being learned from adverse events and near misses.
- Systems are in place to measure and monitor duty of candour and any lessons to be learned.
- Complaints are handled in accordance with national guidance and lessons will be learned from their investigation and resolution (including reports of the Scottish Public Services Ombudsman and the Mental Welfare Commission).
- Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high-quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the standard of care provided, including the performance of clinical colleagues, in the knowledge they will be addressed without detriment to themselves or prejudice to the principles of confidentiality.
- To ensure systems are in place to monitor and measure the mental health and physical health requirements of our patient population, including medicine management, psychological therapies, and rehabilitation services.
- To ensure that arrangements are in place to embed Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented, and reviewed.
- To ensure that poor performance of clinical care will be identified, and remedial action taken.

4.5 Control Assurance

- To ensure that quality of clinical care drives decision making and that clinicians are involved in planning, organising, and managing services.
- To ensure that the planning and delivery of services has taken full account of the perspective of patients and the general public.
- To ensure that systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.
- To ensure that research and development programmes are initiated, monitored, and reviewed.
- To ensure a comprehensive information governance framework is in place which ensures the Codes of Practice on Openness and on Confidentiality of Personal Health Information are fully applied.

The Committee will manage its business through a workplan, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance, effectiveness, and the level of input of members to the Committee relative to added value achieved.
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Clinical Governance Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.
The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

Subject to Annual Review
Next revision: May 2026

Paper No. 25/51

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 13
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

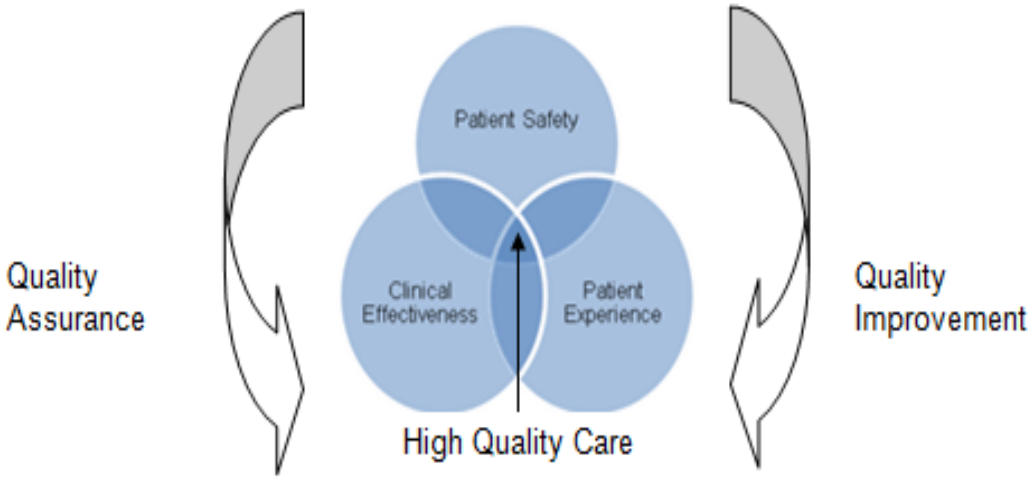
Quality assurance and improvement in TSH links to the Clinical Quality Strategy 2024 – 2029. This strategy was presented to TSH Board in August 2024 and adopted as TSH current strategy to progress clinical quality. The Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. The vision for the outcome of this Strategy is to improve the experiences of care and health provided to 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 its 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 five clinical audits:
    - Compliance to Treatment (T2/T3 Audit)
    - Post Physical Intervention Audit
    - Seclusion Audit
    - RMO Contact with patients
    - Observations of Care Audit
- An update on the work of the QI Forum including current training in progress and TSH3030
- 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 /ADP	The quality improvement and assurance report support the Quality Strategy
Corporate Objectives Please note which objective is linked to this paper	**1. Better Value** d) Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk. 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. n) Embed the principles of Realistic Medicine, through the Realistic Action Plan for 2025/26. **2. Better Health** c) Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient. g) Ensure the organisation is aligned to the values and objectives of the wider mental health strategy and framework for NHSScotland.
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 x 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 APRIL/MAY 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 five audits completed and actioned through the Commissioning Group:

- Compliance to Treatment (T2/T3 Audit)
- Post Physical Intervention Audit
- Seclusion Audit
- RMO Contact with patients
- Observations of Care Audit

Following a request from TSH Board, the Clinical Quality Department have developed a master audit sheet (Table 1) 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.

Table 1: Master Audits

Arran 1	Lewis 1	Arran 2	Arran 3	Lewis 2	Lewis 3	Mull 1	Mull 2	Iona 2	Iona 3
Medication Trolley Audit (to ensure that medication is kept in alphabetical order and dose low to high as per guidance)									
Medicine Fridge Audit (all medicine fridges within the hospital will be fit for purpose and temperature regularly monitored)									
HEPMA Audit (to ensure that medicines are being administered as per the Safe Use of Medications Policy									
PMVA Post physical Audit (to ensure staff are completing the PPIA, NEWS and PRN forms)									
						n/a	n/a		
Unvalidated progress notes audit (to ensure all progress notes are validated within 7 working days to make them a legal entry)									
Nurse Progress Note Audit (to ensure all patients have one nursing entry per shift as per NMC guidance)									
RMO contact with patients									
Observations of care audit is to ensure meals are being served in accordance with the Patient Food and Fluid Provision Guidance									
Seclusion audit measure adherence with the PMVA Seclusion Policy									
			n/a		n/a	n/a	n/a		

Compliance to Treatment (T2/T3) Audit
This audit measures compliance with the Mental Welfare Commission Guide: Consent to Treatment that was published in July 2024. The main findings were very positive with the forms being completed well. There was one area of concern around nurses within the ward not being able to demonstrate where the T2/T3 was located within RiO. This should be checked at each medicine round. There had been a change in practice over the last 12 months where the forms were no longer located within the treatment room (the MWC had raised concerns that during their visit incorrect versions of the T2/T3's were within the treatment room) and should be checked on RiO instead. This was communicated as a matter of urgency to the Nursing Directorate for action. Clinical Quality will visit the wards in July to ensure medication nurses can demonstrate where to locate the forms on RiO.

Post Physical Intervention Audit
This audit measures compliance with the PMVA Post Physical Intervention Policy. Clinical Quality found excellent compliance with the forms being completed within Arran 1, Arran 3 and Lewis 3. Excellent compliance was noted within Arran 1, Arran 2, Lewis 3, Iona 2 and Iona 3 with regards to a PRN form being completed on RiO. Clinical Quality had concerns over the number of NEWS forms that could not be located to evidence that the patient had physical observations taken following the secure hold being placed on them within the Admission & Assessment Service and the Treatment & Recovery Service. The ID Service had better compliance with this. Patient Safety will take forward the recommendations from the audit.

Seclusion Audit
This audit measures compliance with the PMVA Seclusion Policy. Very good compliance was evidenced with improvement areas agreed at Patient Safety around seclusion nursing care plans (as these are not being populated for all seclusions) and the first medical review being completed as again, these were not completed for all episodes of seclusion. The Patient Safety Group will oversee these improvements.

RMO Contact with Patients
The hospital has a standard that all patients should be seen by their RMO at least once per month. The Q1 data gave us excellent assurance that this standard is being met. All patients had been seen by their RMO within the month.

Observations of Care Audit
The audit measure adherence with the Patient Food and Fluid Provision Guidance within the hospital and links with the Food, Fluid and Nutritional Care Standards that is part of the national peer review programme (NHS HIS). Improvement areas included patients not using hand gel before entering the dining room for their meal, staff not always wearing protective aprons and staff not always adhering to policy with regards to no watches, rings, nail varnish or false nails whilst carrying out food service. The Physical Health Steering Group will oversee these improvement areas.

Hospital Wide Variance Analysis (VAT) Flash Report – CPA's

The April variance analysis data showed that attendance had decreased for all disciplines across the hospital. This has been fed back to Service Leadership Teams for them to explore further and discuss ways to improve attendance at the patient's 6 monthly CPA. There was also an issue with the Occupational Therapy and Security interventions on the VAT with all of these decreasing. This is linked to staffing issues within these services:

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: April 25

Overview and areas of good practice

This report refers to all annual and intermediate reviews held across the hospital in April 25.

The monthly VAT report is split as follows:

April 25	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	0	2	2	99.2%	64.3% - decreased from 76% in Mar 25
Arran T & R	2	1	3	99.6%	68.8% - decreased from 81% in Mar 25
Lewis T & R	1	3	4	96.5%	68.8% - decreased from 71% in Mar 25
ID	0	1	1	100%	42.9% - decreased from 69% in Mar 25
Transition	2	1	3	98.8%	58.3% - decreased from 69% in Mar 25

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

All interventions showed random variation with continued good report provision.

Areas of concern

Nursing – Key Worker attendance remained similar to last month at 53.8% A detailed breakdown continues to be forwarded to the Lead Nurses and Associate Nursing Director.

Reduction in all Occupational Therapy interventions due in the main to staffing issues.

Reduction in Security interventions due to staffing issues.

Any challenges with the systems that are being addressed

Work has started on pulling pathway data direct from RiO – with testing scheduled for May, June and July 25.

QUALITY IMPROVEMENT

QI Forum

The QI Forum continues to meet on a six 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

The QI Forum supported the award winning Quality Improvement (QI) initiative - TSH3030 (pronounced "TSH thirty thirty"), offering teams the opportunity to take forward a QI project for 30 minutes a day for 30 days. This ran from 1st to 30th May 2025. Twenty one teams from across TSH registered to take forward projects, with 16 submitting final posters. The completed projects for improvement fell under the following three broad themes

- Staff health and well-being (6)

- Patient health and well-being (4)
- TSH processes (6)

TSH3030 teams worked with a QI trained mentor to develop their projects. Fifteen teams developed mid-way posters describing what they have learnt and how they plan to progress their projects. These posters were judged by Directors with a focus on the aims statement, use of QI methods and poster visibility. 'Word of the week' were also collected from teams through MS Forms to encourage teams to feedback on the process and team learning. Both the mid-way winners and highly commended team posters were displayed on the noticeboard at reception and the intranet, together with the weekly 'words of the week'.

TSH3030 concluded on May 30th, a total of 75 staff and 13 patients completed their TSH3030 QI projects. Many of the teams will continue and develop on their QI journey and sustain and spread the projects. The posters were judged on the 9th June 2025, and an awards ceremony "TSH3030 Oscars" event is planned for the 24th June 2025 to celebrate and recognise the improvement that teams have achieved.

QI Capacity Building

ScIL training is ongoing with four staff in total currently participating, two members of TSH staff are due to conclude in June 2026 and a further 2 have recently started. Recruitment for the next cohort of ScIL is imminent.

QI Essential Training – The 3rd cohort of TSH QI Essential Training was completed in April. The QI Forum are planning future dates for 2025/26 to continue to support staff to an introduction in quality improvement.

NES has continued to evolve the format of QI training, moving to be extensively delivered through on-line learning. The QI Forum is exploring how it supports staff to engage in this approach, particularly if the learner's preference includes face to face learning.

Realistic Medicine

The Realistic Medicine Team have been working on several areas of good practice since the last Board Report. The annual Realistic Medicine Conference took place on the 16th May 2025, with three members of staff from the State Hospital attending this. The event aimed to promote Realistic Medicine as the way we should deliver care in Scotland. It provided an opportunity to celebrate success, share best practice, and provide a collaborative forum for the discussion of system challenges and exploration of innovative approaches to practising Realistic Medicine and delivering Value Based Health and Care.

The Realistic Medicine team collaborated with Nursing Practice Development to develop and submit a virtual poster (appendix 1) for this event, which explored ways of using BRAN questions (Benefit, Risks, Alternative and doing Nothing) in a Forensic Mental Health Setting.

A case study booklet has been created and published by the Realistic Medicine Team at the Scottish Government, which includes a case study from the State Hospital, demonstrating how teams across Scotland are putting Realistic Medicine into Practice. The case study book is a practical guide offering inspiration and support for those adopting Realistic Medicine Principles and deliberating process in transforming care to delivering what matters to people we care for.

As previous noted in the October 2024 QA&QI Board paper, the Learning into Practice Group explored the use of Team Based Quality Reviews (TBQR) within the Service Leadership Teams. Human Factors training, which had been rescheduled from December, was delivered to eleven panel members in May. This training was facilitated by a Senior Lecturer from Dundee University. TBQR panel members not able to attend the training date were asked to complete the Human Factors training on-line module created by NES Healthcare Science to support the design of how, where & with what we do our work practices for patient services. The Learning into Practice Group are scheduled to meet on the 18th June to revise timescales for implementation due to the challenges experienced.

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 150 evidenced based guidance documents issued from a variety of recognised bodies and reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 April to 31 May 2025, 30 guidance documents have been reviewed. There were 9 documents which were considered either not relevant to TSH or were overridden by Scottish guidance and one document which was circulated for information and awareness. The final guidance from the MWC requires to be reviewed and a decision made by the Patient Safety Group regarding the need for a full evaluation matrix.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required
HIS	2	1	0
MWC	7	6	1 (decision pending)
National Institute for Health & Care Excellence (NICE)	21	2	0

There are currently five additional evaluation matrices which have been outstanding for a prolonged period. The review process for the HIS Gender identity healthcare standards was delayed pending the introduction of the Workforce Equalities Group. Once this group initially met, progress has been made with the evaluation matrix completion underway. Completion of the Frailty standards has proved problematic due to the availability of staff – much of this process has had to be done with individuals completing the evaluation matrix and then circulation for agreement when updated. This was tabled at PHSG in May however has to be taken back for further discussion in June 2025. The remaining three evaluation matrices have started the review process and will be progressed within prioritisation of current workloads.

Table 4: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	Gender identity healthcare: Adults and young people	Physical Health Steering Group	Initially reviewed by PHSG. Progress of review then delayed until creation of Workforce Equalities Group. Evaluation matrix now being populated with anticipation of being completed by the end of June 2025.	September 2024	June 2025
HIS	Ageing and frailty standards for the care of older people	Physical Health Steering Group	Ongoing issues re availability of review group members. Two meetings took place February 2025. Further meetings were arranged with members who could not attend. Taken to PHSG for agreement and sign off in May 2025 however to return to meeting for further discussion in June 2025.	November 2024	June 2025

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
SIGN	British guideline on the management of asthma	Physical Health Steering Group	Evaluation matrix created. Initial review to be completed by Practice Nurse/GP and thereafter CQ Facilitator to arrange review group meeting. Practice Nurse/GP having to prioritise within current workload and time restraints	November 2024	August 2025
SIGN	Asthma: Diagnosis, monitoring and chronic asthma management	Physical Health Steering Group	Evaluation matrix created. Initial review to be completed by Practice Nurse/GP and thereafter CQ Facilitator to arrange review group meeting. Practice Nurse/GP having to prioritise within current workload and time restraints	November 2024	August 2025
NICE	Overweight and obesity management	Physical Health Steering Group	To be progressed in absence of current Scottish guidance (publication anticipated March 2027). Evaluation matrix created. CQ Facilitator trying to arrange review meetings however experiencing difficulty re identifying possible dates for attendance therefore consideration to be given re best way forward. To take back to SHC/PHSG for guidance.	January 2025	August 2025

Appendix 1

Moving The Dial

Using **BRAN** Questions in a Forensic Mental Health Setting
Benefits, **R**isks, **A**lternatives, **N**othing

Introduction: The State Hospital is one of four high secure psychiatric hospitals in the UK. It is a national service for Scotland and Northern Ireland and one part of the pathway of care that should be available for those with secure care needs.

Aim: Due to the clinical and legal context of the State Hospital, many of the people we care for may lack the confidence or capacity to ask questions about their care. Others may feel disengaged from their treatment or unwilling to interact with healthcare professionals. Given these challenges, it is essential to adopt approaches that support shared decision making where possible and ensure people understand their treatment and care options.

Method: As part of a Quality Improvement Project to increase the number of patients that have meaningful nutritional and physical health care plans, staff and patients were introduced to the **BRAN** questions to provide a structured framework for engagement with the people that we care for, alongside ongoing efforts to enhance physical care.

To encourage patients to get the most out of conversations about their care, health care staff were trained on the benefits of using the BRAN questions. Guidance was produced with real life examples of Care Plans where BRAN had been used to encourage patients to ask questions to help support more meaningful care conversations. Monthly monitoring of care plans was carried out, focussing on the quality of the documentation and the use of BRAN questions, to recognise good practice and to encourage improvement to continue.

some patients may not have the capacity to engage and have informed discussions due to their mental illness. " We should ask ourself questions are available through the guidance document to provided staff with a better understanding to have open discussions with patients

Process Changes

In March 2024, training commenced to provide staff with the tools to be able to support patients using BRAN. MS Forms was used to complete a staff evaluation on how effectively BRAN questions contributed to care planning and the overall positives of BRAN. Feedback received was positive.

Results

The introduction of BRAN was done using a staggered approach through the hospital. Starting in Arran Hub in March 2024, spreading to Lewis Hub (Second stage) in October 2024 and into Mull and Iona Hubs in March 2024 (Third stage).

Conclusions

By systematically addressing the **Benefits** of continuing treatment, the **Risks** of adverse effects, potential **Alternative** therapies, and the option of doing **Nothing**, staff can support patients in making an informed decision about their care.

This approach strengthened trust and collaboration between patients, ensuring that care planning, decisions were well-informed and documented, demonstrating that BRAN use enabled staff to understand and implement good practice.

Next steps

BRAN is now progressing to our Transition Hub (Mull) as part of a QI project for ScIL.

REALISTIC MEDICINE

The State Hospital
Michelle McKinlay, Tracy Tait, Gordon Skilling,

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE **CGC(M)25/01**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 13 February 2025.

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

Chair:	
Non-Executive Director	Cathy Fallon
Present:	
Non-Executive Director	Stuart Currie
Vice Board Chair	David McConnell
Non-Executive Director	Shalinay Raghavan
In Attendance:	
Head of Psychology	Dr Liz Flynn [for Item 5]
Acting Director of Estates and Resilience	Allan Hardy
Forensic Network Manager	Caroline Kelly [for Item14]
Senior Nurse for Infection Control	Jonathan Lee [Item 9]
Director of Nursing and Operations	Karen McCaffrey
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Complaints Officer	Bonnie Murphy [Item 13]
Head of Corporate Governance	Margaret Smith
Medical Director	Professor Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting and noted apologies from Gary Jenkins, Chief Executive, Robin McNaught, Director of Finance and eHealth and Sheila Smith, Head of Clinical Quality.

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 21 November 2024.

The Committee:

1. Approved the minute of the meeting held on 21 November 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 actions list the committee received the following update:

Action 3 – Committee Research: Professor Thomson advised that one funding payment had been made and four remained outstanding. She noted that this was due to an issue with the University of Edinburgh's new finance system.

The Committee:

1. Noted the updates from the Rolling Action List.

5 PSYCHOLOGICAL THERAPIES 12 MONTH REPORT

The Committee received the Psychological Therapies 12 Month Report presented by Dr Flynn who provided an overview of the plans, innovations, challenges and Key Performance Indicators (KPIs) within the service. Dr Flynn advised that the development of the link nurses had worked well with positive feedback received, however, the initiative would not continue next year as funding had been withdrawn and rota compliance difficult. Progress had been made in relation to the Risk Assessment and Management process around what risk tools staff had been trained to use. Guidance had been provided to the team and a risk clinic had been formed to offer support to colleagues undertaking risk assessments and a supervision policy had been drafted and was in the monitoring phase. Clarity would be sought around what supervision patients had required and the frequency, and the new Psychological Therapies Governance Group would be involved with this piece of work. Dr Flynn added that a multidisciplinary group was being formed to address key Risk Assessment and Management issues around information from outside sources used to populate risk assessments and how this was structured within RiO (the electronic patient records system). A work plan was also in progress which would be submitted to Committee in the next few months.

Mr Currie thanked Dr Flynn for the report and asked for her assessment in terms of progress. Dr Flynn replied that the progress made by the Psychological Therapies team had been positive and had highlighted areas of governance and service delivery and there was a clearer understanding of what improvements could be made to address the areas not meeting their KPI's.

Mr McConnell highlighted that group sessions appeared lower than pre pandemic levels and asked if this was being addressed, and if it was related to staffing resourcing. Dr Flynn replied that demand for group sessions was variable, and that engagement may be due to sessions content or the changing needs of the patient population. She indicated that a refresh of the current offering would be beneficial to assess future viability and that this would be added to the workplan.

Ms McCaffrey thanked Dr Flynn for the feedback around the link nurse pilot. She suggested that Dr Flynn link with the Associate Director of Nursing to discuss other model possibilities to utilise the group of staff and increase their skill set for use within the clinical area. Ms McCaffrey asked if opportunities in relation to lower-level interventions and groups, as well as collaboration with other disciplines to support the delivery of these, was being explored. She further highlighted concerns around the low uptake of therapeutic group supervision sessions and asked if this could be a key focus going forward and requested be cited on future uptake issues.

Dr Flynn agreed with the points made and noted that discussions within the Psychological Therapies Governance Group had taken place to establish how the new supervision policy would be monitored. An alternative system of monitoring had been proposed which aimed to tackle under reporting, to identify what groups and individual supervision had taken place, who was facilitating the training and to explore ways to increase supervision sessions overall. She added that the issues could be discussed at the Psychological Therapies Governance Group and noted that there had been issues with staff being able to attend group sessions on a regular basis.

Mr Moore also thanked Dr Flynn for the report and asked if it was possible to predict the outcome of the skill mix review. Dr Flynn replied that the review would likely highlight the need for qualified Psychologists to facilitate risk assessment work and increase process efficiency and that funding would be sourced from vacant Nurse Therapy posts. A review of the Nurse Therapy team was in

progress and job plans would be created for all staff in the Psychology Therapies team to establish if staff are utilised effectively.

Mr Moore expressed concern that the Risk Assessment and Management Process review may have a potential impact on patient discharges due to delays in completing associated paperwork and noted the importance of rectifying issues quickly to elevate the process to required standards. Dr Flynn advised that positive relationships and communication was being fostered with the three medium secure units and that risk assessments for patients transitioning to medium secure units are being completed collaboratively to ensure the required information is shared. Discussions had also taken place with the RiO Team to establish if an editable version of the risk assessment form could be made available to medium secure services to allow them to add information.

Professor Thomson asked if the review of group sessions would facilitate the creation of a physical health session in collaboration with the Healthy Choices Group. Dr Flynn replied that she would discuss this further with Health Psychologist.

Ms Fallon thanked Dr Flynn for the report and her contribution. She concurred with the comments made and was thoughtful about the length of the paper and also the need to focus on the delivery of clinical care in terms of impacts on patients as this was the key focus of this Committee. There was agreement round the table to reconsider the content of reporting.

Action: L Flynn

The Committee:

1. Noted the Psychological Therapies 12 Month Report.
2. Requested a refresh of the Psychological Therapies Report.
3. Next report due February 2026.

6 CLINICAL GOVERNANCE GROUP 12 MONTH REPORT

The Committee received the Clinical Governance Group 12 Month Report presented by Professor Thomson who provided an overview of the report, summarising each area. She also highlighted that the remit of the group extended to providing a forum for new ideas; and that reporting as outlined is crucial in shaping patient care.

Mr Moore thanked Professor Thomson for overview and referred to the information in respect of outboarding of patients from the State Hospital (TSH) to general hospital for acute care, within the context of changes in unscheduled care across NHSScotland as a whole. He asked about how TSH could retain focus on this area. Professor Thomson agreed about the importance of this and clarified that the monitoring in question referred to within reporting was in respect of clinical cases, rather than overall. She confirmed that reporting on the management of unscheduled care had been routed through the Corporate Management Team (CMT) and would continue to be monitored.

Mr McConnell asked if any work had been undertaken to progress the action of standardising communication between TSH and general hospitals. Professor Thomson noted that there were suggestions of how communication could be standardised prior to patients attending the service, as well as after the return to TSH. This would be included in the report coming to the Committee. Ms Merson added that monitoring unscheduled visits was included in the draft Annual Delivery Plan 2025/26 and that work was ongoing to improve the efficiency of visits utilising the Flow Navigation Centre and Consultancy Connect.

Mr Currie noted the challenges in guaranteeing that patients would be seen quickly and ensuring suitable care to the patient group during extended waits. He added that it would be helpful to explore ways to avoid acute admissions through Hospital at Home if possible. Professor Thomson replied that the Flow Navigation Centre managed logistics to ensure that TSH staff were informed

of when to leave or when an ambulance would be available at a time that aligned with Accident & Emergency capacity and the success of this process would be monitored. Previous review of admissions of TSH patients for acute care had been part of reporting, and this had demonstrated that none were deemed avoidable. It was agreed that further reporting would return to the committee in this regard, as a discussion item.

Action: Secretariat

The Committee:

1. Noted the Clinical Governance Group 12 Month Report.
2. Agreed that Unscheduled Care would be the discussion item at next meeting.

7 ACTIVITY OVERSIGHT GROUP 12 MONTH REPORT

The Committee received the Activity Oversight Group (AOG) 12 Month Report presented by Ms McCaffrey who provided an overview of the report. She highlighted that the AOG was in its second year and reminded members that the initial aspiration of the group had been to adopt a more focused approach and to identify priorities based on the data obtained. The group had focused on resourcing across the site, and the risk of not being able to deliver key goals for individual services. Ms McCaffrey advised that the AOG had agreed that key priorities should be informed by service specific perspectives, and that this would produce a more comprehensive data set to underpin decision-making.

Ms McCaffrey added that the approach had highlighted variations reporting in terms of categories of activities. This affected the quality of data collected and work had been done to streamline categories, simplify processes and agree definitions across services to provide more meaningful data output. She informed members that consistency of activity offerings remained a focus, with improvements made. The aim was to ensure this area could grow sustainably. She acknowledged that the Clinical Quality and e-Health departments had assisted in reduction of manual processes and duplication of effort which was impacting the quality and standard of data.

Ms McCaffrey highlighted Daytime Confinement (DTC) was included within the report and suggested that this should be reported separately.

Mr McConnell thanked Ms McCaffrey for the report and suggested, with regard to DTC figures, it would be beneficial to view an additional month in retrospect to view a more comprehensive picture of activity. Ms McCaffrey outlined the reasons as to why DTC had increased at certain points of the year and underlined the aim to eliminate this. She noted that the provision of ten additional staff members would help to provide stability within nurse resourcing overall.

Mr Moore noted that it was good to see that the KPI's were being reviewed to ensure their continued utility and added that it would be useful to review the data collected. He asked for clarity around the phrase 'build the will for the KPI's' and asked if it referred to staff commitment or greater ownership to be taken forward by the senior management team. Ms McCaffrey replied that it was important for KPI's to be relevant for staff groups delivering services to build ownership. Ms Merson agreed with this point and added that focus should be building from an assurance to an improvement measure.

Ms Fallon noted that a conversation had taken place around how the report would be formulated in future with regard to format, length and relevance of data in chart form, and it was agreed that this would be helpful. It was also considered that future reporting of DTC should be re-considered. She added that DTC had not been a common practice prior to the Covid-19 pandemic, and there should be a focus on understanding why this had changed.

Action – K McCaffrey

The Committee:

1. Noted the Activity Oversight Group 12M Report.
2. Requested a re-fresh of reporting relating to AOG and also to DTC.

8 NURSING RESOURCE REPORT Q3

The Committee received the Nursing Resource Report Q3 presented by Ms McCaffrey who highlighted the success of the recent recruitment initiatives, as well as areas of concerns most notably levels of such as sickness absence. She noted there was lower uptake of supplementary staff shifts during the quarter and the reasons for this would be explored. The uptake of supplementary staff shifts over the year would be mapped to highlight recurrent themes and evaluate the effect this may have on the ability to address deficits. Ms McCaffrey provided an update on work undertaken to explore the reasons for the increase in DTC and points where staff resources had made an impact.

Ms McCaffrey advised that the first annual report in relation to the Health and Care Staffing Act would be presented to the Board in April 2025 and that positive feedback had been received from Healthcare Improvement Scotland and the Scottish Government in relation to how TSH were progressing across all standards.

Mr McConnell thanked Ms McCaffrey for the report and asked for further information around the Supplementary Staffing Register figures, noting that the data presented appeared quite stable. Ms McCaffrey replied that dips had occurred in some weeks throughout the year which had created challenges for services and that a more in-depth analysis would be presented in the next report. She also clarified that the data for 2024-2025 Q3, highlighted in red, was incomplete and may change.

Ms Fallon commented that it would be very helpful for the Committee to receive this report.

The Committee:

1. Noted the Nursing Resource Report Q3

9 INFECTION CONTROL QUARTERLY REPORT Q3

The Committee received the Infection Control Quarterly Report presented by the Mr Lee who highlighted the key points. He advised that the Infection Control Group (ICG) had identified an issue regarding the cleanliness of isolated patient rooms. A resolution had been identified and would be presented at the next Infection Control Committee (ICC) meeting in March. The ICC would incorporate a Water Safety Group as a standing item in line with the National Control Manual, to ensure compliance with legislation in relation to the management and governance of a safe environment. In relation to education, compliance was over 90% and Infection Control was now included as a one-hour session within the induction programme. He informed members of the new system for hand hygiene audits, with data being collected since January 2025. He noted this would provide a more comprehensive and meaningful dataset and provide greater assurance going forward.

Mr Lee informed the Committee that the new national guidance for high consequence infectious diseases, due to be in place by April 2026, outlined that all Health Boards should have the ability to respond to a high consequence infectious disease; this would be looked at in line with Mpox, Ebola and Marburg. This would require TSH to have a protocol in place in the unlikely event it was affected. He noted that Healthcare Improvement Scotland (HIS) inspections had resumed, and that work had begun to promote awareness and prepare staff for these.

Ms McCaffrey thanked Mr Lee for the report and his contribution to this area of work and

highlighted that Mr Lee had been actively engaging with departments across the hospital to better understand the environment and the rationale behind current practices and there had been a focus to promote awareness that compliance is the responsibility of all staff across all departments.

Mr Moore welcomed the planned improved approach in relation to hand hygiene and asked if the HIS inspection would relate to infection control or if it would cover a wider scope to include quality of care and if TSH should prepare for this possibility. Ms McCaffrey clarified that inspections were part of the wider safe delivery of care, and there had been measures put in place to cover all relevant standards. She added that although Mr Lee's focus was infection control, and the questions posed to staff around this area would prepare them for the wider inspection process.

Mr Currie commented that assurance could be taken from the report and asked if the proactive approach to increase staff responsibility for infection control issues had made a positive impact on compliance. Mr Lee replied that he had explored current practices in detail to determine the rationale and added that he considered it would be beneficial for infection control to mirror the existing TSH systems to provide robust support. It was noted that the ICG were proactive and aimed to provide assurance around infection control, and there were no current significant risks to escalate to the Committee.

Ms Merson assured the Committee that comprehensive preparation for HIS inspections and safe delivery of care was being actioned. She added that the HIS model had been explored to identify what papers would be appropriate to supply to them prior to an onsite visit, in relation to the overall TSH Quality Management System.

Ms Fallon thanked Mr Lee for his overview of reporting, and the assurance provided.

The Committee:

1. Noted the Infection Control Quarterly Report Q3.

10 BED CAPACITY REPORT

The Committee received the Bed Capacity Report presented by Professor Thomson who provided an overview of activity in this respect, including transfers across THS Services and capacity in the wider network.

She informed the committee that the contingency plan to use Intellectual Disability beds for Mental Illness patients was still in place but had not yet been utilised. She also noted that the Forensic Network Patient Flow and Capacity Report, requested by the Scottish Government, was submitted in December 2024 and a response was awaited. She added that a paper relating to the escalation process around bed or dispute issues would be submitted to the Scottish Association of Medical Directors for consideration.

Ms Fallon thanked Professor Thomson for the helpful report.

The Committee:

1. Noted the Bed Capacity Report.

11 CORPORATE RISK REGISTER - CLINICAL RISKS

The Committee received the Corporate Risk Register - Clinical Risks report presented by Mr Hardy who provided a summary of the report and highlighted that work was being done to improve the two recurrent high risks 'Failure to prevent/mitigate obesity' and 'Failure to utilise resources to optimise excellent patient care and experience'. He noted that in relation to the review, a meeting with the corporate directorate was scheduled to take place on 7 March. Mr Hardy also highlighted

that the final three points within the current progress table were incorrect and would be amended.

Ms Fallon thanked Mr Hardy for the report and asked about the risk increase which pertained to PMVA training compliance and whether the target level had been achieved. Mr Hardy replied that the risk was at target level and work was being done to declassify this from medium to low.

Ms Fallon noted the inclusion of progress updates for overall directorates and asked if this was required. Mr Hardy agreed that this information was not required and would be omitted from the report going forward.

The Committee:

1. Endorsed the Corporate Risk Register - Clinical Risks as an accurate statement of clinical risk.
2. Agreed that the overall directorate updates should be omitted from the report.

12 INCIDENTS AND PATIENT RESTRICTIONS Q3

The Committee received the Incidents and Patient Restrictions Report Q3 presented by Mr Hardy who provided a high-level summary which included episodes of Physical Restraint, the use of Soft Restraint Kits (SRKs) and Health and Safety incidents. Mr Hardy noted an increase in the use of Personal Attack Alarms (PAAs) which was attributed to high levels of clinical activity and added that efforts were being undertaken to extract learning from episodes of restraint.

He noted that the use of SRKs had increased, and work was being done to understand the increase and ensure that least restrictive practices were being utilised. He noted that Health and Safety incidents, in particular, behavioural and attempted assaults had increased and added that 32 out of 48 attempted assaults were attributable to a small cohort of patients. However, although assaults had decreased, this would have to be balanced against the increase in attempted assaults.

He highlighted the use of CCTV to aid situational awareness and advised that work was being undertaken to look at the policy and the standard operating practice wording to facilitate the required learning. He noted a decrease in self-harm incidents, although the figure remained high. Lastly, Mr Hardy advised that medication incidents had increased, and that a review was being undertaken to establish why these had occurred.

Mr McConnell thanked Mr Hardy for the report and asked if there was a specific output expected from the review in relation to the reason behind the increase in assaultive behaviour. Mr Hardy noted that these figures followed a six-month period with increased clinical activity. He added that there would be scope to adapt the way the organisation and staff learned from these incidents in order to prevent them from occurring. He also noted that managers had been encouraged to use CCTV when investigating incidents.

Mr Moore referred to the incident where a PAA system failure led to a delayed response and asked for more information around this. Mr Hardy replied that the issue was due to a faulty handset which had been resolved – he suggested that such issues could be recorded in more detail next time.

Mr Moore also noted that the report illustrated the significant impact of the Intellectual Disabilities (ID) service on increasing incidents and indicated that it would be helpful to have a detailed account of what the issues are, what is being done about this and what learning had been identified. He added that if these issues were likely to continue, the Board should have further discussions around the weighting of these issues within the ID service, as well as the context in terms of staff resourcing.

Mr Hardy suggested that it may be helpful to include a more detailed account of these issues within the paper to provide this information. Professor Thomson explained that at times a spike in

incidents could occur from a small number of patients and was related to the mental health of certain patients. Professor Thomson noted that the focus on learning from incidents, as well as the utility of CCTV, was a positive initiative with a particular focus on the incidents where staff were injured. She also referred to the Safety Report which had been taken forward in 2018, and which had helped to demonstrate some of the key challenges within the ID Service. She suggested that it would be helpful to explore this further in terms of how to provide further assurance to the Committee, and there was agreement around the table on this.

Action – L Thomson

Ms McCaffrey advised that in relation to the use of CCTV to support the reflective process, it was important to be mindful that this would highlight how individuals responded under these circumstances and what factors had contributed to the escalation of an incident. She further noted that staff would also be able to reflect on how they had personally responded to a situation, how this may impact their response to future incidents and be responsible for taking any learning forward to improve their practice.

Ms Fallon suggested that it may be helpful to highlight the learning from incidents within the SBAR or appropriate section to bring to this attention of the Committee. Mr Hardy indicated that he would work to enhance the report to be more concise and to highlight the detail more effectively to provide assurance to the Committee.

Action – A Hardy

The Committee:

1. Noted the Incidents and Patient Restrictions Report Q3.
2. Requested further consideration of the reporting around the increase in incidents.
3. Requested a refresh of reporting overall.

13 LEARNING FROM COMPLAINTS & FEEDBACK Q3

Members received the Learning from Complaints and Feedback Report Q3 presented by Ms M Smith who noted that Ms Murphy had joined the meeting in her role as the new Complaints Officer. Ms Murphy would provide her initial reflections and outline some of her work initiatives following an overview of the report.

Ms Smith provided a summary of the key points of the report and noted the number of complaints received and close, the issues raised, and learning identified and actioned. She highlighted the key areas where complaints had been upheld within the quarter. She noted that several complaints had been received from carers in relation to the security process upon arriving at the hospital relating to food items. A review had taken place around this, and the protocol had been changed to reflect the feedback and to provide carers with clarity on the process. Complaints had also been received in relation to the Estates Department completing work in patient bedrooms. There had been a complaint about the cancellation of patient activity.

The feedback section reflected similar themes regarding the security process as well as positive comments relating to communication between carers and the Person-Centred Improvement Team (PCIT). Members were advised that a gap in representation at the Patient Partnership Group (PPG) was identified which was being addressed, and that feedback had also highlighted the importance of the Patients' Advocacy Service (PAS) in supporting patients.

Ms Smith invited Ms Murphy to discuss developments within her role and the service. Ms Murphy informed members about the intention to reconvene monthly meetings with PAS and the PCIT to discuss themes, new issues and concerns. She added that she would be attending monthly PPG meetings to connect with patients and garner opinions around the complaints process to ensure accessibility and would liaise with the charge nurse in the atrium to explore ways to increase a

presence within the Skye Centre. She noted the intention to arrange a meeting with the Social Work Operations Manager to obtain knowledge around the Social Work department role within the patient experience and added that she planned to visit an empty ward to better understand the layout and processes of the hospital to inform complaints handling going forward.

Ms Currie noted that it was a positive step to attend the PPG meetings, promoting the complaints service as approachable and accessible as well as communicating the learning received from complaints. He asked whether Ms Murphy felt this would be received well by the PPG. Ms Murphy responded that she attended PPG meetings with PAS which better communicated the message that both services are there to support patients and noted the importance of fostering a strong relationship with PAS. She noted the work taken forward to meet patients alongside their advocate to discuss the outcome of their complaints.

Ms Raghavan asked if the increase in staff attitude & behaviour complaints was due to increased visibility of the complaints department as opposed to an increase in issues resulting in complaints. Ms Smith acknowledged the point and thought that the greater accessibility of the complaints service may encourage engagement with it which was a positive development. She also highlighted that the aim was to resolve complaints at the Early Resolution stage, face to face, linking with Advocacy, which should enable patients to feel supported and have greater confidence in the process and that patients had indicated that they find the complaints process meaningful. Professor Thomson agreed with the importance of strengthening the link between the complaints department and PAS.

Mr Moore noted that it was good to see CCTV was used in the investigation of one complaint and asked for an update on the SAER which had been outstanding for a period of time, and which had also been raised through the complaints process. Ms Smith confirmed that this issue had been highlighted at the last CMT, and that she was linking with the Risk Team to establish the progress made. It was also noted that Ms Murphy would meet with the patient to establish how he would like the matter taken forward at this stage.

Ms Fallon asked if the learning from complaints was communicated to carers and patients. Ms Smith replied that, where appropriate, the learning was communicated and provided an example in terms of the recent complaints and feedback from carers around bringing food items for visits. PCIT had picked this up directly with carers around the revised protocol.

Ms Fallon thanked Ms Smith and her team for the report.

The Committee:

1. Noted the Learning from Complaints and Feedback Report Q3.

14 DISCUSSION ITEM – PEOPLE WITH LIVED EXPERIENCE

Professor Thomson informed members that consideration had been given around how to meaningfully engage People with Lived Experience (PLE) across the forensic estate and obtain their involvement with a view to improving service provision and quality.

Professor Thomson highlighted that the benefits of this engagement could be demonstrated locally as well as how this might be useful throughout the wider forensic estate. She explained that the presentation from Ms Kelly paper would cover the different levels of engagement, how PLE were currently engaged within Scotland and the future possibilities. She added that the paper had been previously submitted to the Forensic Network Advisory Board and the Scottish Government for discussion.

Ms Kelly joined the meeting and explained that work had been completed last year exploring the literature and how third sector agencies approach this area of work and consideration had been given around how to involve PLE within the School of Forensic Mental Health (SoFMH).

Ms Kelly led the committee through a presentation on 'People with Lived Experience' which aimed to provide a brief overview of approaches to engage PLE and what best practise in this area might look like as well as who could be considered PLE and that this may include a wider group than expected. She noted that the theme of co-production was prevalent within the research, and it would be useful to consider what this means in relation to this work area. Ms Kelly highlighted that there were different degrees of involving and empowering PLE and these stages were illustrated through a participation ladder diagram which illustrated the restrictions on PLE involvement within the initial stages. The importance of empowering and providing opportunities for PLE to design, lead and implement initiatives was highlighted and in order to have a meaningful impact on decision making, PLE required to be at the forefront of projects and ongoing work. Ms Kelly discussed the barriers to engagement as well as enablers that could be used to facilitate meaningful collaboration and avoiding situations which encouraged short term involvement. She highlighted the importance of creating dedicated space and time in order to build trust with PLE. Ms Kelly also noted that the SoFMH currently operated at the informing and consulting stages of the participation ladder and efforts were being made to improve this.

Ms Fallon thanked Ms Kelly for a thought-provoking presentation and invited comments.

Mr Currie thanked Ms Kelly and asked how expectations would be managed in relation to PLE expectations around the outcome from their input. He also asked how to verify that the PLE have the relevant experience and added that it was useful to be mindful of the wide circle of people who could be considered to be PLE.

Ms Raghavan reflected on an initiative within the Scottish Government where senior staff within a variety of services were brought to the community to speak to PLE. She noted that feedback was often very direct and agreed that managing expectations around what was achieved from the feedback was important and that it was also important for staff receiving the feedback to be receptive and positive.

Mr McConnell noted that the participation ladder was a helpful way of illustrating the stages and the progress expected and asked what the key barriers were stopping TSH from moving up the ladder and what key activities would enable progress.

Ms McCaffrey thanked Ms Kelly for the presentation and noted that significant groundwork was required to ensure robust governance. She noted the ways engagement had been supported at TSH and added that consideration should be given to what could be done internally and what support would be best sourced from other agencies.

Ms Fallon agreed with the points raised and asked how this piece of work could be cross-referenced with the Carer's Strategy and Realistic Medicine principles at TSH.

Ms Kelly clarified that other services would be at different stages across the forensic estate and added that the main barriers are resourcing and supporting PLE to enable meaningful contribution and manage expectations. She noted that in order to provide support staff require adequate training and there was a clear indication in terms of TSH striving to overcome these barriers through various means and highlighted the importance of supporting management to be receptive and utilise feedback appropriately.

Professor Thomson thanked Ms Kelly and clarified that TSH were at the informing and consulting level and emphasised the need to look at how to progress this piece of work involving the PCIT. She noted that during the design of the new clinical model, the PPG were consulted, though greater input could have been facilitated and added that it was important to be mindful not to create internal barriers.

Ms Fallon thanked everyone for contributions and suggested that it would be helpful for Ms Kelly to attend a future meeting once this work had progressed. She also noted that to achieve these goals, the wider team should be utilised in addition to the PCIT.

The Committee:

1. Discussed and noted the content of the presentation.

15 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

Mr Fallon invited members to highlight any areas of good practice along with any areas of concern.

Mr Currie highlighted an area of good practice in relation to the Complaints Officer attending the PPG to build trust and confidence as well as engagement with patients on a one-to-one level.

Ms Fallon highlighted the positive steps taken to embed infection control across the organisation.

Mr Moore noted patient Risk Assessments, and the impact on transfers due to information sharing issues may be an area of challenge; and he indicated that it would be helpful to have an update on this issue in due course.

Mr McConnell noted concern regarding spikes in the use of SRK's, seclusion and as required medication and that the constituent elements of these had been flagged via the report and indicated the utility of an update on these issues being provided to the Committee.

Professor Thomson informed members that work was being undertaken to look at the use of SRK's, seclusion and as required medication which would be brought to a future meeting of the Committee. Professor Thomson added that it would be helpful to bring a report to the committee in relation to learning from incidents and the use of CCTV and how these elements were progressing.

Action(s) – Secretariat /L Thomson /A Hardy

16 COMMITTEE WORKPLAN 2025

The Committee reviewed and agreed the workplan for 2025. Ms Fallon informed members that several items had been added to the workplan and that a report on Unscheduled Care would come to the next meeting and would ensure the various reports included information around BMI, KPIs, and that the Clinical Care Policy Review would come to the August meeting.

17 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Ms Fallon invited members to share any matters from other governance Committees. She informed members that Physical Health – Supporting Healthy Choices audit would be available at the next meeting for discussion after it had been submitted to the Audit and Risk Committee. She added that she would share matters relevant to the Staff Governance Committee with Ms Radage, such as recruitment, psychology, supplementary staff shifts not being fulfilled, potential of SRK increase on staffing, proactive recruitment practices, feedback on complaints and concerns around attempted assaults and the increase in incidents.

Action: add Physical Health internal audit to next CGC agenda

18 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

The Committee agreed that Unscheduled outings would be the topic for discussion at the next meeting. It noted possible future topics including patient activity, how to measure patient progress and outcomes, the triangle of care, unscheduled care and structured clinical care activity - which is scheduled for the November meeting. Ms Fallon asked members to consider and indicate any priority areas for future meetings to her going forward.

19 ANY OTHER BUSINESS

There was no other business raised at the meeting.

20 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 8 May 2025** at 09:30 hours via Microsoft Teams.

The meeting concluded at 1228 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 14
Author(s):	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 18 May 2025.

1	Clinical Governance Committee Annual Report	The Annual Report for the Committee was reviewed in detail, and there was agreement by Members that this represented an accurate assessment of the year, demonstrating the way in which the Committee had met its remit. It was agreed that the report should be submitted to the Audit and Risk Committee, for review. Subject to this the report would then be submitted to the Board.
2	Annual and 6 Monthly Reports: Supporting Healthy Choices (SHC) Medicines Committee	The Committee received a six-month update report from the SHC Group providing assurance on its activities, as well as its aims going forward. The approach is targeted and focused on areas to give longer term outcomes and benefits for patients. The Committee noted the positive progress made to date on the action plan, and welcomed the refreshed approach being taken. The Committee received the annual report for the Medicines Committee which offered strong assurance on the work of the committee, particularly on incident reporting, prescribing and HEPMA update.
3	Physical Health Audit	The Committee received an internal audit report relating to SHC aspects of patients' physical health, which had provided reasonable assurance in this area.
4	Unscheduled Care	Reporting was received on how unscheduled acute care for State Hospital (TSH) patients who require this is managed, and the established links with NHS Lanarkshire in this regard. The Committee reviewed the detail of this within the context of wider change within NHSScotland on flow navigation to ensure that TSH is exploring the opportunities arising. The Committee welcomes the report recommendations, and the continuous development approach, noting that the oversight through the Corproate Management Team, and that an update will return

		to the Committee.
5	Reporting on: Nurse Resourcing Q4 Daytime Confinement	Reporting summarised the nurse resourcing position for the past quarter, noting agreed changes in this area. Further reporting was provided on daytime confinement, and the targeted approach to eliminating this within TSH by October 2025. The Committee focused on this objective and agreed that refreshed reporting was required in this area given the context and the importance of this for the Board.
6	Infection Prevention and Control (IPC) Q4 Report	The Committee received reporting to present IPC activity under the headings outlined in the HIS Infection Prevention and Control Standards (2022). There was focused discussion on the implementation of audit work, and refresh of knowledge of the relevant standards. The Committee took positive assurance from this, as well as the work of the Infection Control Group in support of the Infection Control Committee.
7	Bed Capacity Report	This report provided data across patient admissions and transfers, patient flow within services in TSH as well as across the wider forensic estate.
8	Reporting on: Corporate Risk Register Incidents and Patient Restrictions Q4 Report	The Committee reviewed the clinical risks within the Corporate Risk Register and agreed that reporting represented an accurate statement of risk. Reporting provided the Committee with the Quarter 4 position on the types and numbers of incidents, including RIDDOR reporting and serious adverse events (SAERs) and patient restrictions during this period. There was agreement to review the content of reporting, in terms of the range of metrics presented, to ensure clarity on the key messages.
9	Learning from Adverse Events	Progress on actions were noted and considered, with good progress having been made in this area.
10	Learning from Complaints & Feedback Q4 Report	The Committee received reporting in relation to complaints and feedback, which highlighted the main issues raised, as well as the learning taken as a result. Positive progress was demonstrated on early resolution of complaints. The Committee also noted the work undertaken to engage with the Patient Partnership Group on ways to encourage feedback from patients about the complaint procedure.
11	Areas of good practice/concerns	Good practice was noted within unscheduled care as well as the Medicines Committee and the SHC 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 /	As part of corporate governance arrangements, to ensure committee business is reported timeously to the Board.
Corporate Objectives Please note which objective is linked to this paper	**Better Care:** 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. 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. **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.
Workforce Implications	There are no workforce impacts be considered.
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 in accordance with Standing Orders.
Risk Assessment (Outline any significant risks and associated mitigation)	None identified as part of reporting.
Assessment of Impact on Stakeholder Experience	No specific impacts
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.	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:	19 June 2025
Agenda Reference:	Item No:15
Sponsoring Director:	Committee Chair
Author(s):	Director of Workforce
Title of Report:	Annual Report 2024/25: Staff Governance Committee
Purpose of Report:	For Decision

1 SITUATION

The attached Staff Governance Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2024/25. This also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

3 ASSESSMENT

In the performance year 2024/25, The State Hospitals Board for Scotland's Staff Governance Committee has refocused our approach in the monitoring of activities in relation to SG standards, both in terms of assurance and also improvement and best practice.

The Committee members support the 'Prioritising Organisational Health' programme of work and this reinforces a commitment to a culture within The State Hospitals Board for Scotland in which the delivery of the staff governance standards is at the forefront to our approach, in terms of people management, staff engagement, learning and development and partnership working.

4 RECOMMENDATION

The Board is asked to note and agree the Staff Governance Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Reporting to demonstrate that committee has met its remit
Corporate Objectives Please note which objective is linked to this paper	**Better Value** 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. l. Ensure the continued delivery and development of the organisation's performance management framework.
Workforce Implications	No specific proposal to consider
Financial Implications	None identified
Route to Board Which groups were involved in contributing to the paper and recommendations.	Submitted for approval, as part of year end reporting.
Risk Assessment (Outline any significant risks and associated mitigation)	Not required
Assessment of Impact on Stakeholder Experience	Not required
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 impact 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

STAFF GOVERNANCE ANNUAL REPORT

1 April 2024 – 31 March 2025

1. Introduction

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'** The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

1. well informed;
2. appropriately trained and developed;
3. involved in decisions;
4. treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
5. provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2024/25, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership. Members of the Staff Governance Committee are appointed annually by the NHS Board. Membership details of the Committee during 2024/25 are detailed below.

2. Committee Chair, Committee Members and Attendees

Committee Chair:
Pam Radage (Chair of Committee, Non-Executive Director)

Committee Members:
Allan Connor (Employee Director)
Stuart Currie (Non-Executive Director)
Cathy Fallon (Non-Executive Director)
Shalinay Raghavan (Non-Executive Director)

In attendance:
Graeme Anderson (Organisational Development Manager)
Alan Blackwood (lay member, Prison Office Association)
Josephine Clark (Associate Director of Nursing)
Colin Cruickshank (POA Representative)
Sandra Dunlop (Head of Organisational Learning and Development)
Gary Jenkins (Chief Executive)
Stuart Lammie (Lead Nurse)
Carron McDiarmid (Non-Executive Director, Public Health Scotland)
Monica Merson (Head of Planning and Performance)
Brian Moore (Board Chair)
Richard Nelson (RCN Representative)
Laura Nisbet (Head of HR)
Margaret Smith (Head of Corporate Governance/Board Secretary)

Stephen Wallace (Director of Workforce)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing and presentations.

3. Meetings 1 April 2024 – 31 March 2025

During 2024/25 the Staff Governance Committee met on four occasions, in line with its terms of reference (Appendix 1). Meetings were held on:

16 May 2024
15 August 2024
21 November 2024
20 February 2025

Attendance of Committee members were as follows:

	Number of Meetings Present
Pam Radage	4
Allan Connor	4
Stuart Currie	3
Cathy Fallon	3
Shalinay Raghavan	2

4. Summary of Reporting

The Committee received reports and monitored areas as follows:

- Workforce (HR, Learning & Wellbeing & OD) Report:
  - Attendance Management
  - Recruitment
  - Employee Relations
  - Staffing Turnover
  - Job Evaluation
  - PDPR Compliance
- iMatter
- Workforce Planning
- Whistleblowing
- Statutory and Mandatory Training Compliance
- Fitness to Practice
- NHSScotland Staff Governance Standard Monitoring Framework
- Evaluation of the Staff & Volunteer Health and Wellbeing Strategy 2023/24
- OD Strategy
- Occupational Health
- Health and Care Safe Staffing
- eRostering
- Corporate Risk Register – Staff Governance Risks
- Workforce Equalities
- Once for Scotland
- Nursing Practice Development

4.1 ANNUAL REPORTS

Staff Governance Monitoring 2024/25

Due to the Staff Governance Monitoring exercise being paused for 2024/25 to facilitate a comprehensive tripartite review of the process, it was the expectation that Boards continue with their ongoing commitments and local assessment through their Staff Governance Committee.

The Scottish Workforce and Staff Governance (SWAG) Committee requested that Boards provide assurance that they are committed to upholding the Staff Governance Standard to support workforce and effective partnership working. They also requested board data on bullying and harassment, whistleblowing and data on retire and return.

The complete response was formally signed and submitted by the deadline of 6th December 2024.

iMatter

Members of the committee received an update on the results of the annual iMatter Staff Experience survey, which highlighted results from the 2024 Board iMatter report that was published in June 2024, together with the results from the national 2024 Health & Social Care Staff Experience Report, published in November 2024.

Occupational Health Service Annual Report 2023/24

The annual report was presented to the 15 August 2024 meeting and noted that the report contained a range of helpful information. The Committee asked for the approach to reporting to be re-framed to lend more focus on performance metrics as well as comparator data to other NHS Boards.

A revised KPI Framework was presented on 20th February 2025 as part of the agreement to extend the Service Level Agreement with NHS Dumfries & Galloway.

4.2 PROGRESS UPDATES

The committee received regular updated reports and monitored issues relating to the following:

- **Personal Development Planning & Review (PDPR)**

The Committee received and noted quarterly updates on Personal Development Planning & Review (PDPR) completion rates. The average monthly compliance rate for 2024/25 was 88.8%, an increase of 2.9% compared to the previous year. The updates provide assurance that staff have an annual review in line with the standards set out in the national PDPR PIN policy and the compliance rate at 31 March 2025 was 89.6%.

- **Attendance Management/Task and Finish Group**

The Committee received and noted the Sickness Absence Task and Finish Group Report presented by to the committee at the meeting on 16 May 2024. It was noted that the key objectives had been concluded as agreed; however, the 5% absence target had not been achieved. The plan was to now focus on making sure there was an embedded process within the business-as-usual framework. The committee agreed to the cessation of the Task and Finish Group and to return to a business-as-usual position.

- **HR Performance – Employee Relations Activity**

In November 2024, the committee received and noted the Workforce Paper which provided information in relation to the number and nature of current Employment Relations cases. An in-depth analysis of the timescales and actions associated with cases, which were beyond initial stages, included the dates initiated, investigation start and predicted end dates.

The committee were reassured that cases progress in accordance with the Once for Scotland policy framework and partnership working is extremely important to ensure that process' can progress in a professional, timely and compassionate manner, ensuring well-being for those involved. The report confirmed that in 24/25, 6 formal cases came to a conclusion, 5 within 6 months and one case took 11 months.

- **OD, Wellbeing and Learning**

The Committee received quarterly reports highlighting the key OD, learning and wellbeing initiatives and interventions being delivered to support and maintain a positive, supportive and enabling working environment in line with the Staff Governance Standards and the TSH Staff & Volunteer Wellbeing Strategy that was implemented in 2022.

Key achievements in 2024/25 included maintenance of high levels of compliance with statutory and mandatory training requirements, implementation of two new leadership development programmes for middle and senior leaders (delivered in collaboration with the West of Scotland Region NHS Boards), and delivery of a comprehensive programme of staff wellbeing interventions and support. The Peer Support Network was also expanded in 2024/25 and this internal support network is being well utilised by staff.

An internal assurance audit of statutory and mandatory training was by undertaken by RSM UK in October 2024 as part of the Board's 2024/25 internal audit plan. The purpose of the audit was to review the control framework for statutory and mandatory training across the State Hospital Board. The internal audit opinion was that the Board can take 'Reasonable Assurance' that the controls in place to manage this risk are suitably designed, consistently applied and effective. Recommendations for improvement that were highlighted within the audit have subsequently been actioned to ensure that the control framework is robust and fully effective in managing risks.

A detailed evaluation of the Staff & Volunteer Wellbeing Strategy was undertaken to review and assess the impact and effectiveness of the Wellbeing Strategy and associated wellbeing activities and interventions. Findings from the evaluation indicated a high level of staff satisfaction with the support provided by the organisation to support their health and wellbeing at work and insights gained from the evaluation have been used to identify key priorities and areas for future improvement in relation to wellbeing provision.

Work was also progressed in 2024/25 to develop an Organisation Development (OD) Strategy to support improvements in organisational performance and health, with the new OD Strategy planned for implementation in 2025/26.

4.3 STANDING ITEMS CONSIDERED BY THE COMMITTEE DURING THE YEAR

Fitness to Practise

The annual report was provided in May 2024 to assure the Staff Governance Committee that all professional staff were registered and fit to practise.

Whistleblowing Quarterly updates

The Committee received quarterly reports on the following dates:

16 May 2024	-	Quarter 4 Update on activity between 1 January 24 to 31 March 24
15 August 2023	-	Quarter 1 update for 2024
21 November 2024	-	Quarter 2 update for 2024
20 February 2025	-	Quarter 3 update for 2024

Notes of Minutes and updates from other meetings

The Committee received and noted minutes/reports from the following:

- Partnership Forum
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue)
- Workforce Governance Group

5. Areas of Best Practice

The following examples were provided throughout the year:

(i) The response following the cyber-attack on NHSD&G and the way this was managed in terms of communication with staff and holding a series of drop-in sessions to provide reassurance.

(ii) The work of the Task & Finish Group did on sickness absence and were now in a position to embed in the work that has been done which is a good role model for other task and finish groups.

(iii) The OD Strategy, which has taken an inclusive and engaging approach.

(iv) Development of the first-year support program to nursing staff.

(v) The Nursing Open Recruitment Day.

(vi) Engagement work as part of development of Medium-Term Plan

(vii) Reporting to the meeting which linked well across workstreams and showed 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.

(viii) Good practice in terms of openness and trust in terms of the Partnership Forum minutes.

(ix) The work undertaken by the working group involved in the planning of the Staff Excellence Awards.

(x) The work of the Estates team throughout the recent storm period noting the exceptional work carried out by the team.

(xi) The committee agreed that the concise nature of reporting and the pack of papers for this meeting had helped to support focused discussion, as an example of good governance.

6. Conclusion

The performance year 2024/25 has seen significant strides forward taken on a number of key Staff Governance issues, with the review of whistleblowing, the creation of the Workforce Equalities Group and the significant engagement and progress supporting the development of our Organisational Development Strategy.

Our focus will remain on ‘Prioritising Organisational Health’ which we anticipate will impact across all workforce and Staff Governance strands, along with the pursuit of the Attendance Management target of 5% absence, which has been challenging to see sustained improvement and the implementation of both our Workforce Plan 2025/28 and our Organisational Development Strategy. From the review of performance of the Staff Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Staff Governance arrangements were in place throughout the year.
I offer my thanks for the continuing support and encouragement of Committee members and to those members of staff who have worked on the Committee’s behalf during 2024/25.

Pam Radage
STAFF GOVERNANCE COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Staff Governance Committee

Appendix 1

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE
TERMS OF REFERENCE

1 PURPOSE

The Staff Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital.

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and at least three other Non Executive Board Members one of whom shall act as Chair.

The Committee can invite the Board Chair to be a member of the committee for the purposes of a meeting, should it be the case that the committee would otherwise be inquorate.

There will be three lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Director of Workforce shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least three clear working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Director of Workforce in conjunction with the Chair of the Staff Governance Committee.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and once approved, submitted at the next Board meeting. The Corporate Services Team are responsible for minute taking arrangements.

The minutes and action list of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

3.5 Other

In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 REMIT

4.1 Objectives

The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital; and that the principles of the national Staff Governance Standards are applied equitably and fairly to all staff.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 Systems and accountability

4.2.1 To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

4.2.2 To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.

4.2.3 To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

4.2.4 To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 People management

To provide assurance to the Board in respect of people management arrangements, that:

4.3.1 Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.

4.3.2 Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.

4.3.3 Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.

4.3.4 Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.5 Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.6 There is timely submission of all staff governance data required by the Scottish Government Health Department and in respect of the Local Delivery Plan.

4.3.7 Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.

4.3.8 Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.

4.3.9 Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

4.4.1 The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.

4.4.2 The planning and delivery of services has fully involved partnership working.

4.4.3 Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

4.4.4 Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that committee. The Remuneration Committee must include, as a minimum, three Non-Executive Directors of the Board. The Remuneration Committee will be a closed committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the Remuneration Committee: these can only be considered by Non-Executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Staff Governance Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

Reviewed June 2024

Paper No 25/54

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 16
Sponsoring Director:	Committee Chair
Author:	Director of Workforce
Title of Report:	Remuneration Committee Annual Report – 2024/25
Purpose of Report:	For Decision

1 SITUATION

The attached Remuneration Committee Annual Report outlines the workplan overseen by the committee during 2024/25.

2 BACKGROUND

Staff Governance is defined as 'a system of corporate accountability for the fair and effective management of all staff. The State Hospitals Board for Scotland's Remuneration Committee fulfils this remit with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

3 ASSESSMENT

In the performance year 2024/25, the Remuneration Committee continued to focus its monitoring activities in respect of the above responsibilities and provided reporting to the National Performance Monitoring Committee in this regard. The committee also considered the award of Consultant Discretionary Points.

4 RECOMMENDATION

The Board is asked asked to approve the Remuneration Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2024/25

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Reporting to demonstrate that committee has met its remit
Corporate Objectives Please note which objective is linked to this paper	**Better Value** 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. l. Ensure the continued delivery and development of the organisation's performance management framework.
Workforce Implications	None
Financial Implications	None Identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Remuneration Committee – agreed virtually Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for reporting
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 impact 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.

DRAFT

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2024 – 31 March 2025

1. Introduction

Staff Governance is defined as '**a system of corporate accountability for the fair and effective management of all staff**.'

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented.
In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2024/25, The State Hospitals Board for Scotland's Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

The NHS Board Vice-Chair remains Chair of the Committee which aligns with practice throughout NHS Scotland. This ensures that the committee chair does not play a role in the Executive and Senior Manager Appraisals process, avoiding potential conflict of interest

2. Committee Chair, Committee Members and Attendees

Committee Chair:
David McConnell (Chair of Committee, Non-Executive Director)

Committee Members:
Allan Connor (Employee Director)
Cathy Fallon (Non-Executive Director)
Brian Moore (Board Chair)
Pam Radage (Non-Executive Director)

In attendance:
Gary Jenkins (Chief Executive)
Stephen Wallace (Director of Workforce)
Margaret Smith (Head of Corporate Governance)

3. Meetings 1 April 2024 – 31 March 2025

During 2024/25 the Remuneration Committee met on four occasions, in line with its terms of reference (Appendix 1).

Meetings were held on:

- 13 June 2024
- 23 September 2024
- 28 November 2024
- 4 February 2025

Attendance of Committee members were as follows:

	Number of Meetings Present
David McConnell	4
Allan Connor	4
Cathy Fallon	1
Brian Moore	4
Pam Radage	4

4. Summary of Reporting

The Committee received reports and monitored areas as follows:

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2024-25.
- Agreement of the Appraisal outcomes 2023-24 for Executive Directors.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2024/25.
- Agreement of the Executive Directors Mid-Year Reviews for 2024/25
- Consultants discretionary points were reported on and approved.
- Agreement on new Consultant Discretionary Points Constituion.
- Agreement of the updated Director on Call arrangements.
- Agreement of the change in responsibility to the payment of non-executive expenses.

The Remuneration Committee also reviewed other issues related to its remit. They received an update of national and regional group involvement.

During this year the committee considered and supported interim arrangements to Executive and Senior Management positions in the organisation to ensure resilience in the Executive Team.

5. Areas of Best Practice

New constitution for Consultant Discretionary Points provides clear process, ensuring delineation of roles for Non Executives and removing any conflict of interests.

Greater control and process around the appraisal process for Senior & Executive staff.

6. Conclusion

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers' performance management and remuneration.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2024/25**.**

David McConnell
REMUNERATION COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit and Risk Governance Committee

Appendix 1

THE STATE HOSPITALS BOARD FOR SCOTLAND
REMUNERATION COMMITTEE

TERMS OF REFERENCE

1 The Committee shall be known as the Remuneration Committee of The State Hospitals Board for Scotland. It will be a standing Committee of The State Hospitals Board for Scotland and will make decisions on behalf of The State Hospitals Board for Scotland.

COMPOSITION

2 The Remuneration Committee members will be appointed by The State Hospitals Board for Scotland and will consist of:

- The Vice-Chair of The State Hospitals Board for Scotland, who will be the Committee Chair
- Four Non-Executive Directors of the Board, including the Employee Director and the Board Chair.

In addition, there will be in attendance (in full or part):

- Chief Executive
- Director of Workforce
- Head of Corporate Governance/Board Secretary

No employee of the Board shall be present when any issue relating to their employment is being discussed.

3 The Director of Workforce will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor.

Executive Director Lead

Generally, the designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference.

Specifically, they will:

- support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;

- liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;

- oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;

- agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Workplan;

- oversee the production of an Annual Report, informed by self-assessment of performance against the Remuneration Committee Self-Assessment Handbook, on the delivery of the Committee's Remit and Workplan for endorsement by the Committee and submission to the Board.

4 Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance and Performance Management Director may be invited to attend meetings of the Remuneration Committee.

5 The quorum for the Remuneration Committee will be attendance by 3 Non-Executive Directors, inclusive of the Chair.

FUNCTIONS

6 To oversee and agree the remuneration arrangements and terms and conditions of employment of Executive Directors and Senior Managers of The State Hospitals Board for Scotland, to include:

- content and format of job descriptions
- terms of employment including tenure
- remuneration
- benefits including pension or superannuation arrangements
- annual salary review

7 To ensure arrangements are in place for the assessment of the performance of The State Hospitals Board for Scotland and to monitor the performance of The State Hospitals Board for Scotland against pre-determined performance criteria to inform oversight of objective setting and support for decisions on individual performance appraisal.

8 To agree The State Hospitals Board for Scotland's arrangements for performance management and to ensure that the performance of the Executive Directors is rigorously assessed against agreed objectives within the terms of the performance management arrangements referred to above.

9 To ensure that clear objectives are established for Executive Directors of The State Hospitals Board for Scotland before the start of the year in which performance is assessed by

- receiving a report from the Chair on the agreed Objectives for the Chief Executive
- receiving a report from the Chief Executive on the agreed Objectives for the other Executive Directors of the Board.

10 To monitor arrangements for the pay and conditions of service of other Senior Managers on Executive Pay arrangements and on Professional/Management Transitional pay arrangements in accordance with appropriate guidance and to implement annual pay uplifts and pay progression in accordance with national guidance.

11 To approve The State Hospitals Board for Scotland's arrangements for the grading of Senior Manager and Executive Director posts and to oversee these arrangements by receiving regular reports from the Director of Workforce.

12 To ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for staff employed under the Executive and Senior Management Pay arrangements. To receive formal reports (at least annually) providing evidence of the effective operation of these arrangements.

13 To consider any redundancy, early retiral or termination arrangement in respect of all State Hospital staff, excluding early retirals on grounds of ill health, and approve these or refer to the Board as the Committee sees fit. In addition, the Committee will oversee the award of discretionary points to medical staff.

14 To fulfil its functions, the Remuneration Committee will take into account a range of factors which will include

- regular reports from the Director of Workforce
- the Remuneration Committee Self-Assessment Handbook
- guidance issued by the Scottish Government Health Department
- an annual report on the application of pay awards and pay movements
- the need to recruit and retain appropriately qualified and skilled Directors and Senior Managers
- equitable pay and benefits for the level of work performed

CONDUCT OF BUSINESS

15 Meetings of the Committee will be called by the Chair of the Committee with items of business circulated to members one week before the date of the meeting.

16 The Committee will seek specialist guidance and advice as appropriate.

17 All business of the Committee will be conducted in strict confidence.

REGULARITY OF MEETINGS

18 Meetings of the Remuneration Committee will be held as necessary to conduct its business. At a minimum, the Committee should meet twice per annum, once to approve the performance assessments and annual Objectives of the Executive Directors and once to approve the annual application of pay awards and pay progression.

REPORTING ARRANGEMENTS

19 The Remuneration Committee will report to the Board.

Membership of the Remuneration Committee will be reported to and agreed by the Board. Appropriate details of Executive Members remuneration will be published in The State Hospitals Board for Scotland's Annual Report.

Annual Report

In accordance with Board and Committee Working, the Committee will submit to the Board each year an Annual Report, encompassing : the name of the Committee; the Committee Chair; members; the Executive Lead and officer supports / attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee.

Where the review by the Committee of its Terms of Reference results in amendment the revised Terms of Reference must be submitted to the Board for approval. The Committee Annual Report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Statement of Internal Control.

20 Details of the business conducted by the Committee will be made available to the Scottish Government Health Department, the form and content being determined by the latter.

21 Reporting, marked as 'official sensitive', on each meeting of the Remuneration Committee will be issued to the Non-Executive Directors of the Board.

Paper No. 25/55

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Workforce
Author(s):	Head of OD & Learning Organisational Development Manager Organisational Development, Learning & Wellbeing Advisor
Title of Report:	Organisational Development and Wellbeing Strategy
Purpose of Report:	For Decision

1 SITUATION

This paper presents the 3 year Organisational Development (OD) Strategy for The State Hospital, which will align with Board's Workforce Plan and to the Board's Medium Term Plan.

2 BACKGROUND

The State Hospital committed to the review and development of a robust Organisational Development Strategy, which focuses on our workforce, our culture and our organization as a whole.

Throughout 2024 and early 2025, we engaged with over half of our staff to understand the current state of organisational health and the challenges we face. In response, we have developed a structured strategy rooted in the OD cycle and supported by global best practices (e.g., McKinsey's model). It focuses on three strategic priorities: Direction, Leadership and Management, and Working Environment, and commits to a three-year cultural and systemic transformation programme.

3 ASSESSMENT

Our Organisational Development (OD) Strategy is designed to address the three key issues (Working Environment, Leadership and Direction) over the next three years, marking a shift from a reactive to a proactive approach in enhancing organisational health and performance.

The new strategy presents a clear opportunity to shift towards a preventive, evidence-informed, and participative culture. This strategy is intended to significantly improve staff well-being, retention, engagement, and patient safety if implemented effectively. The potential benefits of the new strategy should inspire optimism, but will require the change to be led effectively and inclusively across all levels.

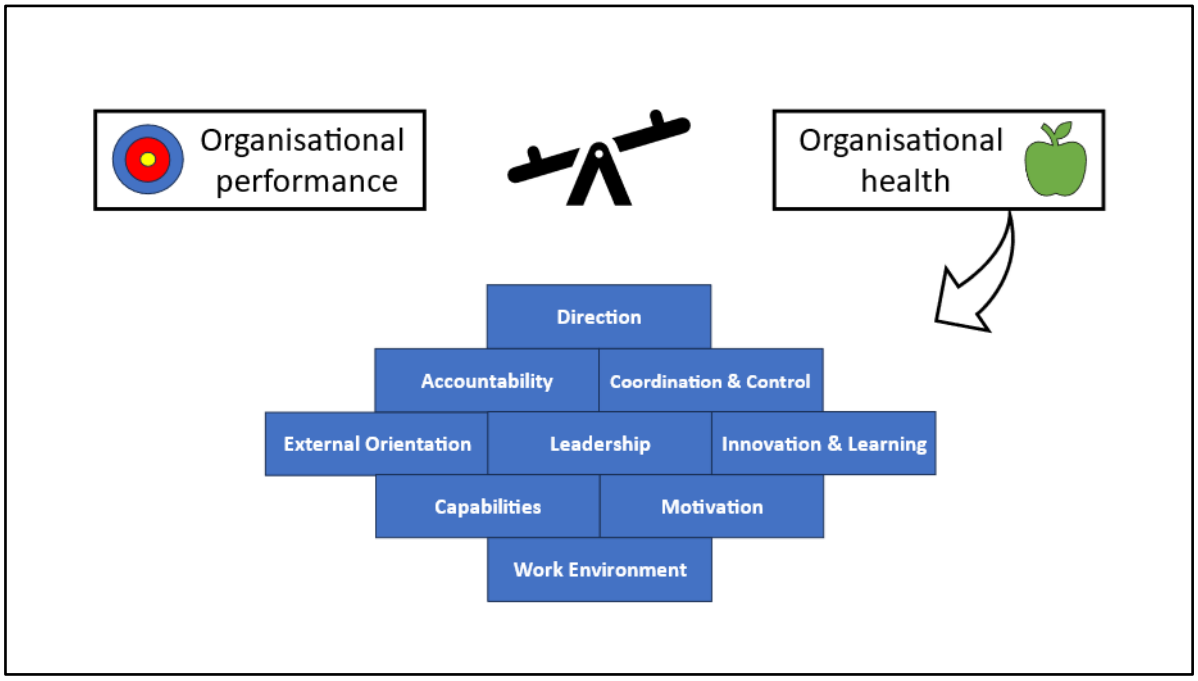
4 RECOMMENDATION

The committee is asked to endorse the following recommendations:

1. Approve the 3 year Organisational Development Strategy as presented.
2. Provide executive support for the proactive implementation of the three-year plan and its three priorities.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Staff Governance, Health & Wellbeing of all Staff.
Corporate Objectives Please note which objective is linked to this paper	4. Better Workforce f. Develop and implement the Organisational Development Strategy, and action plan, using Organistional Health approach.
Workforce Implications	Positive measure in support of Staff Governance Standards.
Financial Implications	The cost of poor organisational health leads to staff absences, poor productivity, retention and recruitment costs.
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)	As outlined in the Strategy itself
Assessment of Impact on Stakeholder Experience	Provide staff with a healthier organisation using best practices and an evidence-based approach.
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.	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 Hospital

Organisational Development (OD) Strategy

2025 to 2028

Developing a healthy and effective organisation

CONTENTS

SECTION 1: INTRODUCTION/ENTRY

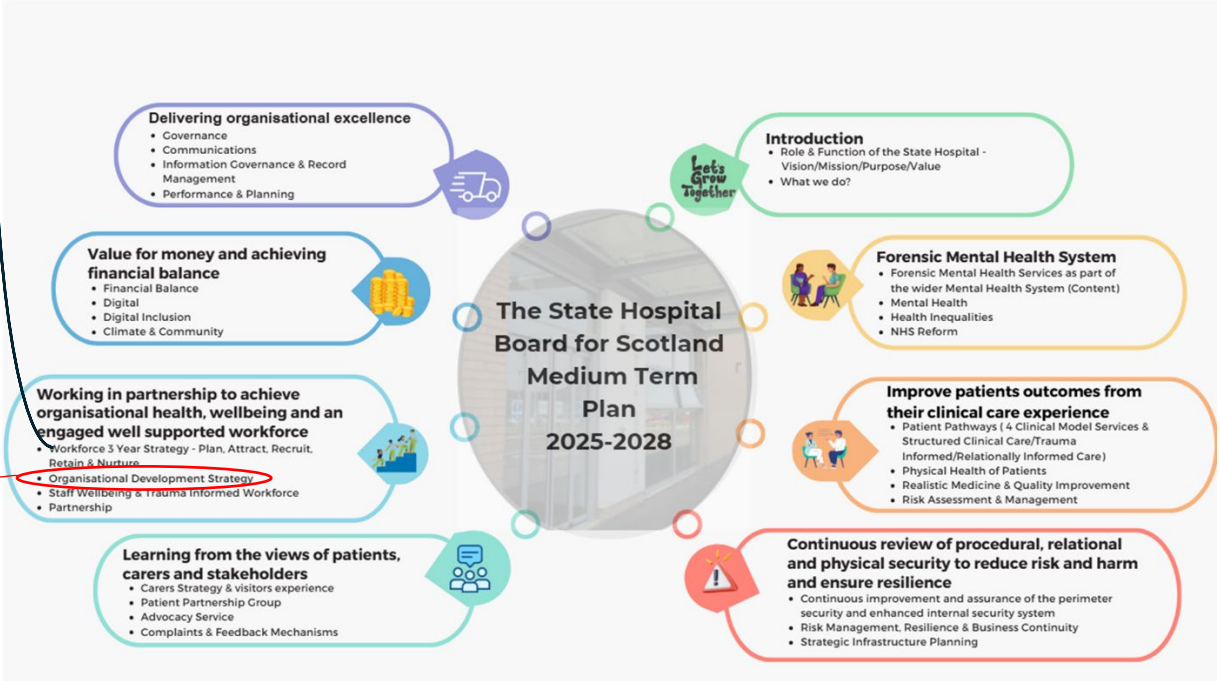
The State Hospital (TSH) has developed a Medium-Term Plan (MTP) for 2025-28, with the purpose of guiding our efforts towards achieving the critical success factors (see image below) essential for realising TSH's vision:

> *To be a leader in delivering relationally informed, person-centred, high-secure mental health care that enables recovery whilst ensuring the safety and well-being of staff, patients, and the public.*

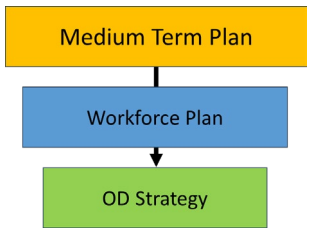
One of these critical success factors is:

> *Working in partnership to prioritise organisational health, support staff wellbeing and develop an engaged, sustainable workforce.*

This critical success factor, overseen by the workforce directorate, is a key area of focus. The subsequent Workforce Plan 2025-28 is organised around five Workforce Planning pillars that form the basis for actions to ensure a sufficient workforce to support recovery, growth, and transformation. These pillars are Plan, Attract, Train, Employ, and Nurture.



The Organisational Development (OD) Strategy 2025-28 is a pivotal part of the broader Workforce Plan, enhancing our prospects for success in the medium-term future of TSH. This document will elaborate on the role, vision, current position, and strategy of Organisational Development, underscoring its crucial role in prioritising organisational health and improving performance.



What is Organisational Development (OD)?

Currently, Organisational Development is not a well-understood field within TSH.
So, what is it?

> *OD is about building and maintaining the health of the organisation as a total system (Schein 1988).*

Below is a grid for easy reference that defines OD and its core characteristics:

What	OD is a field of applied behavioural science that expands our understanding of human and group behaviour. Such knowledge also guides and steers our work in developing organisational effectiveness by improving performance and internal health, especially during a time of change.
How	Using group and human dynamic processes from applied behavioural science research, theories and methods to facilitate self-organising movement of groups and organisations.
Outcome	Dual goals: 1. to improve the organisation's effectiveness (performance) that benefits the constituents of the organisation. 2. maintaining the health of the organisation and supporting the people who work within the system in a sustainable way.
Focus	Total system (alignment and interface between parts)
Role	Third-party role – to help support the system in doing their own work
Target	The human system within the social system
Source of Knowledge	1. Scientific Literature - *Empirical Studies* 2. The Organisation - *Internal Data* 3. Stakeholders - *Priorities and Concerns* 4. Expert Practitioners - *Specialists who apply behavioural science disciplines, including sociology, psychology, anthropology, management studies, organisational behaviour, and behavioural economics*.
Values	1. Respect for human differences. 2. Commitment to social justice and equity. 3. Belief in lifelong learning.

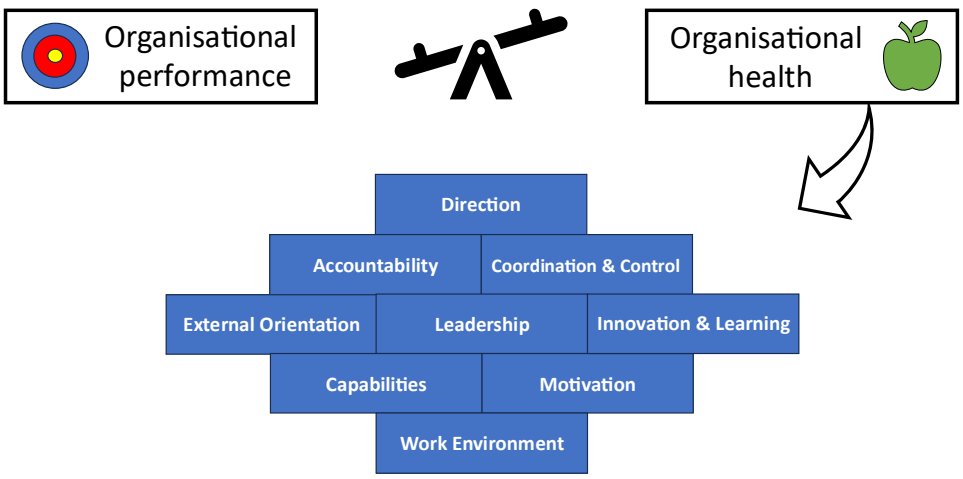
Relating the above to The State Hospital, specifically:

Our OD **purpose** (why we exist):	To maintain and develop the organisation's performance and health.
Our OD **vision** (where we aspire to be)	The State Hospital is Scotland's healthiest and most productive NHS board.
Our dual **goals**:	Dual goals: 1. to improve the organisation's effectiveness (performance) that benefits the constituents of the organisation. 2. maintaining the health of the organisation and supporting the people who work within the system in a sustainable way.

Our Model for Organisational Health and Performance

In 2003, McKinsey consultants began to take an interest in organisational health. They designed an organisational health index to encourage leaders to take an interest in the internal state of health of the organisations they advised. They believe any leaders interested in performance must also pay equal attention to their organisation's internal health, as it will impact performance. Their concern came in a timely fashion as there was a greater and greater drive for performance, almost at any cost. The burn-out rate was high regardless of what employee engagement activities were taking place.

Between then and 2025, 22 years on, employees and managers have supported over 2,000 companies across over 100 countries. Data began accumulating as consulting teams from different regional offices worldwide used the model with their clients. By 2024, the database had over 1 billion data points, and from these data points, McKinsey had identified nine key organisational dimensions or outcomes, together with 43 management practices (see images below).



Practices are behaviours – 'what people see' – driving outcomes

43 management practices (this is causation, not correlative)

Accountability
- Role Clarity*
- Consequence Management
- Performance Goals
- Feedback
- Personal Ownership*

Direction
- Shared vision
- Strategic Clarity*
- Common Purpose

Coordination & Control
- People Performance Review
- Operational Management
- Financial Management
- Risk Management
- Operationally disciplined
- Employee conduct

External Orientation
- Customer Orientation
- Competitive Insights*
- Business Partnerships
- Social Responsibility
- Government and Industry relations

Leadership
- Decisive Leadership
- Consultative Leadership
- Empowering Leadership
- Supportive Leadership
- Challenge Leadership

Innovation & Learning
- Top-Down Innovation
- Employee Innovation
- Knowledge sharing
- Data-driven decision making
- Capturing External Ideas

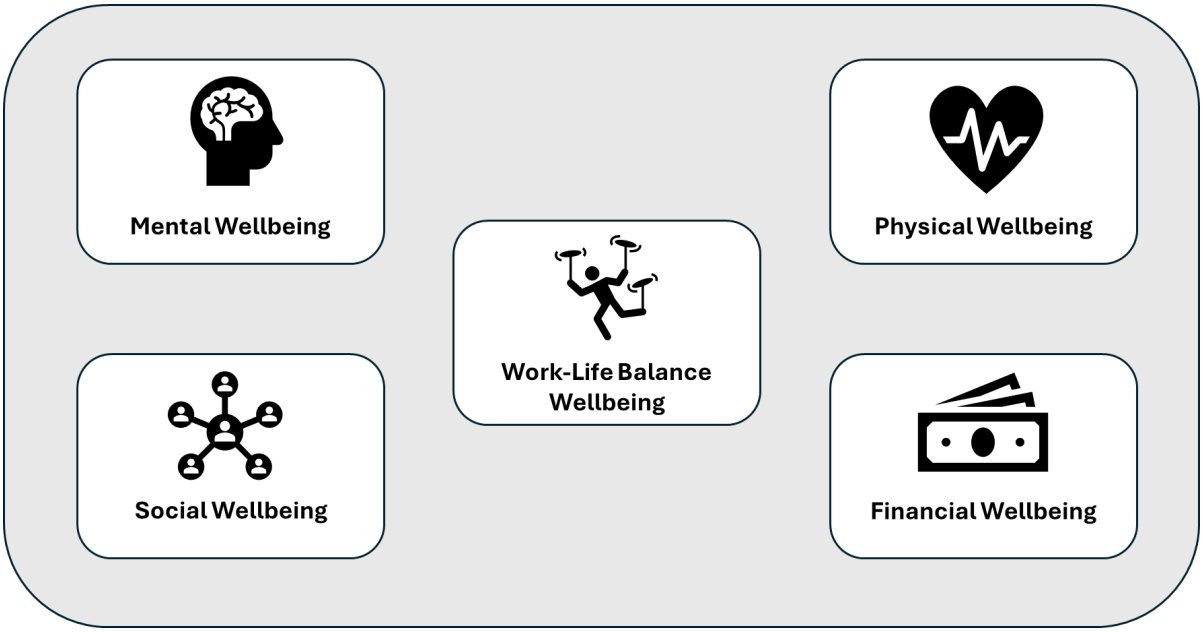
Capabilities
- Process-based capabilities
- Talent Acquisition
- Talent Development
- Talent Deployment
- Tech Enablement

Work Environment
- Open and trusting
- Performance Transparency
- Inclusion and Belonging
- Healthy working norms

Motivation
- Meaningful values
- Inspirational leaders
- Financial Incentives
- Reward & recognition
- Career Opportunities

Our Well-being Pillars

Our Organisational Development strategy will also incorporate wellbeing into the overall approach as recommended in the 2024 Wellbeing Evaluation. Our pillars are divided into five. The action planning section later in this document will outline our commitments for each of these pillars.



Our method for OD will be based on the OD cycle of work:

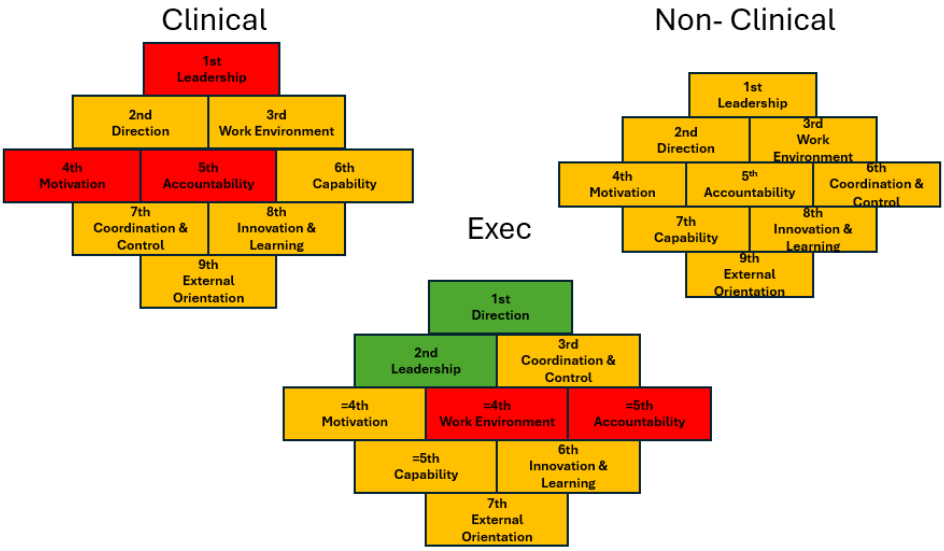
The OD cycle, which shows the key phases of work, is a dynamic process that requires continuous adaptation through various iterations as processes and relationships evolve.

The OD cycle, which will serve as the backbone of this strategy document, is instrumental in demonstrating how the diagnostic work undertaken in 2024/25 has led to the strategy outlined later in this document.

SECTION 2: DATA COLLECTION & DATA ANALYSIS

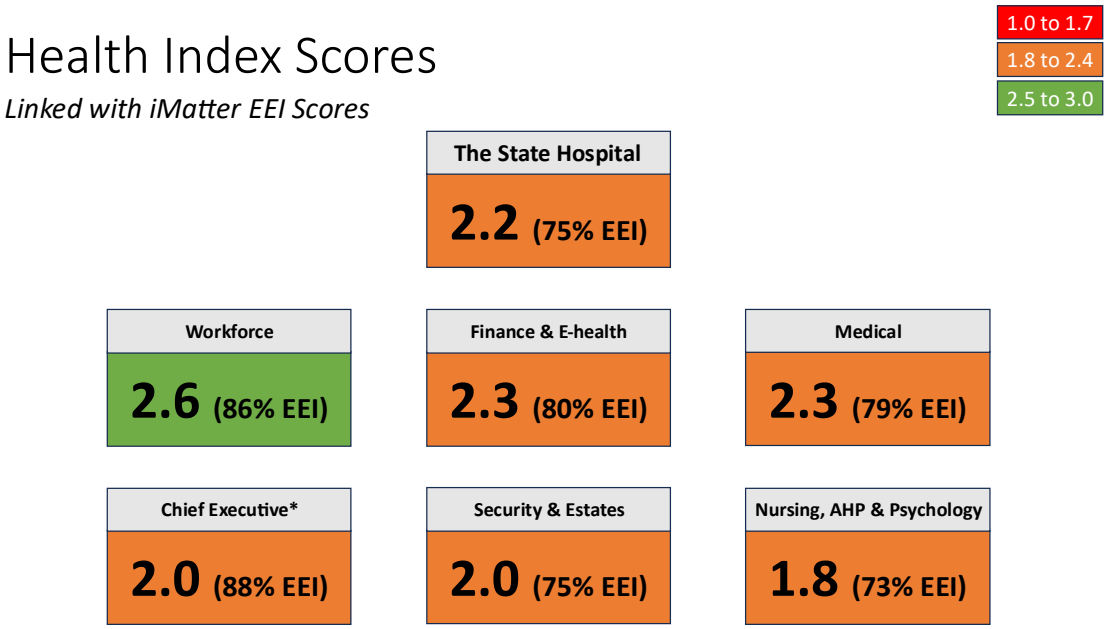
In 2024/25, the executive team's clear commission to understand the current organisational health and engage teams in over 40 face-to-face sessions involving more than 400 staff was pivotal in shaping our understanding of the organisation's health.

To remind you of the exercise completed, we asked each team to prioritise the nine dimensions and use an RAG system: Red, Amber, and Green. Red indicates areas needing immediate attention, Amber indicates areas with potential issues, and Green indicates areas performing well. The results below tell us how effective we are at each dimension.

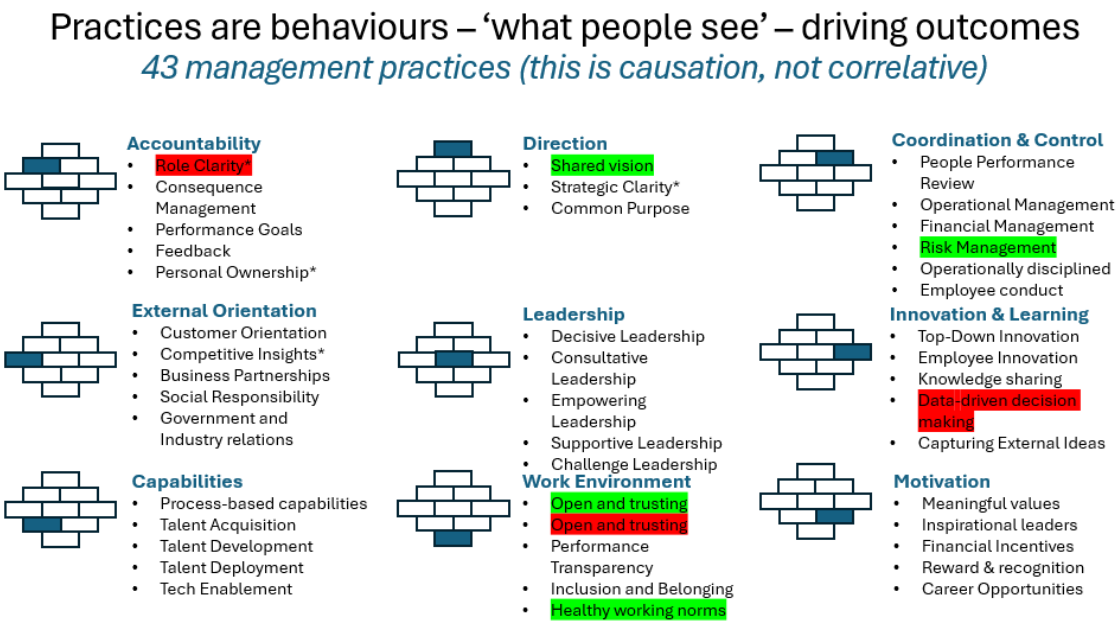


The data above reveals differing perceptions across the groups. There are similarities in the data. For instance, leadership and direction are the top priorities for all three groups, and innovation & learning and external orientation are the bottom two. You can also see the differences in the colour distribution and how different this looks across the groups. This data gives us a benchmark of where we are now, but will help us understand where we need to improve and allow us to get targeted and focused on how we make positive and sustainable change.

The image below breaks the data down further into our six directorates and shows each health index. This broadly correlates with the Employee Experience Index (EEI) within our iMatter results in 2024. It indicates that the Workforce Directorate has the highest health index and EEI and that the Security & Estates and Nursing directorates have the lowest health index scores and EEI scores.



Change begins with awareness. Without awareness, there can be no change. That's why we also worked with our Head of Corporate Planning, Performance and Quality as part of the broader Medium-Term Plan to dive deeper into the management practices that underpin the nine dimensions of health above to understand precisely what practices are broken and what practices, if we got them right, would make the most significant impact on our organisational performance. The results showed us...



Alongside identifying our health outcomes and management practices, as shown above, we also reviewed and evaluated our Well-being Strategy 2021 to 2024 and understood our staff's current state of well-being. Below is a summary, conclusion and recommendations from that report:

Summary and conclusions

What do we do, well?

- Our well-being centre is a shining example, with its comprehensive facilities and beneficial activities, it is a source of pride for our organisation.
- The high level of awareness and effective messaging about our Wellbeing offering ensures that our staff are well-informed and engaged.
- Our current well-being offering is comprehensive and well-regarded by staff, providing a sense of security and care.
- Staff have positive experiences when they engage with well-being offerings.
- Line manager support has improved significantly from the previous report, which is crucial in promoting a positive well-being culture.

What could we do better?

- Accessibility and system-level factors are adversely impacting our staff's well-being. This is our biggest challenge, and addressing it will have a longer-lasting and more sustainable impact.
- Although line manager support has improved, as shown above, this is not the case for everyone, and continued emphasis on management development is crucial. Line managers, in turn, require training, resources, and flexibility to support their teams, and leaders at all levels should be supported to create a healthier organisation.
- Poor mental health is on the increase, and prioritisation of mental health support is required.

The Way Forward

Although the findings from this evaluation provide evidence that many elements of the well-being strategy are working effectively and showing positive returns, further work still needs to be done. It is important to maintain this momentum by affirming our commitment to the health and well-being of our staff through ongoing resourcing of the Wellbeing Centre and associated operational costs.

Our focus on Organisational Development will facilitate more of a focus on the fundamentals in terms of a positive culture, energising environment, effective managers and strong working relationships.

The evaluation highlights very clearly that well-being is supported by feeling safe and secure, but equally staffing levels, shift patterns, more flexible working, compassionate and supportive leadership, strong sense of team, etc) were mentioned as key issues in creating the optimum conditions to enable staff to benefit more fully from the wellbeing activities and support provided and to achieve longer-term and sustainable improvements in workforce wellbeing and health.

The findings have also highlighted that wellbeing needs and issues are not identical across all staff groups, and different groups require different things. A more tailored and bespoke approach is therefore required to meet the needs of different groups and to address the issues and challenges highlighted within this report.

RECOMMENDATIONS

1. The State Hospital should continue with our efforts and affirm our commitment to the health and well-being of our staff through ongoing resourcing of the Wellbeing Centre and associated operational costs.

2. Directorates, with support from the workforce team, should develop bespoke directorate wellbeing action plans to address the specific needs of their staff (including taking action where required to remove barriers to access and facilitate staff engagement and participation in wellbeing activities and events).

3. Senior leaders should drive action to tackle the broader system-level factors impacting employee wellbeing and maximise opportunities (e.g., implementing the reduced working week, shift patterns, etc.) to ensure optimum conditions to support positive well-being and health.

4. Continued emphasis on management development to equip our managers with the knowledge, tools and skills to effectively support individuals and teams, including mandatory attendance at the 'Mentally Healthy Workplace Training for Leaders and Managers'.

5. Integration of the Wellbeing Strategy into the broader OD strategy, which aims to improve, maintain and develop the organisation's health and effectiveness, and development of clear performance metrics to support the ongoing monitoring of employee wellbeing and to measure the impact of future interventions to support improvements in wellbeing and mental health.

Comparing all the above from the nine dimensions, management practices, iMatter EEI scores and the summary, conclusions and recommendations from the Well-being evaluation. It remains clear that the health of the organisation needs to improve. The rest of this document will outline the health improvement programme the organisation will look to implement to improve the health and performance of the organisation.

SECTION 3: ACTION PLANNING

As indicated in Recommendation 5 of the Wellbeing evaluation regarding incorporating wellbeing into the broader OD strategy, this is where we begin. The diagram below illustrates our connected health and well-being services.

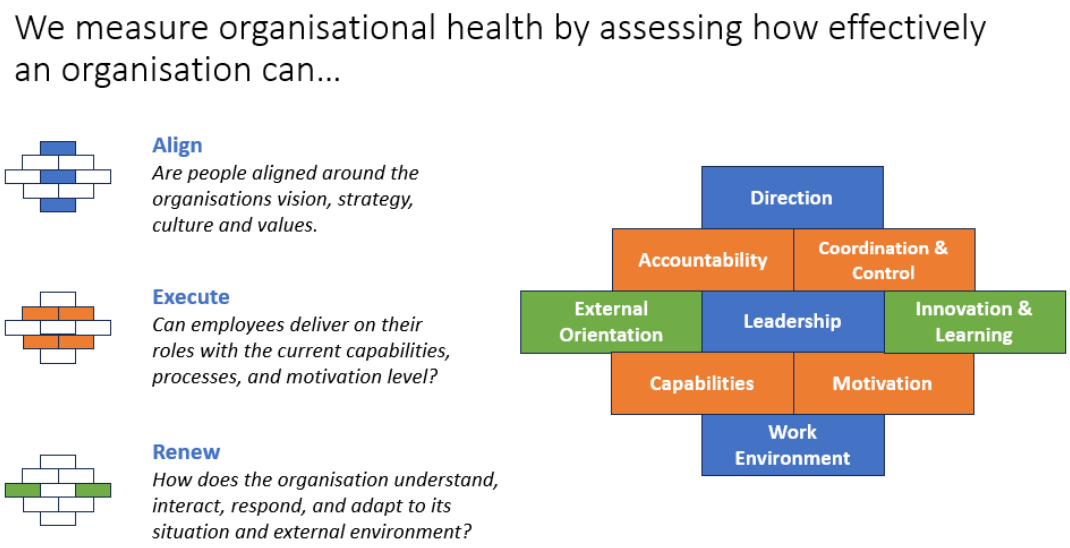
The diagram is an infinity loop representing the interconnectedness of health and well-being. Our strategy aims to rebalance the focus between wellbeing (Focus 2), which mainly addresses issues after they arise, and a more preventative approach that ensures the organisation adopts a proactive stance towards enhancing health outcomes (Focus 1).

The diagram also depicts the three organisational priorities:

1. **Direction**: A clear sense of the organisation's direction and how it will get there that is meaningful to all employees.
2. **Leadership**: The extent to which leaders inspire actions by others.
3. **Working Environment**: The shared beliefs and quality of interactions within and across organisational functions.

The organisation selected these in the diagnostic work we completed last year, as shown in the Data Collection & Analysis section. This is crucial as the best health improvement plans are based on the organisation's priorities and concerns.

Coincidentally, these priorities selected by the organisation also align with the scientific literature, which states that improving organisational health begins with ensuring alignment with the organisation's vision, strategy, culture, and values.



Although we have identified our three organisational priorities, which have been selected by the organisation and fully personalised to us, it would make sense to also engage with the McKinsey data. McKinsey has identified three particular “health recipes” that have revealed the primary variables and accelerants of organisational health. The three recipes are leadership factory, continuous improvement engine, talent, and knowledge core.

Organisational health recipes	**The focus of the recipe**
Leadership factory	Developing and deploying strong leaders at all levels
Continuous improvement engine	Involving all employees in the drive for performance and innovation
Talent and knowledge core	Attracting and inspiring top talent

Linking these three health recipes to our three organisational priorities is essential. One of our organisational priorities, Leadership, is clearly connected to the ‘Leadership Factory health recipe’. However, the other ‘two health recipes’ must be integrated into our broader organisational priorities. In other words, we must ensure that our recruitment plan and drive for continuous improvement are incorporated into our broader objectives.

This strategy will also align with national frameworks throughout NHS Scotland. As showcased in this document, our organisational priorities of Direction, Leadership, and Working Environment, alongside Wellbeing support, align closely with the national frameworks below. This creates consistency, validity, and a clear pathway for action and change.

HIS's Quality Management System

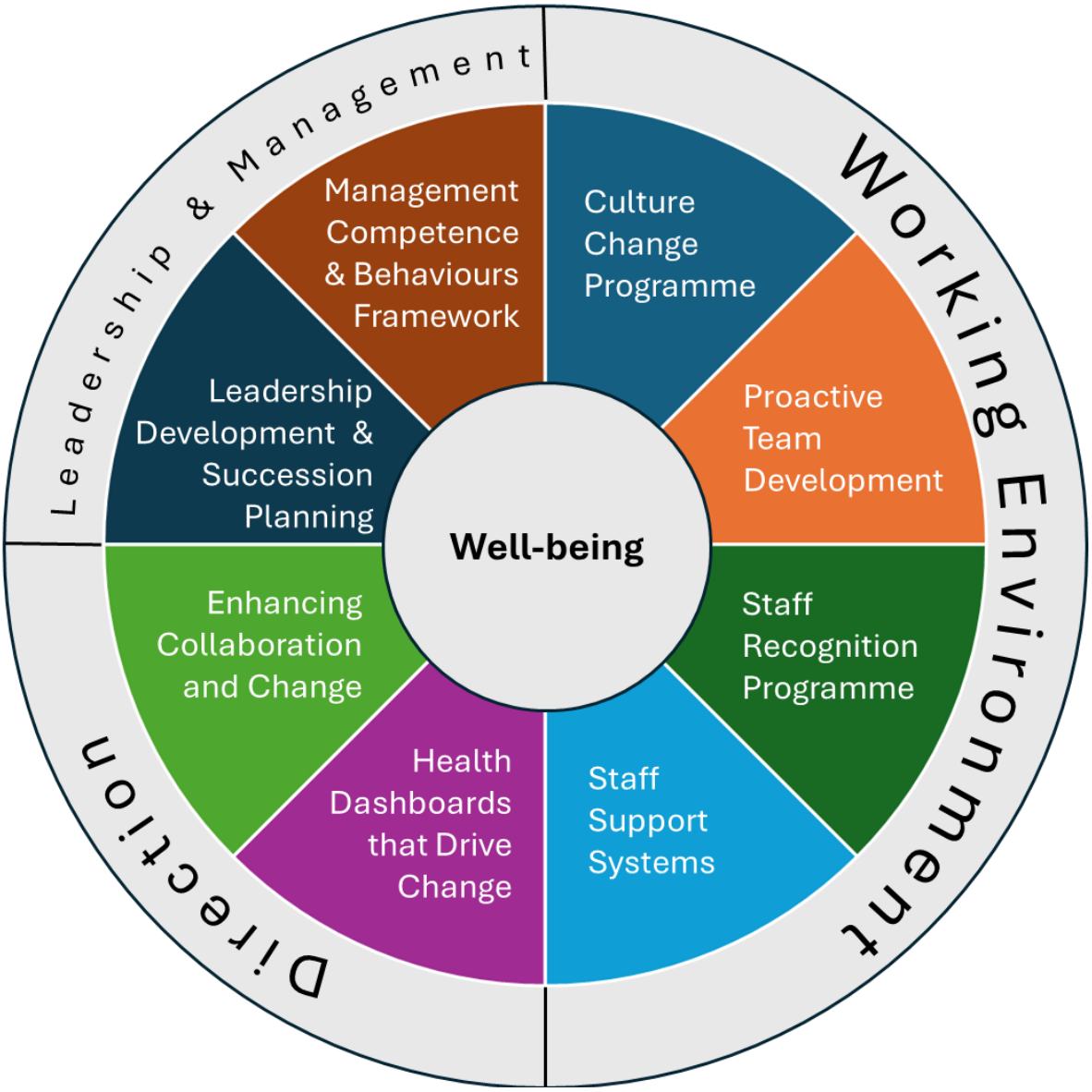
The QMS framework defines quality assurance as the independent verification of a system's ability to reliably deliver high-quality care.

Excellence in Care

The framework document supports staff with the principles of Excellence in Care. It is research-led and consists of 16 key elements. The framework explains how the elements work together to deliver high-quality care.

The Excellence in Care framework has been co-developed with a range of stakeholders. It considers other strategic and improvement priorities within the system.

What will we do to improve the health of each of these three priority dimensions?



The above outlines our three organisational priorities around the outside, and the coloured segments articulate our commitments to improving the health of each of the three priorities. The inner circle, titled "Well-being," is broken down into Physical, Mental, Social, Work-Life balance and Financial well-being.

Below are links to our strategic priorities, commitments and success metrics. These are high-level, measurable, and meaningful across the 3-year timeframe. They are a bridge step that can strengthen the transition from our strategic intent (priorities and commitments) to operational execution (action plans). They will help us assess whether the priority is making a difference, beyond individual commitments and actions. There is also a breakdown of the pledges for the well-being support offering.

WORKING ENVIRONMENT

Create a psychologically safe, inclusive, and supportive workplace.

Commitments

Culture Change Programme

Embed a positive, values driven cuiture through an inclusive programme that enhances psychological safety

Proactive Team Development

Build high-performing teams via continuous development, collaboration, and shared purpose

Staff Recognition Programme

Foster appreciation through meaningful recognition that strengthens morale and values

Staff Support Systems

Enhance well-being support, access to resources, and timeely assistance to improve staff experience

Success Metrics

- iMatter EEI score improves year-on-year (eg.. 5% annually)
- 80% of staff report feeling psychologically safe in culture survey
- Reduction in staff absence due to stress or burnout
- 70% of teams participate in structured development
- Recognition rates (number of staff recognized formally/informally)

DIRECTION

Ensure clear, shared direction and data-informed decision-making.

COMMITMENTS

DIRECTION, COLLABORATION & CHANGE

Strengthen shared direction and collaborative working across Directorates and teams, enabling joined-up approaches to change and improvement

HEALTH DASHBOARDS THAT DRIVE CHANGE

Use health dashboards proactively to inform decision-making, highlight trends, support early intervention, and drive meaningful improvements in outcomes and experience

SUCCESS METRICS

- 80% of teams use the health dashboards inplanning or review meetings
- Number of improvements/actions triggered by dashboard insights
- Staff understanding of organisational priorities (via pulse surveys)
- Number of cross-team or cross-organisation collaborations launched
- Uptake in change/improvement programmes across services

LEADERSHIP AND MANAGEMENT

Develop confident, capable leaders and mangers.

COMMITMENTS

LEADERSHIP & SUCCESSION PATHWAY

Invest in leadership development at all. levels while buiiding a transparent and inclusive succession pipeline, ensuring a resilient, confident, and futu-ready leadership workforce

MANAGEMENT COMPETENCE & BEHAVIOURS

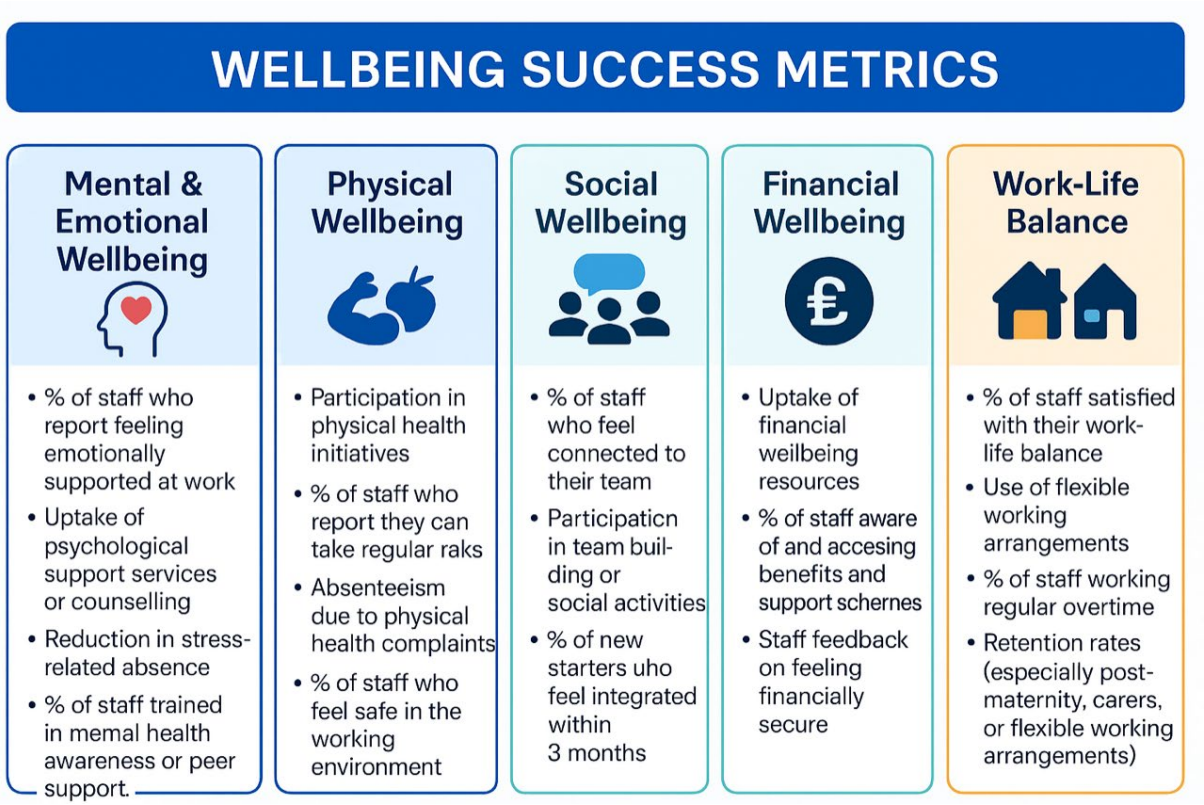
Define, develop and embed a clear management competence and behaviours frarnework that promotes consistency, supports accountability, and aligns with organisational values

SUCCESS METRICS

- 100 % of managers trained in the core competencies and behaviours framework.
- Increase in internal promotions into leadership roles.
- Succession coverage for key leadership posts (e.g. 28 °°0% roles with a named successor).
- Leadership diversity (e.g. % from underrepresented groups).
- Staff confidence in leadership increases in iMatter.

Our Wellbeing Pillars & Success Metrics

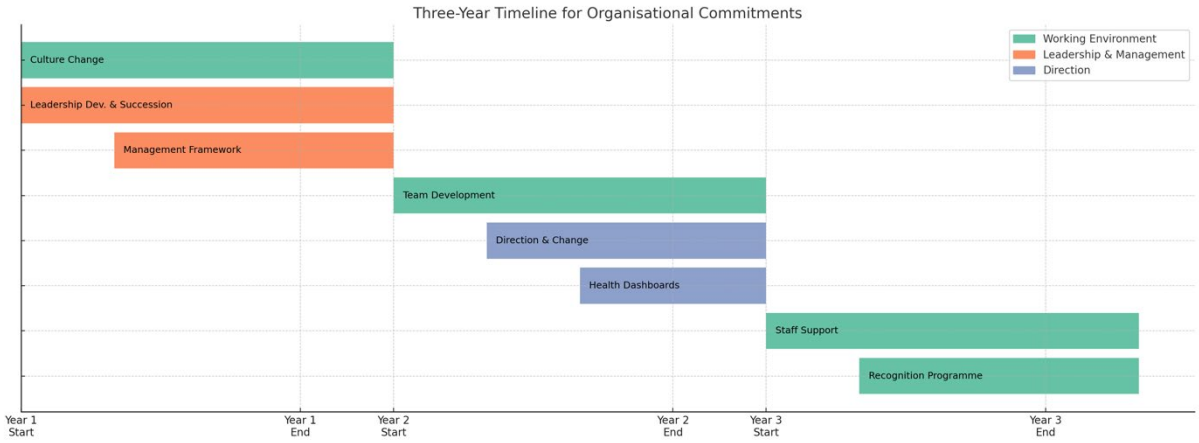
Alongside the preventive approach to organisational health, we will continue to offer support for the well-being of everyone across the organisation. Wellbeing is central and core to our performance, sustainability, and humanity. It transcends tick-box exercises or isolated initiatives — true wellbeing permeates our people's daily experiences. It's evident in team communication, workload management, leader engagement, and individual support during challenges. A supportive environment addressing mental & emotional, physical, social, financial, and work-life balance needs fosters thriving, not just surviving. Real wellbeing is systemic, embedded in our culture, leadership, and daily collaboration.



SECTION 4: ACTION TAKING

Making it happen

The sheer amount of work required to transform our internal health can be overwhelming, so a careful, realistic, and practical approach must be considered when taking action to improve our health. As McKinsey states, it is wise to begin by focusing on one or two areas, drawing on the momentum of that success.



Three-Year Roadmap for Organisational Commitments

Year 1: Lay the Foundations

Goal: Establish the cultural bedrock, develop leadership capability, and define expected behaviours.

1. **Culture Change Programme** *(Working Environment)*
   - Q1–Q4: Establish shared values, behaviours, and cultural expectations.
   - Enables: Clear foundation for team development, recognition, and staff support systems in later phases.

2. **Leadership Development & Succession Planning** *(Leadership & Management)*
   - Q1–Q4: Identify current and future leaders; build capacity to lead culture and change initiatives.
   - Supports: Culture embedding, behaviour framework adoption, and direction setting in Year 2.

3. **Management Competence & Behaviours Framework** *(Leadership & Management)*
   - Q2–Q4: Co-design and roll out standards for effective management aligned to the new culture.
   - Links to: Performance reviews, team dynamics, and leadership development content.

Year 2: Strengthen the System

Goal: Empower teams, clarify organisational direction, and enable intelligent use of data.

4. **Proactive Team Development** *(Working Environment)*
    - Q1–Q4: Conduct team assessments (e.g. Affina OD), provide structured development interventions.
    - Builds on: Shared culture, competent managers, and leadership role modelling from Year 1.

5. **Direction, Collaboration and Change** *(Direction)*
    - Q2–Q4: Co-create strategic direction, organisational goals, and change principles.
    - Enabled by: Engaged leadership, aligned teams, and shared cultural language.

6. **Health Dashboards That Drive Change** *(Direction)*
    - Q3–Q4: Develop real-time indicators and build capacity to use them for local action.
    - Reinforces: Strategic alignment, performance accountability, and team ownership.

Year 3: Embed and Sustain

Goal: Reinforce the desired culture through practical support and recognising what matters.

7. **Staff Support Systems** *(Working Environment)*
    - Q1–Q4: Shape and enhance wellbeing offers based on staff feedback and cultural insights.
    - Informed by: Earlier listening exercises, team development, and leadership priorities.

8. **Staff Recognition Programme** *(Working Environment)*
    - Q2–Q4: Celebrate staff who exemplify desired behaviours and impact.
    - Anchored in: Behaviour framework, leadership messaging, and cultural change success.

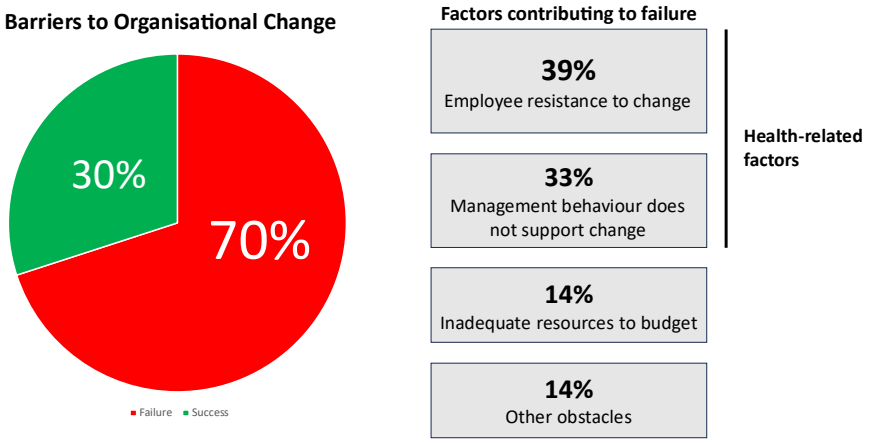
This roadmap ensures that each commitment builds logically on the one before it, reinforcing culture, enabling capability, and embedding change sustainably.

We will develop a long-term action plan containing details of the specific actions we will take over each phase to progress the delivery of our aims and approach. Action plans will be created annually to ensure they are realistic, practical, and underpinned by the broader organisational strategy and service plans. Appendix A outlines the key actions for each commitment.

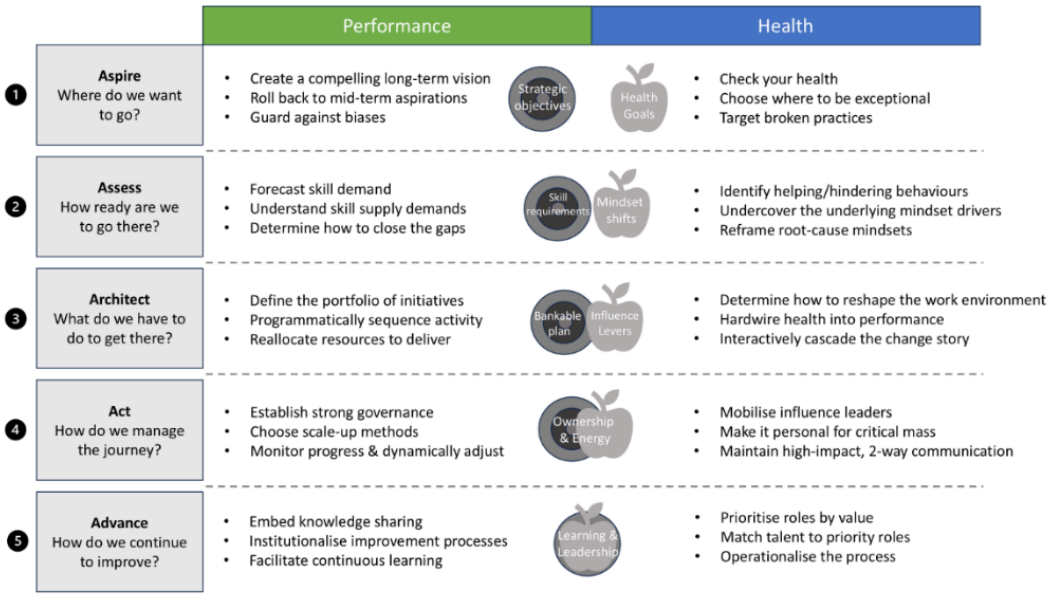
Ultimately, everyone in the organisation should feel connected to our approach and vision; that is why we will also develop a communication plan to continuously engage the workforce throughout our strategy and keep them informed of the plans and activities.

Managing the Change

This strategy ultimately focuses on leading large-scale change. However, 70% of change initiatives fail in organisations. The usual suspects—inadequate resources, poor planning, bad ideas, and unpredictable external events—account for less than a third of change programme failures. In fact, 70% of failures stem from what we would categorise as poor organisational health, evident in symptoms such as negative employee attitudes and unproductive management behaviour (see image below).



The model we will employ to drive this change initiative will be intrinsically linked to performance and health. The five frames of organisational health and performance are designed to enable leaders to effectively lead large-scale change by emphasising each aspect equally. Change programmes can enhance their chances of success from 30% to 79% and, on average, deliver 1.8 times more impact than if the focus is disproportionately placed on one aspect over the other.



SECTION 5: EVALUATION

In short, success can be measured in various ways. If the evaluation process creates unnecessary burdens and generates irrelevant data, it will become redundant and obsolete. That is why our approach to measuring the success of our OD Strategy will be a cyclical process of collaboration, reflection, review, and improvement, in which everyone will play a crucial role. This is a vital objective for us to build up relevant measures to track health improvement.

Our evaluation process will be comprehensive and integrated. This approach ensures that balancing health and performance is not merely a goal but a central factor in the success of our workforce and TSH as a whole through a constant feedback loop and improvement.

Our comprehensive and integrated approach: Combining Affina OD, McKinsey's OHI, iMatter, pulse surveys, and key outcome metrics into a single coherent framework gives us a 360° view of organisational health—from team-level culture to system-level performance.

1. Purpose of Each Tool

Tool	Focus Area	Frequency	Level
Organisational Health Index (OHI)	9 dimensions of organisational health	Annually or biannually	Org-wide
Affina OD	Team-based culture	Annually	Team
iMatter	Staff experience & engagement	Annually	Org & Team
Pulse Surveys	Real-time insights into specific themes	Quarterly	Org & Team
Outcome Metrics	Sickness, retention, patient outcomes, etc.	Monthly/Quarterly	Org & Team

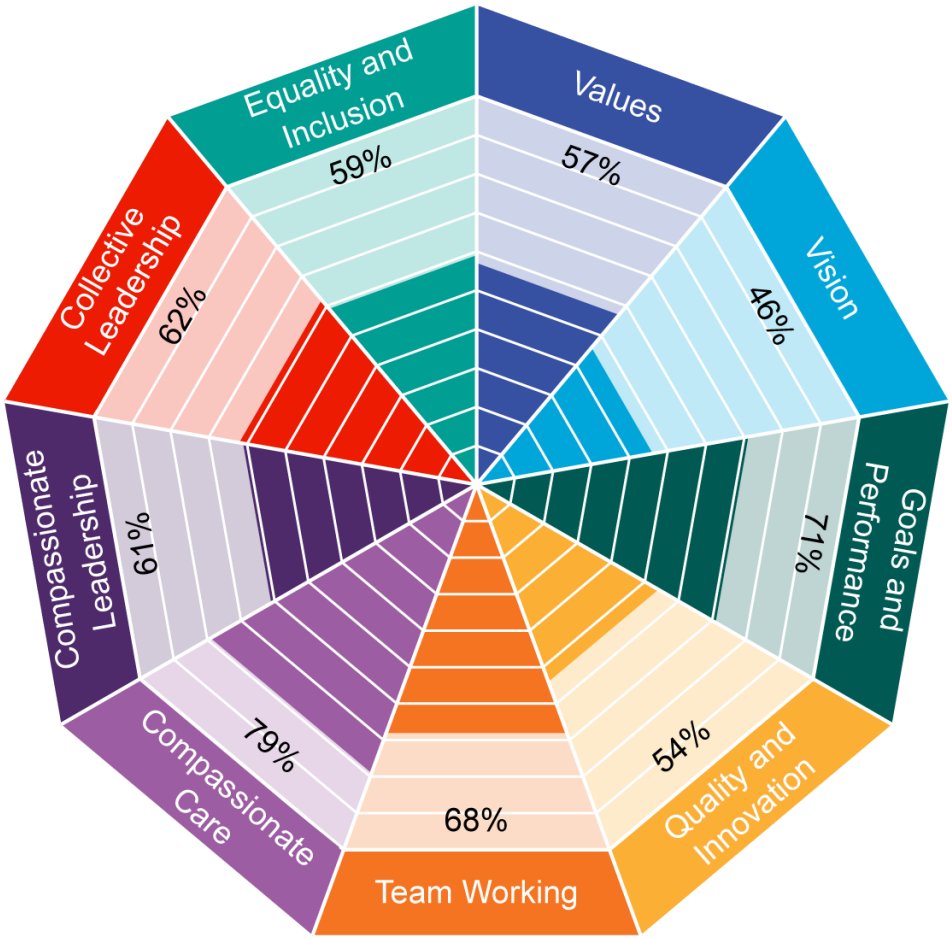
2. How It All Works Together

The goal is to build a healthy, high-performing culture across teams and services in a complex care environment.

The framework operates as a continuous learning and improvement cycle, with each tool providing a different but complementary perspective:

a. Affina OD (Team Culture Assessment)

This is the starting point for team-level diagnostics. Affina OD explores:

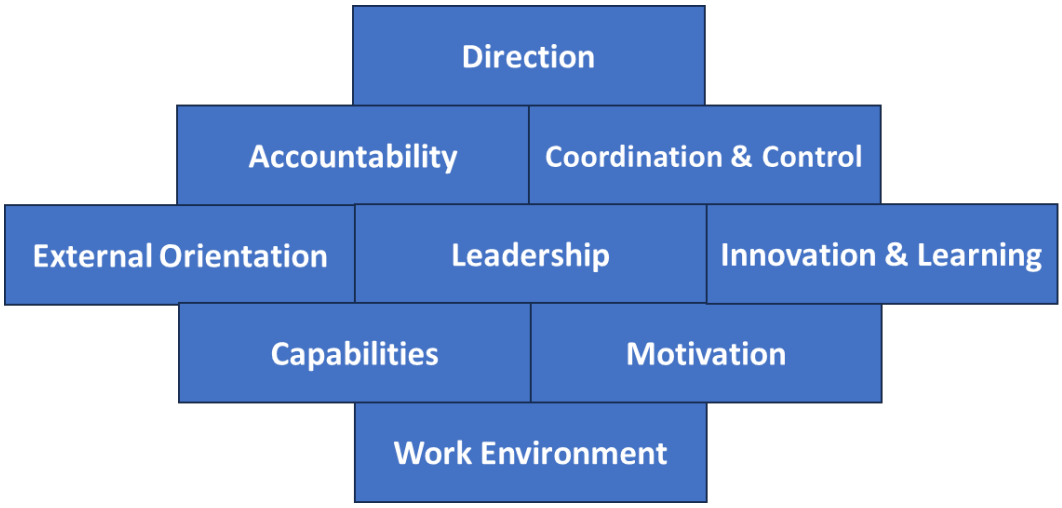


It's used annually to shape team development plans and set the cultural foundation, making it a crucial starting point for team-level diagnostics.

b. McKinsey OHI (Organisational Health Index)

OHI provides a broader system view, benchmarking the organisation's health across 9 dimensions and 43 management practices.

It helps identify which parts support or hinder strategic goals.

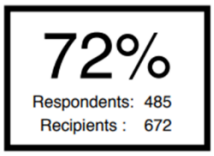


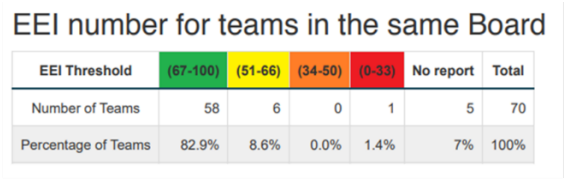
c. iMatter (Staff Engagement)

Running in parallel, iMatter captures how staff feel within the system and allows us to compare against other NHS Scotland Boards.

It's a temperature check on their views about the organisation, management, and individual experience at TSH, ultimately measuring experience and engagement.

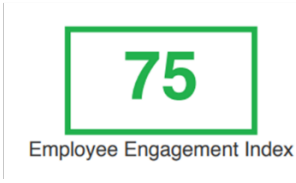
Themes often reinforce or validate patterns seen in Affina OD and OHI.





EEI number for teams in the same Board

EEI Threshold	(67-100)	(51-66)	(34-50)	(0-33)	No report	Total
Number of Teams	58	6	0	1	5	70
Percentage of Teams	82.9%	8.6%	0.0%	1.4%	7%	100%



d. Pulse Surveys (Real-Time Feedback)

Pulse surveys are our feedback loop in action. They zoom in on areas identified in Affina, OHI, or iMatter, allowing quick:

- Testing of interventions (e.g., team debriefs, leadership changes)
- Monitoring of trust, communication, or psychological safety in real-time

They ensure the system stays responsive, not reactive, empowering us to take control of our organisational health and performance.

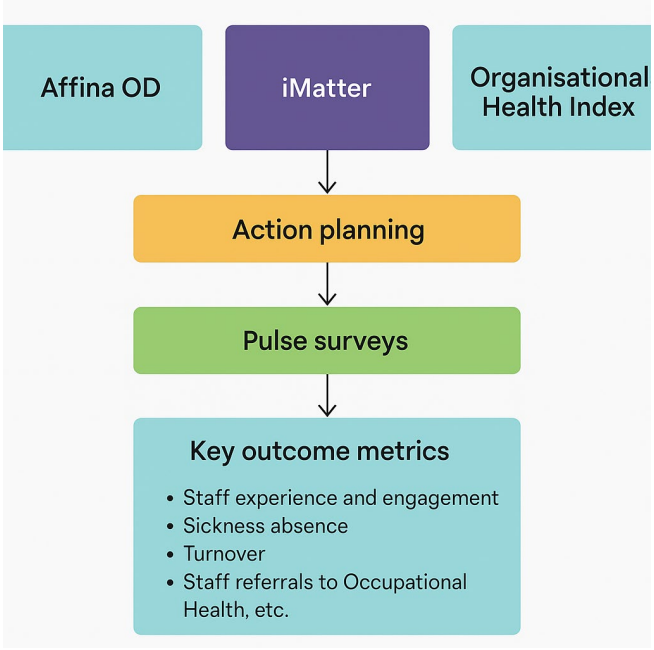
e. Outcome Metrics (Impact Measurement)

These are the "so what" measures. They show whether improvements in culture, engagement and health are translating into better results:

- Reduced sickness absence
- Lower turnover
- Fewer referrals to Occupational Health
- Etc.

By tracking these alongside survey scores, the system becomes evidence-informed and action-driven.

f. The Flow of how it links together



Insights from Affina OD, iMatter and OHI drive focused action-planning interventions.

The focused action-planning interventions are tracked via
Pulse surveys to validate and monitor the effects of the changes.

Outcome metrics measure the real-world impact.

Together, they inform a learning cycle where health and performance are continuously adjusted based on evidence.

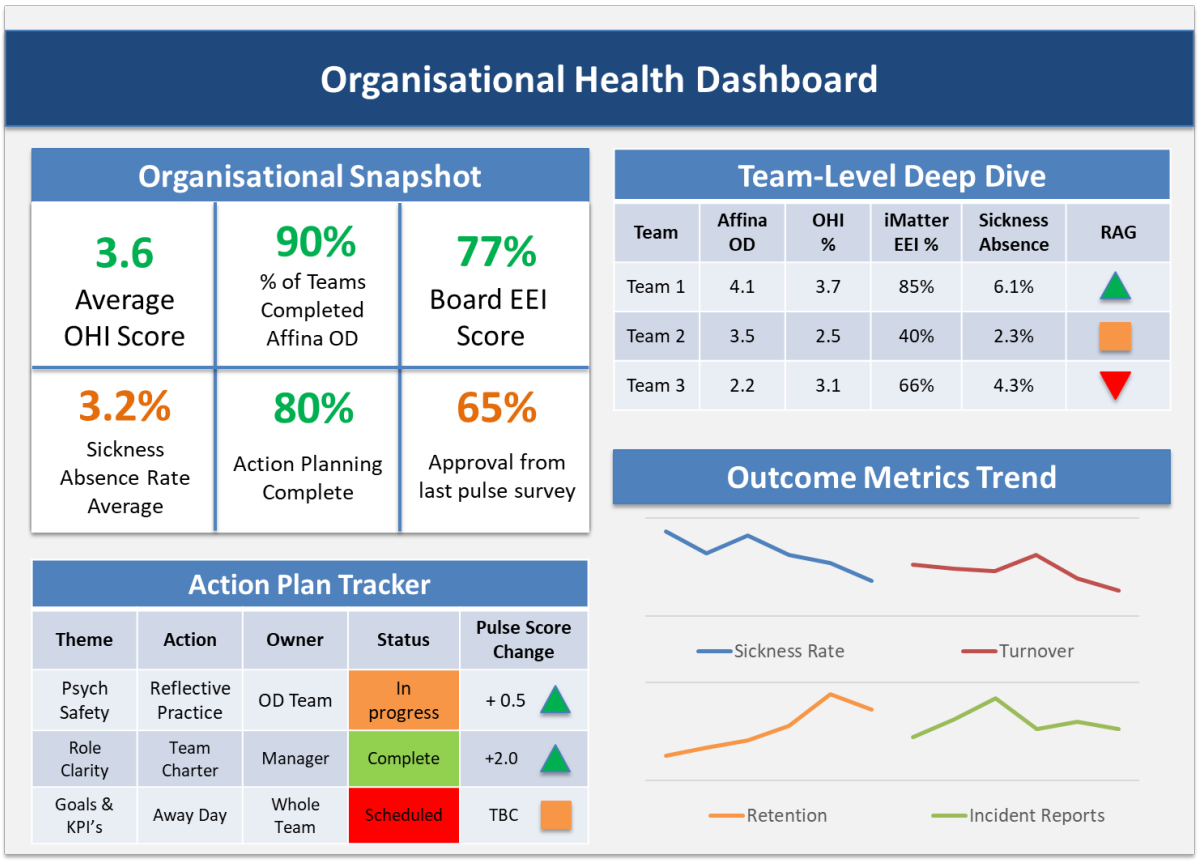
3. Visual Integration

We turn the above into visual dashboards that integrate all this information, providing clear, actionable data that drives change.

Dashboard Sections:

- Culture Heat Map (across teams using Affina OD)
- OHI 9 Dimensions Trend (org-level)
- iMatter Themes and EEI Summary
- Pulse Survey Scores + Commentary
- HR Metrics Correlation Table
- Improvement Actions Tracker

Here is a mock-up example:



SECTION 6 – CONCLUSION

Crucially, this strategy document underscores the pivotal role of the Organisational Development Strategy in our overarching Medium-Term Plan and Workforce Plan. It introduces McKinsey's Organisational Health model, emphasising the significance of balancing performance and health. Furthermore, it delineates the OD cycle and our methodical approach to implementing OD within the organisation.

The data collected in 2024/25, following extensive consultation with half of our staff, has revealed the challenges we face in enhancing the organisation's health and informed this strategy. While we, as OD practitioners, are spearheading the change, our collective responsibility is to foster a healthy and high-performing environment where all can flourish.

Moving forward, our strategy is clear: we are transitioning from a reactive approach to a proactive, preventive approach. This means taking ownership of our individual, team, and organisational health while tackling challenges head-on. These challenges are multifaceted and vary among staff groups. However, we have identified three key priorities to address over the next three years of this strategy: Direction, Leadership & Management, and Working Environment, with clear commitments to improving the health of each. This shift empowers us to be proactive and prepared for the future.

Finally, with a clear agenda of intent established and momentum gained through our engagement in creating this strategy, we must be cautious in managing this change. As shown, most change efforts fail in organisations, largely due to employee resistance and managers not role-modelling the changes we want to see. Therefore, it is crucial that everyone feels included in the change process and is consistently consulted and listened to. This is why it is essential to utilise our wealth of data to make evidence-based decisions that enhance the health and performance of the organisation.

Appendix A – One page on the key actions of each of the eight commitments

Wellbeing - Action Plan.docx
Proactive Team development - Action
Management Competence & Behav
Health Dashboards that Drive Change - A
Culture Change - Action Plan.docx
Staff Support Services - Action Plan
Staff Recognition Programme - Action F
Leadership Development & Succ
Enhance Collaboration & Chan

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 18
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 May 2025.

2 BACKGROUND

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

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.

3 ASSESSMENT

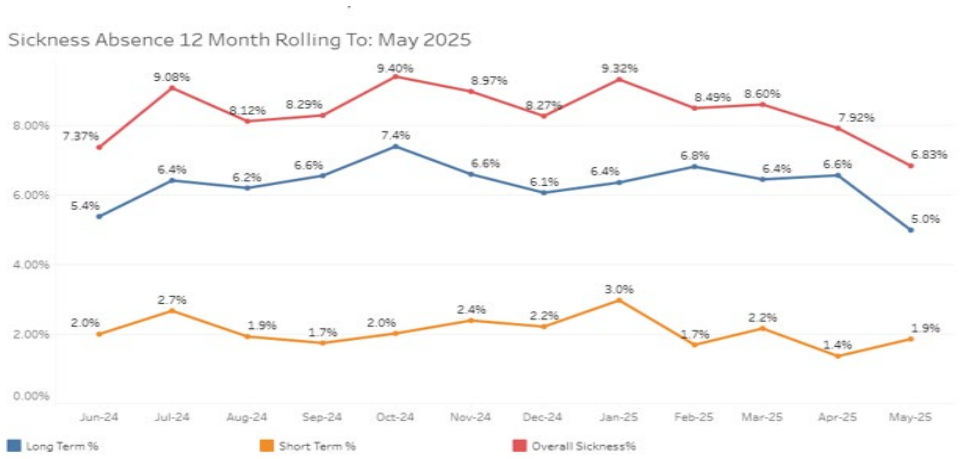
(a) ATTENDANCE MANAGEMENT

TSH Sickness Absence (June 24 to May 25)

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

There has been a significant decrease in sickness absence rates since March (8.6%) until May (6.8%), as outlined in Graph 1 below:

GRAPH 1



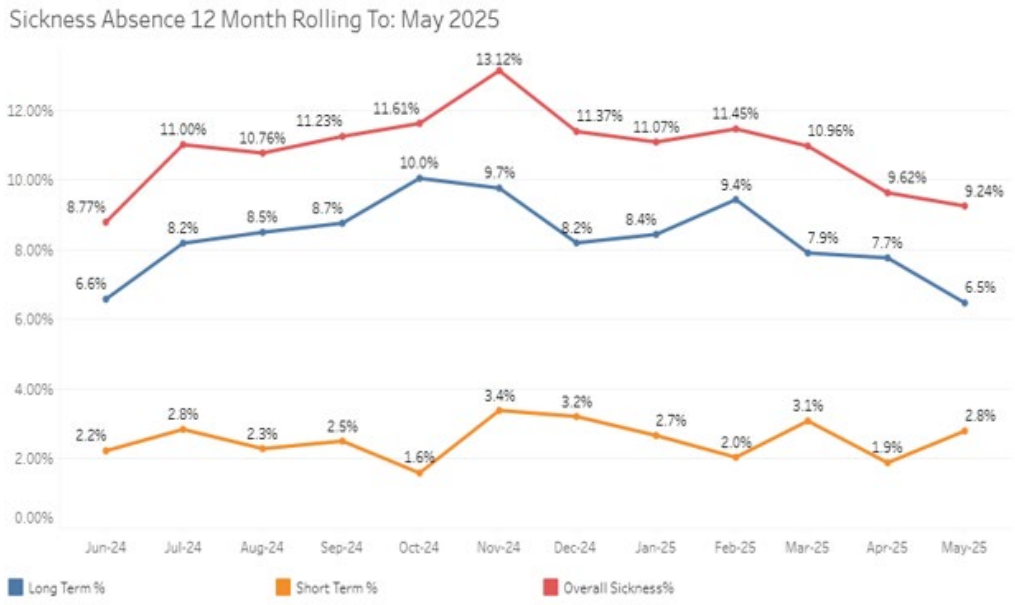
A significant drop-in long-term absence has contributed to this reduction (long term absence accounts for 5%) with a slight increase in short term (1.9%).

As previous documented and discussed in detail in Staff Governance Committee, it is encouraging to see the reduction and the impact of ongoing efforts to maximise attendance at work, however, it is crucial that we remain focused to sustain these lower levels over time.

Nursing Sickness Absence (June 24 – May 25)

The reduction in absence is reflected in Nursing (from 10.9% in March to 9.14% in May), albeit still higher than the national target. Sickness within Nursing remains the major challenge for TSH. Nursing have seen a reduction in long term absence and an increase in short-term reflecting the Board wide pattern as described in the graph below:

GRAPH 2

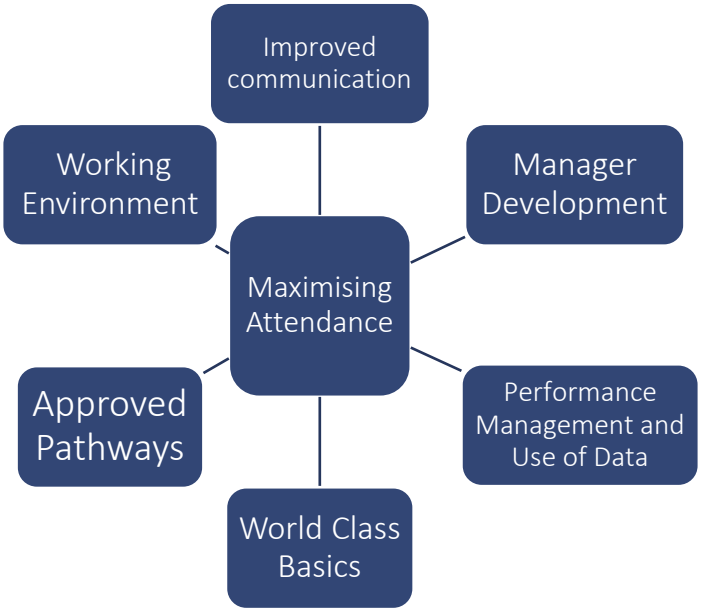


ATTENDANCE MANAGEMENT OBSERVATIONS

Patterns/Trends for TSH:	Positive continued reduction in absence over April and May. Focus required to sustain this over summer period when absence tends to increase.	
Identified Departments of Concern:	Arran 3 Lewis 1 Arran 1 Skye Centre	20.4% 13% 11.4% 11.1%
Identified Departments of Improvement since March 2025:	Housekeeping Arran 2 Lewis 3 Mull 2	From 8.3% to 3.6% 7.8% to 2.9% 14.3% to 3.5% 16% to 3.8%
Reasons:	**Key reasons for long-term absence:** Anxiety/Stress/depression/other psychiatric illnesses, Injury/fracture, other Musculoskeletal. **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 May: 16 staff were invited to a Stage 1 meeting, 4 members of staff was invited to a Stage 2 meeting and no staff were invited to a Stage 3 meeting. Development of 'absence pathways' for managers reflecting the common reasons for sickness absence Continuation of escalated meetings with Lead Nurse / Head of Service, extended beyond nursing.	
Benchmarking:	Rowanbank The Orchard Clinic	8.35% 16.25%

MAXIMISING ATTENDANCE – FUTURE ACTIONS

A detailed paper was presented to Staff Governance Committee outlining the key barriers and challenges as we see them now, and outlined the future actions that are person centred and supportive in managing absence in line with the Once for Scotland policy. The key areas for improvement are summarised below and align with a number of the aspirations of the OD Strategy:



(b) RECRUITMENT

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

TIME TO HIRE	89 days (KPI of 75 days)	KPI impacted by requirement to extend closing dates due to lack of suitable candidates
VACANCIES ADVERTISED	6 posts were progressed during May. This included posts to support the Women's Service or backfill internal moves to the new service.	
SUMMARY OF NURSING VACANCIES:	In May, there are 11.6 WTE Band 5 Registered Nurse vacancies & no HCSW vacancies. Detailed work is ongoing to manage the nursing resource across the site as new appointments are made in line with the Women's service.	
EMPLOYABLITY:	TSH participated in a Demonstrator Programme in partnership with South Lanarkshire Council, hosting placements which ended on 31st March 2025 (based in admin positions). This was very positively received, and a reflection event has taken place with the Council to review approach for next time which is planned for July 2025 (in Housekeeping and Catering as well as Clinical Admin).	

SUPERNUMARY STAFFING

Since March 2025 there has been a significant decrease in the reliance on supplementary staffing which has positive impact on patient care due to the reduction in DTC and financial savings particularity in the Nursing Directorate.

This has been directly impacted by the appointment of the additional HCSWs in Nursing, which was approved by the Board in December 2024.

OT & EXCESS	39 WTE	A decrease of 10.42 since March 2025
NURSING	24 WTE	A decrease of 7 since March 2025
SSR	7.8 WTE	A decrease of 3.62 since March 2025

(c) EMPLOYEE RELATIONS
LIVE CASES

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

- One new ER cases commenced in the month of May

- The one case in excess of 6 months will be concluded in June

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	5	1	7
Bullying & Harassment - formal	0	0	0	0	0
Grievance - formal	1	0	0	0	1
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 April and May 2025 therefore, YTD total is 4.
- Turnover YTD is 0.67%.

(e) JOB EVALUATION

Progress

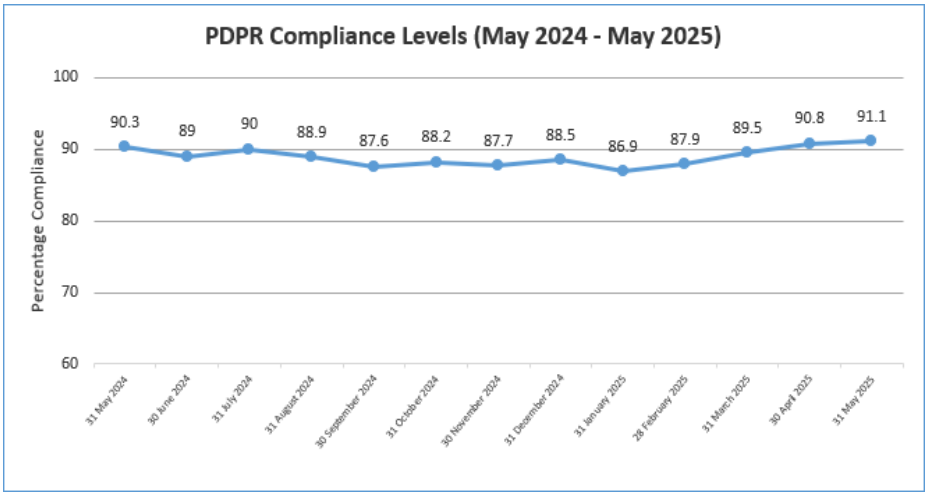
- One new Job Description was received in May and one was carried from April.
- 2 outcomes were given both within 14 weeks

Status

- Summer JE panel dates and Quality Check dates are scheduled.

(f) PDPR COMPLIANCE

PDPR also remains stable, with a small increase in month to 91.1%, remaining above the national target of 80%. Focus remains on maintaining compliance and improving the quality, impact and outcomes for TSH Staff.



4 RECOMMENDATION

The Board is invited to note the content of the report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Update report Supports delivery of Staff Governance Standards and Workforce Plan
Corporate Objectives Please note which objective is linked to this paper	**4. Better Workforce** Paper covers various objectives
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; ☐ 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:	19 June 2025
Agenda Reference:	Item No: 19
Sponsoring Director:	Director of Workforce
Author(s):	Head of HR
Title of Report:	Protecting Vulnerable Groups (PVG) - Update
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on progress to date following the introduction of changes made by Disclosure Scotland with effect from 1 April 2025 relating to Protecting Vulnerable Groups Legislation.

2 BACKGROUND

Under the Disclosure (Scotland) Act 2020, Disclosure Scotland has introduced a number of changes to current processes, which will impact on The State Hospital.
The key changes are summarized below:

- Protecting Vulnerable Groups (PVG) Scheme becomes a legal requirement
- Level 1 and Level 2 will replace the current 'Basic', 'Standard' and 'Enhanced' disclosure levels.
- Applicants will have the option to request an independent review of certain disclosure content and must provide their approval before Disclosure Scotland shares this information with the organisation. A 28-day window is granted for applicants to provide their approval.
- Applicants will be able to explain the context for certain spent convictions before they're disclosed.

Additionally, from 1 April 2025, PVG membership will be mandatory for all regulated roles with the definition of regulated having been updated.

In Scotland, a 'regulated role' refers to a position, whether paid or voluntary, that involves performing specific activities where individuals have contact with children or protected adults. In a healthcare setting, examples of such roles may include;

- *Jobs providing health care for children or protected adults.*
- *Staff or volunteers in hospitals or hospices providing cleaning, food preparation, caretaking or maintenance services that is provided for children or protected adults.*

3 ASSESSMENT

In response to these changes and to meet the short timeframe of 30 June 2025 to have applications with Disclosure Scotland, the Workforce Directorate have commenced a programme of work to carry out the required checks for these staff.

Staff groups affected have received targeted communications advising them that a member of the HR team will be located within the Occupational Health building Mondays, Tuesdays and Thursdays throughout May, this allows the required Disclosure Scotland identification checks to take place to facilitate the initial stages of the application process.

The number of staff who are required to become PVG members is **237**, effective 9 June 2025, **176** staff have now been logged onto the system and will receive direct communication from Disclosure Scotland to progress their PVG application.

Department	Staff Nos requiring PVG	Seen by HR	Staff still to meet HR	No. Applied for by HR	No. Actioned by Staff	No. Staff to Action log-in	No. Outstanding at Disclosure Scotland	Other	No. Complete PVG ISSUED
Board and Senior Managers	10	9	1	9	9	0	7		**2**
Clinical Admin inc Skye Centre Admin & PAs	29	26	3	26	17	9	14		**3**
Communications	2	2	0	2	2	0	1		**1**
Corporate	7	7	0	7	6	1	6		
eHealth inc Hlth Records	20	20	0	20	13	7	11		**2**
Estates inc Portering & Switchboard	26	25	1	25	22	3	13		**9**
Finance	7	6	1	6	5	1	5		
Hotel Services-Catering	16	16	0	16	16	0	8		**8**
Housekeeping inc Laundry, Sewing	54	51	3	51	34	17	21		**13**
WF Directorate	14	14	0	14	14	0	7		**7**
Clinical Quality inc Research	7	7	0	7	6	1	5		**1**
Procurement	7	7	0	7	7	0	7		
Security	34	26	8	26	22	4	17		**5**
Risk & Resilience	2	2	0	2	1	1	1		
Forensic Network	2	2	0	2	2	0	2		
TOTALS	**237**	**220**	**17**	**220**	**176**	**44**	**125**		**51**

The progress of this work is being monitored closely with and further targeted communication to staff and Managers being issued.

As well as the direct impact of these changes in relation to additional disclosure checks, there is the potential for extended delays in 'normal' recruitment and onboarding if Disclosure Scotland are not adequately staffed to support the increase in PVG applications over the next two months. This could have implications for all recruitment including that for the Women's Service. At time of writing there is no indication of what this impact could be, however this has been added to the Corporate Risk Register.

4 RECOMMENDATION

The Board is invited to note the content of the report.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP	Workforce Planning
Corporate Objectives Please note which objective is linked to this paper	**4. Better Workforce** 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. i) Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation.
Workforce Implications	Implications in terms of: - Volume of additional staff who require checks and potential ER issues which may result from current staff group - Recruitment Timeline being extended if Disclosure Scotland are unable to process number of applications. - Resource implications for workforce team to support
Financial Implications	Additional Cost for additional staff who require a check and ongoing cost for renewals every 5 years as outlined in the paper.
Route to BOARD Which groups were involved in contributing to the paper and recommendations.	CMT, Staff Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Risk in: - Failing to meet the legislative timeline - Potential delays in recruitment/onboarding, in particular the Women's Service at present - ER challenges regarding returns or non-disclosures
Assessment of Impact on Stakeholder Experience	Impact of legislation on existing staff will be considered throughout implementation
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.	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

STAFF GOVERNANCE COMMITTEE **SGC(M)25/01**

Minutes of the meeting of the Staff Governance Committee held on Thursday 20 February 2025.

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	Cathy Fallon
Non-Executive Director	Shalinay Raghavan
In attendance:	
Head of Organisational Learning and Development	Sandra Dunlop
Chief Executive	Gary Jenkins
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
RCN Representative	Richard Nelson [in part]
Head of Corporate Governance	Margaret Smith
Director of Workforce	Stephen Wallace
Associate Nursing Director	Josie Clark

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting, and noted formal apologies from Mr Stuart Currie, Non-Executive Director. It was also noted that Ms Laura Nisbet, Head of Human Resources and Mr Alan Blackwood, POA Representative were unable to attend today's meeting.

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 21 November 2024. Minutes were agreed as an accurate reflection however, Ms Fallon wished to clarify that a point she made in relation to carers and relatives attending the Staff Excellence Awards in that this related to staff relatives being allowed to attend.

<u>The Committee:</u>

1. Approved the minute of the meeting held on 21 November 2024.

4 MATTERS ARISING AND ROLLING ACTIONS LIST

Ms Radage noted that most of the actions would be covered during the meeting however, asked for clarity on whether Action point 3: the Meet the Board Videos was now closed off or if further work required to be undertaken with the Communications Department. Mr Wallace clarified that this point has now been added to the Communications departmental work plan, therefore allowing it to be closed off as an action for this committee.

The Committee:

1. Noted the updates from the Rolling Actions List.

5a CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

Mr Wallace informed members that changes have been made to the structure of the agenda to bring it into alignment with the staff governance standards and explaining the rationale for this. He noted that the aim was that the information contained within the reports was to give assurance to the Committee, whilst also focussing on work being undertaken around continuous improvement.

Mr Wallace then presented the Corporate Risk Register - Staff Governance Risks quarterly report detailing the current position on the four risks sitting under the Workforce Directorate. He noted that regarding the Agenda for Change Nurse (AfC) Band 5/ Band 6 review, there had been a low number of applications received to date. However, he added that potentially this would increase within the next few months.

Mr Wallace advised that he had a meeting scheduled with the Risk Manager for a general review of all risks therefore, a more detailed update would be available for the next meeting.

Ms Fallon requested clarity around the risk rating for Prevention and Management of Violence (PMVA) training with Mr Wallace confirming that the risk for this remained at medium. In answer to a query on the availability of the draft Workforce Plan 2025-2028, he confirmed that this would be covered within today's meeting agenda.

Mr Connor queried the risk rating around the AfC job evaluation process noting that the rating of medium had been due to the potential impact of the banding review process. However, due to the low number of applications being received, he asked if consideration should be given to lowering this with the option to raise the rating if the need arose in the future.

Mr Jenkins noted the relevant point raised by Mr Connor and provided some context to members on the reasons for the job evaluation process having been added to the risk register, which had been due to significant process delays historically. Mr Jenkins added that the rating for this risk would be part of the discussions between Mr Wallace and the Risk Manager, therefore this risk may change between now and the next Staff Governance Committee meeting.

Ms Radage agreed with the points, noting that the importance of ensuring that the risk around PMVA was kept up to date and current.

The Committee:

1. Agreed the Corporate Risk Register.
2. Risk Rating of HRD 113 to be reviewed.

5b OCCUPATIONAL HEALTH UPDATE

Mr Wallace then presented the Occupation Health Update to the Committee which contained

detailed information surrounding the service currently being provided by NHS Dumfries and Galloway through a Service Level Agreement (SLA); noting that the current SLA was due to conclude on 31 March 2025. He highlighted the key points to the Committee, as well as the preferred option to extend the service as agreed by the Corporate Management Team (CMT). He provided the rationale for this also noting that the cost for this option would be covered from within the existing directorate budget. He also provided an outline of the Key Performance Indicators (KPIs) which would be used to monitor ongoing performance delivery.

Mr Jenkins highlighted that this report had been presented to various internal groups for discussion including the Partnership Forum. He also noted that NHS Dumfries and Galloway had shown willingness to work alongside and engage well with the State Hospital (TSH) as well as modifying services to meet demand.

Mr Connor welcomed the improvement in the flexibility around appointments under the preferred option that had been put forward. Mr Connor also queried whether this new SLA would cover physiotherapy services as noted within the paper. Mr Wallace clarified there would be no change to how this service was provided presently.

Ms Fallon welcomed the report, particularly the work undertaken around establishing the KPI's. Ms Radage agreed with the comments made by Mr Jenkins noting that the current service provided by NHS Dumfries and Galloway had been good value. Ms Radage asked how long the service could be extended before having to undergo the tender process. Mr Wallace noted this current extension process was for two years, and a review would be undertaken at that point as to the way forward. Mr Jenkins noted that a two-year extension fitted well from an internal dynamic and with the changing national landscape in two directions.

Ms Radage acknowledged the report and asked Mr Wallace to thank Ms Nisbet and wider team for the work taken in relation to this, noting the importance of the Occupational Health Service for general wellbeing.

The Committee was asked to endorse the decision to renew the contract with Occupation Health through Dumfries and Galloway and noted the proposed KPI's.

<u>The Committee:</u>

1. Endorsed the extension of the SLA as outlined and noted the relevant KPIs.

5c WORKFORCE EQUALITIES GROUP UPADTE

Mr Wallace presented the Workforce Equalities Group Update highlighting that the first meeting of this group took place on 30 January 2025 with volunteers in attendance from across the organisation. He noted that the meeting held had been positive with the immediate aim being working together collectively to ensure the provision of a safe, inclusive working environment for all at TSH. Mr Wallace then highlighted key points from that first meeting and focus for the next scheduled meeting, also noting that work would continue to extend the membership of the group.

Ms Fallon welcomed the update, noting the good progress made so far. Ms Fallon also noted that in previous discussions it was suggested that a Non-Executive Director could potentially become an Equalities Champion, asking if further discussion regarding this point was still to take place. Ms Radage also welcomed the good progress made so far by the Workforce Equalities Group and agreed that having a Non-Executive Director in the role of Champion would be a helpful addition.

With agreement from the Committee, Ms Smith would circulate a request for volunteers among the Non–Executive Directors for this role.

Action: Ms Smith

Mr Moore noted that within the minutes of the Partnership Forum meeting which took place in November 2024, there was a statement in relation to a Unison report regarding the connection between incidents of violence relating to gender and race and further that the Workforce Equalities Group would pick up on this. Referencing this report, Mr Moore asked what the general findings had been regarding the issue of violence in correlation to gender and race. Mr Wallace provided assurance that this had been picked up on by the Group, with work progressing to analyse the report further to establish any potential implications for TSH, and to link this to the Workforce Governance Group as well.

Mr Jenkins thanked Mr Wallace for the fresh approach he had led to take this group forward, noting the traction and pace to date. Ms Radage mirrored these comments on behalf of the Committee.

The Committee:

1. Noted the Workforce Equalities Group Update.
2. Request for Non–Executive Director for Champion role.

6a MAXIMISING ATTENDANCE

The Committee received the report on Maximising Attendance from Mr Wallace who summarised the content and highlighted the key areas for members to note. In doing so, he highlighted the need for all changes that are implemented to be sustainable, and to be embedded over the longer term.

Ms Fallon thanked Mr Wallace and Ms Nisbet for the comprehensive report and asked if there were areas of good practice in respect of attendance management and if so, suggested further investigation could be undertaken and learning shared to benefit all areas. Mr Wallace agreed that there were areas of good practice but added that it could be difficult to compare practices from one department to another due to the differences in size and staffing numbers, however this would be reviewed to see where learning could be shared. Ms Fallon agreed that it may not be possible to compare different service areas, however, asked if it was possible to compare ward areas and look at influencing factors there.

Mr Moore welcomed the approach contained within this report but noted concerns regarding the levels of sickness absence. He underlined the need to support managers and staff, as well as to adhere to policy and procedures to ensure a consistent approach to absence across the organisation. Mr Moore referred to the financial risk of high levels of absence and the continued use of overtime to support service delivery, and that a correlation between these factors would be helpful.

Mr Wallace noted that the work being undertaken by Ms Nisbet would identify areas of good practice which would then be reviewed. Mr Wallace also noted the financial point raised by Mr Moore and advised that this was an element that was currently being looked at.

Mr Connor queried whether the AfC reduced working week was incorporated into the baseline figures and asked if there were any concerns going forward regarding skill mix, due to the ratio of nursing assistants to registered nurses, following recent recruitment. He also asked if the newly recruited healthcare assistants would be incorporated into the baseline figures. Mr Wallace confirmed he would check this point in respect of the reduced working week and that the correct skill mix would be considered when revising the working arrangements. There was discussion around the work pattern for the additional healthcare assistants, and Mr Jenkins provided assurance that this was under discussion and that any proposal would be taken through the usual operational channels alongside partnership colleagues.

Mr Jenkins emphasised the need to build leadership skills across teams, linked to responsibility for performance in their areas, including attendance management. He advised that he was working closely with the Director of Nursing and Operations in this regard to ensure that there was

improvement and gave assurance that he remained committed to this, to achieve sustained change.

Ms Radage noted the helpfulness of the information contained within the report regarding the absence levels within other NHS Boards and remarked that the interventions referenced by Mr Wallace and Mr Jenkins were insightful. Ms Radage commented that the person-centred approach would in time become beneficial in taking steps towards a positive change. In reference to the report, she noted the content was beneficial and contained the relevant information for discussion at this forum, focusing on strategy.

Ms Dunlop highlighted that in addition to all other work being taken to tackle absence levels there was a key role for Organisational Development in terms of longer-term prevention measures, particularly around creating a positive working environment.

Mr Jenkins and Ms Radage both agreed, and Mr Jenkins highlighted the different opportunities and pathways offered to staff to support access to work.

Ms Radage noted the importance of raising awareness of the options offered to staff to help them to remain at work.

The Committee:

1. Noted the Maximising Attendance Report.

6b WHISTLEBLOWING REPORT – QUARTER 3

The Committee received the Whistleblowing Report for Quarter 3 presented by Mr Wallace, who noted that there had been no formal cases raised during the period. He highlighted that one case was raised with the Whistleblowing Champion; however, it did not meet the criteria for whistleblowing and was managed through the business-as-usual policy.

Mr Moore highlighted that a letter had been received from the Cabinet Secretary asking for a statement on how the organisation was implementing Whistleblowing standards. It was noted that this would be completed by Ms Raghavan, Whistleblowing Champion and presented to the Board prior to submission to Scottish Government.

The Committee:

1. Noted the Q3 Whistleblowing Report.

7a WORKFORCE PLANNING 2025-2028

The Committee received the Workforce Planning Report 2025-2028 report from Mr Wallace, who informed members that this was an update paper which covered the approach to the draft three-year work plan. Mr Wallace noted that the content of the report outlined how support would be given to services to reach their objectives aligned to the TSH Medium Term Plan 2025-2028. He provided an overview of the report and highlighted key areas and next step and advised that the draft plan would be progressed through the CMT prior to being submitted to the Staff Governance Committee. He added that the Scottish Government had not set a definitive timescale for the plan to be finalised, and at this stage the requirement was to submit the return documentation only. This would be appended to the Medium-Term Plan, due for submission on 17 March 2025.

Ms Fallon queried the governance route in terms of an update pending reporting, in the wider context of reporting going to the full Board or being remitted to committee level. Ms Smith acknowledged that this was an area under review more widely in terms of leadership and decision-making routes. She noted that this would be on the agenda for the next Board Development

Session in May, including an opportunity to discuss Non-Executive and Executive input and expectations. Mr Jenkins noted Ms Fallon's point as being valid and reiterated the point raised by Ms Smith.

The Committee noted that the draft workforce plan was not required to be submitted to Scottish Government and agreed that it would be essential for the Board to take oversight of the plan.

The Committee:

1. Noted the Workforce Planning 2025-2028 Update

7b WORKFORCE GOVERNANCE GROUP UPDATE

The Committee received the Workforce Governance Group Update from Mr Wallace, who provided an overview of the paper and noted the content of the meeting that was held on 21 January 2025. He highlighted that the new vacancy process had been approved and implemented, and that the minutes from the Workforce Governance Group meetings would be provided to the Committee going forward rather than a formal update report.

Ms Radage welcomed the update and the inclusion of the minutes from future meetings.

Action – Secretariat

The Committee:

1. Noted the Workforce Governance Group Update.
2. Agreed that the Committee should receive minutes in future.

8a OD, LEARNING & WELLBEING UPDATE

The Committee received the OD, Learning & Wellbeing Update. Ms Dunlop provided an overview of the report and highlighted the key points. She noted that PDPR compliance had been maintained at just under 90%, and that there had been a review undertaken on the process for obtaining feedback from staff on the quality and impact of their PDPR reviews. She highlighted that 100% of staff who started within the organisation since April 2024 had completed the Healthcare Support Worker workbook, if their role required this, however, due to operational challenges not all relevant staff had completed it within the three-month target.

Ms Dunlop referenced the 'Time for Talking' counselling service offered to staff and noted that there had been eight staff in total who had used this service and advised that the service would be featured in a staff newsletter to promote it and to encourage staff engagement.

Mr Fallon welcomed the detailed report and noted the positive use of the Peer Support Network.

Mr Moore asked if the staff surveys conducted at intervals with newly appointed staff were still being carried out. Mr Wallace confirmed that HR were still doing so and had committed to this to the end of the calendar year. The responses received from staff were useful in terms of feedback, but the process was resource intensive. The intention going forward was to replicate the process as part of the recruitment and retention strategy. In this respect, options would be explored on how best to do so whilst minimising the resource impact.

Ms Radage noted the benefits of the newly appointed staff surveys and welcome the detail within the report. She referenced PDPR compliance and asked if focus would be on helping line managers to understand the importance of these reviews. Ms Dunlop agreed that managers should be empowered to give the time and commitment to ensure that this was a meaningful process for staff, with a longer-term goal being to embed this into day-to-day practice.

Mr Wallace noted that PDPR reviews were an integral part of each manager's role and that they should be supported to achieve this. He added that meaningful conversations between managers and staff should be taking place through 1 to 1 meetings and team meetings; and not only during PDPR reviews, and ways to incorporate and embed this into daily practice should continue to be explored.

The Committee:

1. Noted the OD, Learning and Wellbeing Update

8b (i)STATUTORY and MANDATORY TRAINING AUDIT & (ii) RECOMMENDATIONS

The Committee received the Statutory and Mandatory Training Audit for noting, as well as a report outlining the recommendations from the audit and the actions taken since.

Ms Dunlop provided context on the audit and explained that this had been carried out by internal auditors RSMUK and formed part of the Board's internal audit plan. She noted that the overall findings were positive with three areas identified for improvement and highlighting the areas and gave an overview of the steps being taken to address these.

Ms Radage welcomed the update and noted the timely manner in which the actions had been put into place and highlighted the reasonable assurance provided by the audit.

Ms Fallon also welcomed the update and noted the positive points within the report. Ms Fallon asked if there were any departments that required more help than others, noting that some modules had not being completed due to operational issues, and asked if it was known what the issues were, so that these could be addressed going forward.

Ms Dunlop noted that the areas where there were challenges were mainly front facing services such as Nursing and Security. She highlighted that the overall levels of compliance were good but there were a small number of individual staff within each department with low levels of compliance. Ms Dunlop noted that one action to address this would be to work with managers to secure more protected time to allow staff time to complete modules. She advised that sickness absence could also be impactive, as this could account for a backlog of training modules in some cases. Lastly, she noted that the use of the scorecard function for departments would help promote the managerial responsibility to ensure compliance in their area.

Mr Jenkins concurred that protected learning time would assist staff to complete mandatory training on time and underlined the importance of the mandatory training compliance featuring on performance scorecards.

The Committee:

1. Noted the Statutory and Mandatory Training Audit Recommendations

8c NURSING PRACTICE DEVELOPMENT UPDATE

The Committee received the 6 monthly Nursing Practice Development update presented by Ms Clark who provided an overview on the progress of the six priorities that Nursing Practice Development were focussing on over 2024- 2025. She highlighted that a staff needs analysis survey was carried out to ascertain what areas staff would like more support and education around, and thanked Ms Dunlop for her support in helping the team to carry this out.

Ms Clark outlined the key priorities for the coming year which included a one-year evaluation of the Clinical Care Policy, and analysing the outcomes from training surveys to help to develop a training

plan and that work would continue on staff education, as well as on building engagement and uptake of clinical supervision.

Mr Connor welcomed the update and asked if it was known how many staff received or used clinical supervision and the frequency of staff access to this. Ms Clark advised that part of the focus for 2025-2026 would cover this with the implementation of a database to capture this information.

Ms Fallon asked how the training and development needs of other disciplines were captured, and the potential impact this may have on patients. She referenced the range of staff she had met with on walkrounds, and the importance of the inclusion of all staff groups. Mr Wallace noted the broad approach taken through the Corporate Training Plan, which encompassed the whole hospital and that within services there would be tailored approached taken based on the needs of each staff group. Ms Dunlop agreed with the points noted by Mr Wallace and added that the Learning and Development Team engaged with all services.

Mr Jenkins also agreed with the points raised and added that protected learning time would be available for all disciplines and that this may present a good opportunity for these staff members.

Ms Fallon also noted that recent conversations with student nurses on placement at TSH had all commented on the positive experience they had had at the hospital.

Mrs Radage welcomed the report, finding the details helpful and agreed with the points raised by Ms Fallon.

The Committee:

1. Noted the Nursing Practice Development Update

9 PARTNERSHIP FORUM APPROVED MINUTES

The Committee received the approved Partnership Forum Meeting minutes from September, November and December 2024.

Ms Fallon noted concern in relation to points raised within the December minutes around CCTV, and how this was used effectively to review the use of PMVA techniques. Mr Jenkins provided further context in this respect for the benefit of the Committee. He emphasised the need for strict governance around the use of CCTV, including the policy and procedures which were under review and acknowledged the need to provide staff with assurance that a review of CCTV would be conducted within this framework. Mr Connor agreed and added that communication had been circulated to staff to highlight that the use of CCTV was a supportive mechanism for staff and emphasised the need to reassure staff in this regard.

Ms Radage welcomed the provision of the minutes to the Committee which provided insight into all aspects of the organisation. Ms Fallon agreed with this point and noted the minutes provided an additional layer of assurance.

The Committee:

1. Noted the Approved Partnership Forum Minutes.

10 COMMITTEE WORKPLAN 2025

Members received the Committee workplan for 2025 from Mr Wallace who explained the updated areas. It was agreed that the Maximising Attendance report should be added as a standing item at each meeting for the remainder of this year.

Action – Secretariat

The Committee:

1. Noted the Committee Workplan 2025.
2. Added Maximising Attendance as a standing item at each meeting.

11 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

The following areas were highlighted:

Ms Fallon referenced the Partnership Forum minutes and noted this to be an example of good practice, openness and trust in the approach taken.

Members agreed that the concise nature of reporting and the pack of papers for this meeting had helped to support focused discussion and noted this as an example of good governance.

Mr Wallace highlighted the work undertaken by the working group involved in the planning of the Staff Excellence Awards.

Mr Jenkins highlighted the work of the Estates team during the recent storm and noted the exceptional work carried out by the team. He suggested that a note of recognition and thanks was formally passed on to the department on behalf of the Staff Governance Committee, with Ms Radage supporting this.

12 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

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

13 ANY OTHER BUSINESS

There were no additional items for discussion.

14 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 15 May 2025** at 0930 hours via Microsoft Teams.

The meeting concluded 12.05 pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 20
Author(s):	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 15 May 2025.

1	Staff Governance Committee Annual Report	The Committee reviewed the content of the report, considering the refreshed approach to agenda setting, and reporting which had helped to support focused discussion on key aspects throughout the year. There was agreement that the Committee was functioning well and had fulfilled its remit. There was agreement that it would be helpful to continue to align annual reporting to be considered across the standing committees of the Board, going forward i.e. encompassing areas of good practice or of concern.
2	Workforce Plan 2025-28 Update	It was noted that work was progressing to develop the plan, including engagement to date and that the plan was based on the five pillars of workforce planning. The plan would be finalised with a final draft to be presented to the next meeting in August. There was discussion on some key aspects including succession planning and leadership development, recognising potential risk factors in a small organisation.
3	Fitness to practice Report	The Committee received assurance reporting, noting no lapses in professional registration across the course of the year.
4	Workforce Report	Reporting provided a summary of performance over the full range of workforce metrics, including attendance, recruitment and retention as well as employee relations and employability scheme. The Committee thought reporting was helpful in focusing on the key data required to give meaningful insight into performance. There was discussion in particular on the importance of resolution of employment cases as timeously as possible, and also positive reflection on the development of the Workforce Equalities Group.
	Maximising Attendance	The Committee received reporting with detailed data analysis n absence rates for the State Hospital (TSH) metrics in comparison to wider NHSScotland, Reporting provided further background about the management strategies in place to maximise attendance, and the range of supportive mechanisms made available to staff. There was further context in terms of the costs to the organisation of high rates of absence. The Committee discussed this in detail, highlighting the risk to TSH and need for long term improvement.
5	Rostering Update	The Committee received assurance reporting about the progress

		made in the actions required following internal audit. There was consideration of the findings of the audit, and the need to improve compliance rates in record keeping and to establish effective means of ensuring adherence across the site. The Committee noted that proactive audit work was in place and that reporting would come return in this respect, with follow up on the internal audit actions being submitted through the Audit and Risk Committee. This was noted as an area of concern which would require further assurance reporting.
6	Corporate Risk Register - Staff Governance Risks	The Committee received reporting detailing the corporate risks related to staff governance. The Committee noted the current activity in this area to review existing risks and consider movement as well as the need to consider addition of further areas e.g. sickness absence.
7	OD and Wellbeing Strategy Quarterly Update Report	The Committee received the draft Organisational Development (OD) and Wellbeing Strategy and discussed the headline aspects of this including the much more proactive approach being taken. This was noted to be inclusive and focused on embedding the strategy across the organisation. The Committee considered that good progress had been made already, and that the strategy would strengthen this. There was consideration of how to progress leadership development aspects, as well as the metrics underpinning the strategy and taking an evidence-based approach to improvement. The Committee endorsed the strategy and recommended that it should be submitted to the Board for final approval. The Committee also received quarterly reporting on activity within the OD Learning and Wellbeing.
8	Partnership Forum	The Committee received the approved minutes of meetings of the forum over the last quarter, taking assurance from the openness and transparency demonstrated within these.
9	Workforce Governance Group	The Committee received the approved minutes of the Workforce Governance group from March 2025, noting the refreshed agenda for this group, and that discussions reflected the key priorities around staff governance.
10	Areas of good practice /Concerns	The internal audit on nurse rostering was noted, with further assurance being required on progress of actions. Good progress was noted on PVG checks for staff against the deadline for completion of this. The work around employability scheme was also noted as good practice.

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 /	As part of corporate governance arrangements, to ensure committee business is reported timeously.
Corporate Objectives Please note which objective is linked to this paper	**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. f. Develop and implement the Organisational Development Strategy, and action plan, using Organisational Health approach. 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.
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	N/A

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:	19 June 2025
Agenda Reference:	Item No: 21
Sponsoring Director:	Committee Chair
Author(s):	Director of Finance and eHealth
Title of Report:	Audit and Risk Committee Annual Report 2024/25
Purpose of Report:	For Decision

1 SITUATION

The Report outlined in Appendix 1 is presented to the committee to meet the requirements within the Committee's Terms of Reference to submit an annual report of the work of the Committee to the Board. The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control.

2 BACKGROUND

The preparation of an Annual Report by the Audit & Risk Committee is an important assurance process for the Board in its consideration of the effectiveness of internal controls. The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Areas of Best Practice
- Review of Terms of Reference

An effective system of internal control is fundamental to securing sound financial management of the Board's affairs.
The consideration and review of internal and external audit reports, and management responses, together with reports submitted by other officers, assist the Committee in advising the Board with regard to material risks.

3 ASSESSMENT

This report was presented to the Audit and Risk Committee for approval at its meeting of 19 June 2025, prior to submission to the Board.

4 RECOMMENDATION

The Board is asked to note the Audit and Risk Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2024/25.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP	Year end reporting to demonstrate that the committee has met its remit
Corporate Objective	**Better Value 3(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.
Workforce Implications	None identified as part of reporting
Financial Implications	None identified as part of reporting
Route To Board Which groups were involved in contributing to the paper and recommendations	Submitted by the Audit and Risk Committee to the Board
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	No impact identified
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 impacts 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

Appendix 1

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE ANNUAL REPORT

1 April 2024 – 31 March 2025

1. Introduction

The Audit and Risk Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

The main objectives of the Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Committee fulfils its remit, this may involve assessing the attendance and performance of each member.
New members receive a suitable induction and declares his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

2. Committee Chair, Committee Members and Attendees

Committee Chair:
David McConnell (Chair of Committee, Non Executive Director)

Committee Members:
Allan Connor (Employee Director)
Stuart Currie (Non-Executive Director)
Pam Radage (Non-Executive Director)

In attendance:
Gary Jenkins (Chief Executive)
Robin McNaught (Director of Finance and eHealth)
Monica Merson (Head of Planning and Performance)
Brian Moore (Board Chair)
Margaret Smith (Head of Corporate Governance/Board Secretary)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing and presentations.

3. Meetings 1 April 2024 – 31 March 2025

During 2024/25 the Audit and Risk Committee met on four occasions, in line with its terms of reference (Appendix 1).

Meetings were held on:

20 June 2024
26 September 2024
30 January 2025
27 March 2025

Attendance of Committee members were as follows:

	Number of Meetings Present
David McConnell	4
Allan Connor	4
Stuart Currie	4
Pam Radage	4

4. Summary of Reporting

The Committee received and considered reports as undernoted and made recommendations and/or monitored areas as required:

Internal Audit Reports:

- Complaints
- New Clinical Model
- Consultant Discretionary Points
- Statutory and Mandatory Training
- Physical Health – Supporting Healthy Choices
- Roster Compliance

Workplan Reporting

- Risk Strategy
- Adverse Events Action Tracker
- Attendance Management – Risk Report
- Cyber Security Report
- Committee Workplan 2025
- Financial Report

a. Annual Reports

Annual Reports from Governance Committees

i. Audit and Risk Committee
ii. Remuneration Committee
iii. Clinical Governance
iv. Staff Governance

Annual Accounts

v. Statutory Annual Accounts
vi. Patient Funds Accounts

Annual Reports

vii. External Audit Annual Report to the Board and the Auditor General for Scotland
viii. Annual Audit Committee Assurance Statement to the Board
ix. Internal Audit Annual Report 2023/24
x. Audit Scotland Reporting, including NHS in Scotland 2024
xi. National Single Instance (NSI) and NSS Audits
xii. Review of draft Governance Statement
xiii. Review of Scheme of Delegation and Standing Financial Instructions
xiv. Review of Board Standing Orders and Code of Conduct
xv. Review of Accounting Policies
xvi. Review of Committee Terms of Reference
xvii. Review of Effectiveness of Committee
xviii. Risk and Resilience Annual Report
xix. Climate Emergency and Sustainability Annual Report 2023/24

xx. Procurement Annual Report 2023/24
xxi. Legal Claims Annual Report 2023/24
xxii. Anchors Strategy Annual Update
xxiii. Summary of Losses and Special Payments
xxiv. Report on Waivers of SFI Tendering Requirements

b. Progress Updates

The Committee also received regular updates on the following –

i. Completion of audit actions
ii. Policy review completions
iii. Risk register reviews
iv. Counter fraud activity and outcomes of fraud reviews
v. Adverse events
vi. Cyber security matters
vii. NIS audit review
viii. Scottish Public Finance Manual update

c. Standing Items Considered by the Committee during the Year

Standing Items

i. Internal Audit Tracking Report
ii. External Audit Update
iii. Financial Performance Update
iv. Policy Update
v. Corporate Risk Register
vi. Fraud Update and Action Plan

d. Notes of updates from other meetings

The Committee received and noted minutes/reports from the following:

i. Security, Resilience, Health and Safety Oversight Group Update
ii. Finance, eHealth and Audit Group Update
iii. Climate Change and Sustainability Group Update

5. Activities / Risk Management

5.1 Corporate Risk Register

An update on the latest progress of the Corporate Risk Register went to each Audit and Risk Committee in the 2024/25 period. The paper details any changes to current grade of the approved risks, updates on any current high and very high risks, any new risks for consideration and updates on the general development of the risk register. The latest paper in March 2025 showed that all approved risks were within their review period. The latest updates of the 3 'High Graded' risks were given: MD30 – Failure to prevent/mitigate obesity, ND70 – Failure to utilise our resources to optimise excellent patient care and FD90 – Failure to implement a sustainable long term model. Updates included the latest progress on the control measures in place to reduce the risk to an acceptable level. The paper provides assurance to the Audit and Risk Committee with regards to any increased areas of concern within the Corporate Risk Register as well as ensuring risks are regularly updated and reviewed.

5.2 Category 1 and 2 Action Tracker

After the conclusion of a Category 1 or 2 Adverse Event Review recommendations are made to reduce the chances of the adverse event recurring. The tracker provides assurance to the Audit and Risk Committee that all actions have been appropriately considered and either actioned or reasons given for being unable to implement an agreed recommendation. The report also provides an update on any ongoing reviews and new reviews that have been commissioned by the Corporate Management Team. The latest report detailed 3 outstanding recommendations that are due for action alongside 5 new recommendations that were added in December 2024. The report was provided to each meeting of the Audit and Risk Committee in 2024/25 allowing the group to have sight of current progress of the recommendations made.

6. Areas of Best Practice

Improvement

- Regular reporting now from Finance, eHealth and Audit Group, and Security, Resilience, Health and Safety Oversight Group
- Regular reporting on TSH financial position

Concern

- The members reviewed Committee effectiveness through formal assessment in September 2024, reporting to the Audit & Risk Committee that month – there were no matters of significant concern noted. It was noted that there was a potential lack of full independence of Committee members from other Governance Committees and Board, but that was acknowledged as an inevitable consequence of the size of the Board.

7. Conclusion

From the review of performance of the Audit & Risk Committee, it can be confirmed that the Committee has met in line with the Terms of Reference, and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Audit & Risk Governance arrangements were in place throughout the year.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2024/25**.**

David McConnell
AUDIT AND RISK COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit and Risk Governance Committee

Appendix 2

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Audit and Risk Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

2 COMPOSITION

2.1 Membership

The Committee is appointed by the Board and shall be composed of at least three Non-executive Board members.

Membership will be reviewed annually and disclosed in the Annual Report.

2.2 Appointment of Chairperson

The Chair of the Committee will be a Non-Executive Director, appointed by the Board.

2.3 Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive), Director of Finance and eHealth, Chief Internal Auditor, a representative from External Audit and any other appropriate officials shall normally attend meetings and receive all relevant papers. Other Directors may also be invited by the Chair of the Committee to attend meetings as required.

All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Committee members must regularly attend the Committee. This will be monitored, and attendance will be reported to the Board annually.

3 MEETINGS

3.1 Frequency

The Audit and Risk Committee will meet at least four times a year to fulfil its remit and shall report to the Board at least twice in each financial year.

The Chair of the Committee may convene additional meetings as necessary.
The Accountable Officer should attend all meetings but if he/she does not, be provided with a record of the discussions.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least three clear working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Audit Committee meeting. In line with Board Standing Orders, the Committee should approve the minutes prior to submission of these to the Board.

4 OTHER

In order to fulfil its remit, the Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and / or the External Auditor or Internal Auditor. It is expected that this should occur at least once in each financial year.

The Chief Internal Auditor and the representative(s) of External Audit will have free and confidential access to the Chair of the Committee.

The Chair of the Audit Committee should be available at the Board's Annual Accounts Approval Meeting to answer questions about its work.

5 REMIT

5.1 Objectives

The main objectives of the Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Committee fulfils its remit, this may involve assessing the attendance and performance of each member.
New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008.
http://www.scotland.gov.uk/Publications/2008/08/08140346/

5.2 Internal Control and Corporate Governance.

5.2.1 To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment; Risk management strategy, procedures and risk register;
- The effectiveness of the internal control and risk managements systems
- Decision-making processes;
- Receive and consider stewardships reports in key business areas.
- Information;
- Monitoring and corrective action

5.2.2 To review the system of internal financial control which includes:

The safeguarding of assets against unauthorised use and disposition.

- Maintenance of proper accounting records and
- the reliability of financial information used within the organisation or for publication.

5.2.3 To have a mechanism to keep it aware of topical legal and regulatory issues and ensure the Board's activities are within the law and regulations governing the NHS.

5.2.4 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.2.5 To present an annual assurance statement on the above to the Board to support the Directors' Governance Statement on Internal Control.

5.2.6 To take account of the implications of publications detailing best audit practice.

5.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

5.2.8 To review audit reports and management action plans in relation to physical security of the Hospital.

5.2.9 To provide assurance to the Board that plans are in place to ensure service continuity and to provide contingencies for emergency situations.

5.2.10 To provide assurance to the Board that plans and mechanisms are in place to ensure that Fraud is properly monitored and reported.

5.3 Internal Audit

5.3.1 To review and approve the Internal Audit Annual Plan.

5.3.2 To review the adequacy of internal audit staffing and other resources.

5.3.3 To monitor audit progress and review audit reports.

5.3.4 To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.

5.3.5 To consider the Chief Internal Auditor's annual report and assurance statement.

5.3.6 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.3.7 To review the terms of reference and appointment of the Internal Auditors.

5.4 External Audit

5.4.1 To review the Audit Plan, including the Performance Audit Programme.

5.4.2 To consider all statutory audit material, in particular:

- Audit Reports (including Performance Audit Studies);
- Annual Reports;
- Management Letters.

5.4.3 To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies (following consideration by the Staff Governance Committee or Clinical Governance Committee where appropriate).

5.4.4 To review the extent of co-operation between External and Internal Audit.

5.4.5 Annually appraise the performance of the External Auditors.

5.4.6 To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

5.5 Standing Orders and Standing Financial Instructions

5.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

5.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

5.5.3 To review the Scheme of Delegation.

5.6 Annual Accounts

5.6.1 To review annually (and approve) the suitability of accounting policies and treatments.

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

5.6.5 To review and recommend approval to the Board of the Annual Accounts.

5.6.6 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

5.6.7 To review and recommend approval to the Board of the Patients Funds Annual Accounts.

6 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7 PERFORMANCE OF THE COMMITTEE

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

The committee shall provide guidelines and/ or pro forma concerning the format and content of the papers to be presented.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

Subject to annual review
Last reviewed March 2025

Paper No 25/61

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 23
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Patients' Funds Accounts
Purpose of Report:	For Decision

1 SITUATION

The Board is required to approve the Patients' Funds Annual Accounts. These were approved by the Audit & Risk Committee at their meeting of 19 June 2025 for presentation to the Board.

2 BACKGROUND

Patients' funds are the balances of money held by TSH on behalf of patients. The Board's Patients' Funds Annual Accounts are presented in a format directed by the Scottish Government Health & Social Care Directorate (SGHSCD) and require to be audited by external auditors, approved by the Audit Committee and authorised by the Chief Executive and Finance & eHealth Director. The 31 March 2025 audit is now complete and the accounts are presented to this meeting for approval.

3 ASSESSMENT

The accounts generally show unpredictable fluctuations in average funds held – simply due to the level of patients' spending and income being fairly inconsistent from one year to the next. The average balance held per patient therefore also fluctuates, with a third consecutive year of a net outflow of funds.

	March 2025	March 2024	March 2023	March 2022	March 2021
Opening Balance	£646,124	£670,191	£677,098	£568,095	£432,617
Receipts	£541,249	£527,390	£613,305	£559,727	£513,243
Payments	£589,962	£551,456	£621,212	£450,724	£377,765
Net in/(out)flow of funds	£(48,714)	£(24,067)	£(6,907)	£109,003	£135,478
Closing Balance	£597,411	£646,124	£670,191	£677,098	£568,095
No. of patients at 31 March	104	98	109	113	114
Average funds per patient	£5,744	£6,593	£6,148	£5,992	£4,983

The Patients' Funds Accounts are audited by Wylie and Bisset who have issued an unqualified audit opinion.

4 RECOMMENDATION

The Board is invited to agree to the following recommendation – to approve the Abstract of Receipts and Payments of Patients' Private Funds for the year ended 31 March 2025, for signature by the Chief Executive and Director of Finance and eHealth.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP	Annual accounts for Board approval require to be presented to Audit and Risk Committee for approval before presentation to Board
Corporate Objectives Please note which objective is linked to this paper	**Better value (3c)** – 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
Workforce Implications	None
Financial Implications	None
Route to Committee Which groups were involved in contributing to the paper and recommendations.	Paper prepared by the Finance and eHealth Director
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified 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).	No identified implications
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

STATE HOSPITAL **SFR 19.0**
PATIENTS PRIVATE FUNDS
FOR YEAR ENDED 31 MARCH 2025

ABSTRACT OF RECEIPTS AND PAYMENTS

2024 £		2025 £
	RECEIPTS	
	Opening Balances:	
665,066	Cash in Bank	641,124
3,225	Cash on Hand	3,101
1,900	Other Funds	1,900
670,191		646,124
515,548	From or on behalf of Patients	530,036
11,841	Interest on Patients' Fund Account	11,212
1,197,581	**Total Receipts**	**1,187,373**
	PAYMENTS	
551,456	To or on behalf of Patients	589,962
0	Extra Comforts etc.	0
	Closing Balances:	
641,124	Cash in Bank	593,074
1,900	Cash on Hand	1,900
3,101	Other Funds	2,437
646,124		**597,411**
1,197,581	**Total Payments**	**1,187,373**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
646,124	Credit Balances	597,411
0	*Less: Debit Balances*	0
646,124		597,411
0	Interest Received but not Credited	0
646,124	**Total Closing Balance**	**597,411**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance _____ Date _____

The abstract of Receipts and Payments was submitted at the Board Meeting on 19th of June 2025 and duly approved

Chief Executive _____ Date _____

1. Note to SFR19

The Scottish Government Health Directorate requires The State Hospitals Board for Scotland to prepare, on an annual basis, an abstract of receipts and payments of patients' private funds administered by the Board. The abstract of receipts and payments of the patients' private funds has been prepared by the Board, on a cash basis, in accordance with the requirements of the 2024/25 NHS Board Accounts Manual.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 24
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Corporate Planning Performance and Quality
Title of Report:	TSH Annual Delivery Plan 2025/26 and Medium Term Plan 2025/28
Purpose of Report:	For Noting

1 SITUATION

The State Hospital (TSH) developed both its Medium-Term Plan (MTP) 2025-28 and an Annual Delivery Plan (ADP) 2025-26 to set out the delivery priorities over the year. TSH submitted the MTP 2025-28 and ADP 2025-26 to Scottish Government on 17th March. A formal letter was received form the Director of Mental Health in Scottish Government accepting both plans.

2 BACKGROUND

Scottish Government produced Delivery Plan Guidance for NHS Boards to develop Annual Delivery Plans for 2025-26. TSH's ADP was submitted as requested to Scottish Government by 17th March 2025.

3 ASSESSMENT

The ADP 2025-26 and MTP 2025-28 were developed following detailed directorate planning sessions. TSH Directorates and Teams developed 3-year plans which were consulted on during a planning event on 31st October 2024, following this the team and directorate plans were used to develop the ADP 2025-26 and the MTP 2025 -28. The key deliverables from the ADP 2025-26 are summarized in Appendix 1.

The diagram below outlines the critical success factors for TSH and the key areas for delivery for the MTP 2025-28.

TSH Medium Term Plan 2025 – 28
Structure and TSH Critical Success Factors

4 RECOMMENDATION

The Board is invited to note the content of the report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	The Annual Delivery Plan sets out the key delivery priorities for TSH over the period.
Corporate Objectives Please note which objective is linked to this paper	The ADP links across all corporate objectives
Workforce Implications	Not assessed formally – the plan outlies the key strategic responsibilities for TSH in terms of workforce and aligns with the 3 year Workforce Plan 2025 - 28
Financial Implications	Not assessed formally – the plan outlies the key financial responsibilities for TSH and aligns with TSH 3 year Finance Plan
Route to Board Which groups were involved in contributing to the paper and recommendations.	CMT
Risk Assessment (Outline any significant risks and associated mitigation)	Not formally assessed however the CRR reflects key areas of delivery and aligns with the ADP
Assessment of Impact on Stakeholder Experience	
Equality Impact Assessment	
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; ☐ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

TSH - VISION is to be a leader in delivering relationally informed, person centred, high secure mental healthcare that enables recovery whilst ensuring the safety and wellbeing of staff, patients and the public.

Critical Success Factors & Key Themes	Annual Delivery Plan - Deliverables for 2025-2026								
Mental Health & NHS Reform	TSH will engage with the outcomes and recommendations from the Forensic Governance	TSH will contribute to achieving improvements aiming to exploring regional agreements to enhance cohesion in service	Engage and collaborate to support reform and transformation						
Women's service	Phase 1 - establish an interim acute admission and assessment ward for pre-trail & pre-sentence women	Phase 1 - Scope and develop an outreach service	Phase 2 – Long term						
Health inequalities	Continue with implementation of Anchors Strategy and develop revised strategy								
Improving patient's outcomes from their clinical are experience	Continue to embed the clinical model	Develop staff skills and capabilities on positive behaviour support planning	Review of risk assessment process	Develop approach to measurements of outcomes for patients	Review the approach to Structured Clinical Care and TSH strengths and weaknesses				
	Work towards the elimination of DCT	Contribution to Excellence in Care assurance framework	Review the approach for adopting new evidence, standards and guidelines related to local audits	Explore the development of master improvement plan from audit projects	Development of Research and Development Strategy				
	Improve efficiency of the pharmacy ordering process	Embed and monitor new CPA process to ensure it delivers	Implement recommendations from Unscheduled Care Short Life Working Group	Reduce weight gain	Increase uptake of activity for patients	Progress RM and VBH&C Principles	Champion quality assurance and improvement		
Continuous review of procedural, relational and physical security to reduce risk & harm and ensure resilience	Development and audit of security standards	Development of quality assurance framework	Review and upgrade the current incident management and Health and Safety platform	Strategic Infrastructure Planning - BCP & Capital budget					
Learning from patients views of patient, carers & stakeholders	Implementation of Carers Strategy	Review information available for Carers and establish a Carer's support group	Stakeholders awareness and skills development						
Working in partnership to achieve organisational health well-being and an engaged well supported workforce	Develop & implement work force plan	Raise awareness of Occ Health	Revised Maximising attendance approach	Launch OD Strategy	Establish dashboards	Implement business partner model aligning workforce	Support sustainable workforce	Develop Equalities Action Plan	Review employability agenda, with community
Value for money and achieving financial balance	Develop & implement Action plan	Establish dashboards	Digital inclusion and infrastructure	Business Service Transformation	Engage with the adoption of national digital programme	Prep for NIS audit in 2026			
Climate	Continue to work towards net zero target	Plan maintenance Programme							

Appendix 2

Annual Delivery Plan 2025/26

NHS Board: The State Hospital

Contents

INTRODUCTION

The State Hospital (TSH) has developed its Medium Term Plan 2025-2028 (MTP) which provides detail of the high level priority actions for delivery. This Annual Delivery Plan 2025/26 (ADP 2025/26) has been developed to reflect the first year's delivery of the key priorities in the MTP. It both reflects the local needs and priorities of TSH and also Scottish Government and NHS Scotland's national priorities as they relate to forensic mental healthcare. This delivery plan sets out currently anticipated areas of risk, service change and how the long-term sustainability of services can be supported. It also highlights any national or local performance measures to evidence the anticipated impact that plans will have on service delivery.

NHS Boards are required to ensure that their annual delivery plans reflect current work underway through the NHS Scotland Planning and Delivery Board. These, where relevant, have been identified throughout the delivery plan. TSH has also considered national strategies such as the Mental Health and Wellbeing Strategy and National Performance Framework in developing the delivery plan and ensuing alignment to national direction.

ROLE AND FUNCTION OF TSH

TSH is the national high secure forensic mental health care provider for Scotland and Northern Ireland. The organisation provides specialist individualised assessment, treatment and care in conditions of high security for patients with major mental disorders and intellectual disabilities. 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 and reduce risk. 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 is based within a single site in Carstairs, South Lanarkshire. The site is in a rural location. The hospital has 120 beds available for male patients, 108 beds for patients with Major Mental Illness and 12 beds for patients with Intellectual Disabilities. In 2025 TSH will open an interim high secure inpatient service for women.

An extensive consultation exercise was carried out in 2024/25 with staff, stakeholders and patients. This activity supported the development of the Medium Term Plan 2025-28 and the revised vision, mission and critical success factors that are required to deliver excellent forensic mental health care and treatment. The following was agreed:

The vision is to be a leader in delivering relationally informed, person-centred, high-secure mental health care that enables recovery whilst ensuring the safety and wellbeing of staff, patients, and the public.

The mission of the hospital is to assess and treat major mental disorders in a secure and person centred care environment that manages risks, supports recovery, rehabilitation and onward progression.

Critical success factors are the central things we do to achieve our mission and focus on:

- Improving patient outcomes from their clinical care experience.
- Continuous review of procedural, relational and physical security to reduce risk and harm and ensure resilience.
- Learning from the views of patient, carers, and stakeholders.

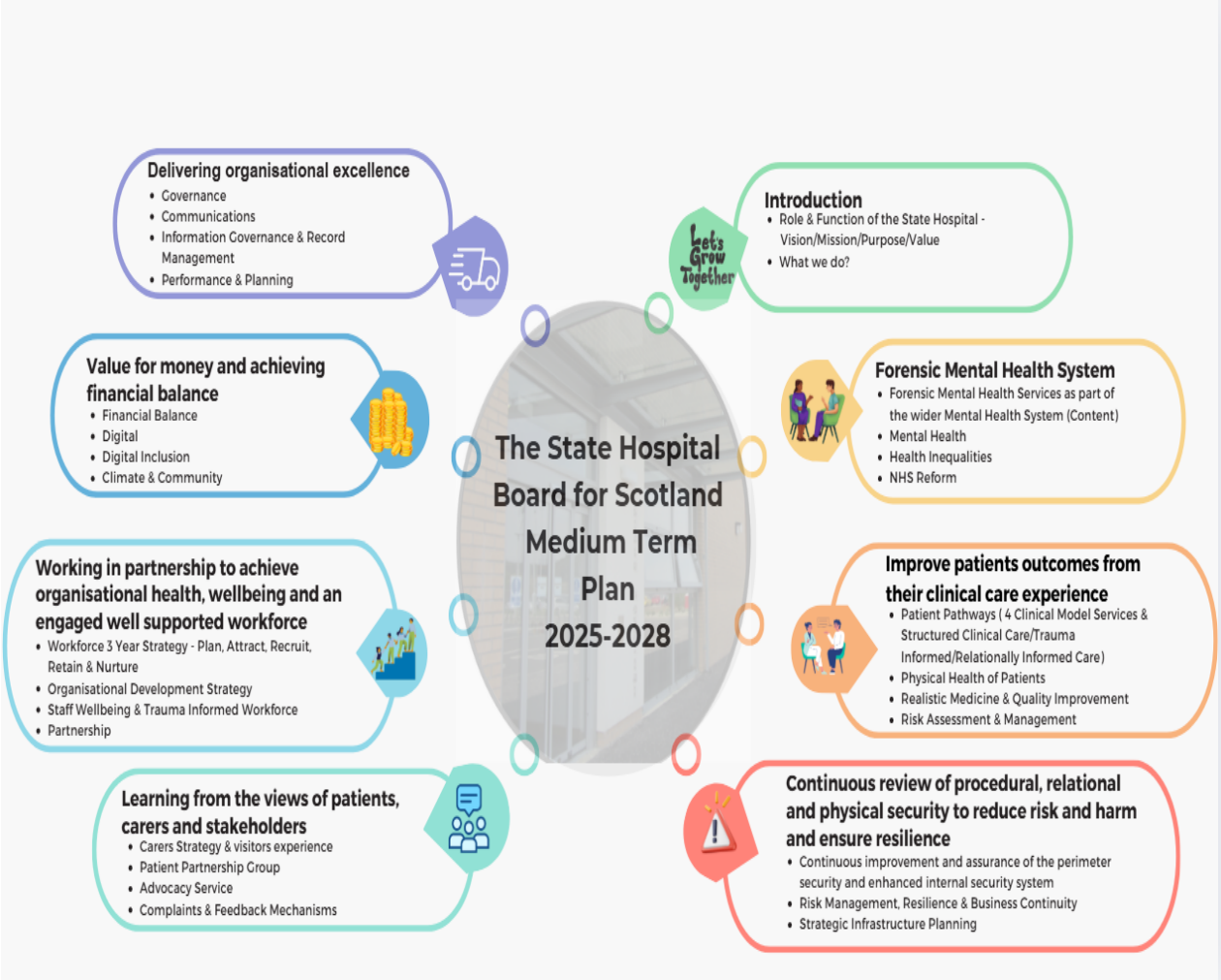
- Working in partnership to achieve organisational health well-being and an engaged well supported workforce.
- Value for money and achieving financial balance.

The values of TSH align with NHSScotland, they are:

- Care and compassion.
- Dignity and respect.
- Openness, honesty and responsibility.
- Quality and teamwork.

TSH MEDIUM TERM PLAN 2025-28

The Medium Term Plan 2025-28 (MTP) structure is presented below. The Annual Delivery Plan 2025-26 (ADP 2025-26) has been developed to reflect the first year's delivery of the key priorities in the MTP. The MTP has been developed following extensive engagement across all staff groups. Each directorate and all Heads of Service have developed local three year plans, these have been used to develop the overall MTP. All directorates also discussed and reflected on the vision and mission of TSH, which has been revised following the consultation. The critical success factors which are central to the achievement of TSH vision and mission have been used as pillars to structure the MTP. Through the engagement process, and over the delivery of this MTP, the focus has been on delivering effective care and treatment whilst focusing on the balance and calibration of organisational performance and health.



MENTAL HEALTH

The Mental Health and Wellbeing Strategy was launched in 2023 and outlines the legislative background, strategic ambition and focus for Mental Health and Wellbeing in Scotland. The associated Mental Health and Wellbeing Workforce Action Plan 2023-25, and the Mental Health and Wellbeing Strategy Delivery Plan 2023-25 were launched in November 2023. These documents outline priorities for Scottish Government which include strategic planning and governance of Forensic Mental Health Services and the provision of a high secure female service in Scotland.

The provision of the Mental Health (Care and Treatment) (Scotland) Act 2003 allows for detention in hospital and compulsory medical treatment on the grounds of mental disorder. Rigorous safeguards apply which include the right to independent advocacy, an independent mental health tribunal for Scotland and the independent Mental Welfare Commission. Scottish Government have committed to consider changes to practice and legislation to improve or simplify the delivery of forensic mental health services. There are two recent publications of particular relevance to Mental Health direction for Scotland, these are:

1) The Independent Review of Forensic Mental Health Services.
2) Scottish Mental Health Law Review.

TSH are aware and aligned to the ongoing development and delivery of relevant recommendations from these reports.

FORENSIC MENTAL HEALTH SERVICES AS PART OF WIDER MENTAL HEALTH SYSTEM

TSH operates as the high security provider within a wider Forensic System. TSH is an active cross-boundary collaborator and connects with a range of partners in health, criminal justice, policy, and resilience. TSH links with the Forensic Network and wider NHS and independent providers of health care. TSH have provided leadership in the Healthcare and Custody Oversight Group, collaborate on National Executive Leads and participate in the national Strategic Planning Board with a focus on Mental Health. It is recognised that this is a dynamic landscape, and that the emerging strategic direction of forensic services for Scotland is evolving. TSH will continue to review its cross-boundary collaboration and seek areas for improvement in cross system leadership where appropriate.

To facilitate further collaboration in Forensic Mental Health Services, the Scottish Government commissioned the Forensic Network to carry out further work on capacity across the estate in September 2024. The Forensic Network brought together NHS Boards and Forensic Mental Health Services to develop a plan to improve access to services and reduce variation between services. The focus was to reduce variation in referral criteria, minimise differences in management of waiting lists, achieve greater cohesion in the delivery of secure in patient services, and streamline escalation and dispute resolution processes. The Forensic Network reported findings to the Scottish Government. TSH will contribute to achieving improvements outlined in this plan, including exploring regional agreements to enhance cohesion in service delivery.

Forensic Mental Health Board for Scotland

The Scottish Government, in response to recommendation one of the Independent Review into the Delivery of Forensic Mental Health services has committed to develop plans to establish a Forensic Mental Health Board for Scotland. This Board would be established with the aim of delivering a national approach to the planning and governance of forensic mental health inpatient services.

A Forensic Governance Advisory Group was established in October 2024 to advise ministers on operational and practical changes needed to transition from the existing governance arrangements

for adult mental health services to a Forensic Mental Health Board for Scotland by exploring options detailed in their Terms of Reference. The group will provide a report to advise on how best to improve integration of existing national and local pathways of care providing adult forensic service. The group are due to report in May 2025.

NHS Scotland Reform

As part of NHS Scotland, TSH has a contribution to the strategic priorities that will support delivery of public service reform. The NHS requires major reform to ensure that it is a sustainable health service that is fit for the current and future population needs. Scottish Government vision is to enable people to live longer healthier and more fulfilling lives and is supported by four key areas of work: improving population health, a focus on prevention and early intervention, providing quality services and maximising access, all underpinned by person centred approach.

No	Planning Commitment	TSH Board Action	Delivery timescale
1.1	TSH will engage with the emerging strategic direction for the development of the Forensic Mental Health Board for Scotland.	TSH will engage with the outcomes and recommendations from the Forensic Governance Advisory Group and work with Scottish Government and other stakeholders to progress these.	2025/26
1.2	Forensic Network recommendations to improve access to Forensic Mental Health Services.	TSH will contribute to achieving improvements outlined in this plan which is aimed at exploring regional agreements to enhance cohesion in service delivery.	2025/26
1.3	Public service reform and cross system collaboration.	Engage and collaborate to support public service reform and transformation.	2025/26

Risks

Risks emerging from the above actions will be reviewed regularly by the Corporate Management Team (CMT), reported to TSH Board and if required will be added to the Corporate Risk Register to manage risks and mitigate potential impacts. The items will also form part of the quarterly performance review and sponsorship meeting with the Mental Health Directorate.

Performance Measures to evidence impact of plan on service delivery

TSH has a set of Corporate KPI which are reported quarterly to TSH Board and management groups. There are no specific Corporate KPIs relevant to the above system change and strategic direction of forensic mental health, as this is an emergent process. TSH will connect with Scottish Government Mental Health Sponsorship Team to address emerging issues from Public Sector Reform and Forensic Mental Health System change. TSH contributions will be reported through the management group structure of CMT, Organisational Management Team (OMT), the Partnership Forum and quarterly through the Strategic Planning, Performance and Governance Group. The corporate governance mechanisms of the Board and sub committees' structure will also receive updates and engage where appropriate. The Board Chair and CEO together with Directors will engage and advise where appropriate.

WOMEN'S HIGH SECURE FORENSIC SERVICE DEVELOPMENT IN SCOTLAND

The Scottish Government, in response to recommendation three of the Independent Review into the Delivery of Forensic Mental Health services has committed to the development of a plan to deliver services in Scotland for woman who need high secure care and treatment in the short and long term. There is currently no provision for high secure forensic mental health care and treatment

for women in Scotland. TSH have been working alongside stakeholders to support this commitment. Discussions with legal and ministerial colleagues in November 2024 resulted in an agreement to develop an interim service model of female high secure patients at TSH.

A high secure female service in Scotland is an additional service, separate from the current funding TSH receives to deliver a male high secure service. A female service requires both capital and revenue funding to be taken forward as a separate funding stream. In January 2025, funding was confirmed by the Mental Health Directorate to progress with both Phase 1 and 2 aspects of the female high secure service in TSH. A project team was then established to take forward planning.

In early 2025, the project team commissioned a feasibility study on Phase 2 of the development of a medium to long term female high secure service. They also commenced development of plans for the interim service in collaboration with key stakeholders. A Project Initiation Document was agreed by CMT and TSH Board in February 2025. A project governance and reporting structure is in place to receive regular reports on progress and risks.

The development of the high secure female service will be taken forward in two interconnected phases.

Phase 1 – Interim and Outreach Service Model

TSH will progress a High Secure Female service development in Q1/2 2025 with the objective to:

- Develop and implement an interim woman's service model for patients who have been clinically assessed as requiring high security care and treatment.
- Develop and implement an outreach service model from high security to medium security providers and Scottish Prison Service, based on the Rampton outreach model. The outreach service will aim to work in partnership with service teams to support the management of patients who may require referral and admission to TSH.

Phase 2 – Medium - Long Term Service Model for high secure female inpatient services

Oversee the development and implementation of capitol development following the outcome from a professional design team feasibility report. This will create a dedicated care and treatment centre. Timelines and project milestones will be agreed following the outcome of the design team's feasibility study, it is anticipated it is likely to be circa 36 months.

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 TSH.

A female high secure service would be segregated from the male service to protect patients and support recovery. This is in line with how similar services are delivered in England. A female high secure service will require segregated arrangements to provide:

- Access to Activity.
- Grounds/Outdoor access.
- Dedicated therapeutic and recreational physical environment.
- Activities Centre.
- Access to Healthcare Services.

There is a risk that women are unlikely to move beyond 'safety and stabilisation' in their clinical treatment journey if they are within a mix gender environment.

Options to Develop the High Secure Female Medium - Longer Term service model

TSH commissioned a Lead Advisor to develop and produce an Initial Design Assessment proposal for a National High Secure Healthcare Service for Women in Scotland. The Lead Advisor will coordinate a design team with all required experience to produce the Initial Assessment proposal for the project. The Initial Assessment proposal for the project will be presented Q1 2025/26.

The initial design assessment will consider four options for the development of the service on site in TSH and make recommendations on the feasibility, costs and benefits of each option for full consideration. The project will require to be compliant with all current statutory standards and regulations.

Following this approach future work will be required to develop the following:

- Outline Business Case for National High Secure Service for Women.
- Full Business Case for National High Secure Service for Women.
- Construction Phase for National High Secure Service for Women.

The timeline for completion and go live for the medium to long term service model is dependent on the outcome of the design team feasibility study, and agreement from NHS Assure. 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.

Board actions in 2025/26 to develop a National High Secure Service for Women

No	Planning Commitment	TSH Board Action	Delivery timescale
2.1	Phase 1 - TSH to establish an interim high secure forensic mental health service for women.	TSH develop infrastructure for establishment of an interim model for women, this will include: • Clinical operating model. • Ward modifications. • Admission criteria and process. • Workforce model including recruitment and training.	2025/26 Q1/2
2.2	Phase 1 – Forensic Female Outreach Service.	Scope and develop an outreach service model. The aim will be to support medium secure units and Scottish Prison Service to assist in managing patients who may require referral and admission to TSH female service, or who are displaying behaviours that necessitate a high secure referral.	2025/26 Q2
2.3	Phase 2 - TSH will develop an initial design feasibility assessment for a Medium – Longer term Forensic Female High Secure Service.	Planning proposal detailing the options, risks, financial and capital investments will be submitted to Scottish Government.	2025/26 Q1
2.4	Phase 2 - TSH will develop required planning and governance approaches to achieve development of Forensic Female High Secure Service	Outline Business Case.	2025/26 Q3
2.5	Phase 2 - TSH will develop required planning and governance approaches to achieve development of	Full Business Case.	2025/26 Q4

No	Planning Commitment	TSH Board Action	Delivery timescale
	Forensic Female High Secure Service.		

Risks

Risks emerging form the above actions will be reviewed regularly by the Project Oversight Board, reported to CMT and TSH Board, if required will be added to the Corporate Risk Register to manage risks and mitigate potential impacts on current TSH services. The development of a high secure female service is a significant addition to TSH function. As a complex project it will require full project management and governance, including risk and issues registers. TSH will report significant risk to the Scottish Government Mental Health Policy Team through the sponsorship arrangements.

Performance Measures to evidence impact of plan on service delivery

TSH has a set of Corporate KPI which are reported quarterly to TSH Board and management groups. There are no specific Corporate KPIs relevant to above area at this stage. Performance in this area will be tracked through Project Management monitoring and reporting processes. A Project Oversight Board will be established to oversee the work programme. The Oversight Board will be chaired by a 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.

HEALTH INEQUALITIES

There are many, diverse and interacting determinants of mental health and wellbeing, with these being driven by structural factors such as unequal distribution of income, power and wealth, global, national and local economic and political forces and priorities, and societal attitudes. Within TSH individual health inequalities and health behaviours are addressed later in this plan through the supporting healthy choices and physical health projects. The more structural elements of population health and health inequalities are addressed in this section with a focus on improving health through supporting a circular economy via TSH Anchors strategy.

The State Hospital Anchors strategy 2023-25

Scottish Government commissioned all NHS Boards to produce an Anchors Strategic Plan as an initial three-year strategy to demonstrate how TSH plans to take action to contribute to community wealth. The initial themes include:

- Progressive Procurement - TSH can direct investment into the local region through procurement practices. It may be possible to consider giving local suppliers greater weight in procurement processes, which in turn can create new employment locally.
- Employment - TSH is a relatively large local employer within an area of deprivation. Development of recruitment practices to encourage community members to consider employment in TSH would be useful to consider.
- Sustainable use of land and property - consideration given to the use of land and sustainable practices.

The Anchors strategy has a range of commitments in each of the initial themes. TSH have developed an action plan to ensure that key commitments are taken forward. Reporting is through the Risk and Audit Committee and onwards to TSH Board and Scottish Government through the Anchors Strategy baseline metrics report. As Scottish Government evolve their approach to Anchors institutions and organisations TSH will adapt the strategy to reflect requirements.

Board actions in 2025/26 to address health inequalities

No	Planning Commitment	TSH Board Action	Delivery timescale
3.1	Anchors implement strategy 2023-2025.	Continue with implementation of action plan with focus on: • Progressive procurement. • Employment. • Land and assets.	2025/26 Q1-4
3.2	Develop Anchors Strategy 2026-2028.	Develop revised strategy based on learning from previous strategy and in line with Scottish Government commission.	2025/26 Q3

Risks

Risks emerging form the above actions will be reviewed regularly by the Anchors Strategy Group and if required will be added to either Local Risk Registers or the Corporate Risk Register to manage risks and mitigate potential impacts on current TSH services.

Performance Measures to evidence impact of plan on service delivery

There are no specific Corporate KPIs relevant to above area. Performance in this area will be tracked through the management of the Anchors Strategy Action Plan which is reported through the Risk and Audit Committee.

IMPROVED PATIENT OUTCOMES FROM THEIR CLINICAL CARE EXPERIENCE

PATIENT PATHWAYS

A new clinical model was introduced in July 2023 to provide patients with a recovery pathway through TSH and address issues raised by staff around feelings of safety, confidence and practice. The new clinical model saw the establishment of four new services: Admissions and Assessment, Treatment and Recovery, Transitions, and Intellectual Disability. Service Leadership Teams were also established for each service, with an overarching leadership group overseeing the implementation of the model, (Clinical Model Oversight Group). Clinical Model Guidance was developed to guide and support implementation with detailed sections on the four new services. Referral between services is now expected with all major mental illness patients being admitted into Admission and Assessment wards, then progressing, if required, though the Treatment and Recovery and onwards to Transitions service. Patients with an Intellectual Disability are admitted directly to the Intellectual Disability service.

Each service has developed a three year implementation plan to outline what they seek to achieve. All four clinical model services in 2025/26 plan to continue to embed the clinical model and support team development. Service identity is also evolving, and each Service Leadership Team will continue to embed their specific part of the patient recovery pathway. The clinical guidance document will be reviewed as part of the maturation of each service. Any updates to the clinical guidance will be received through the Clinical Governance route with the Clinical Model Oversight Group having oversight of the patient pathway and overall effectiveness of the clinical model.

To support development and delivery of clinical service in TSH, priorities have been identified to progress the following areas. Further information can be found in the MTP, however we anticipate deliverables on the following areas in 2025/26:

- Continuous improvement for risk assessment and analysis of risk.
- Measurement of outcomes for High Secure Forensic Mental Health Services.
- Review of new approaches and frameworks for care delivery such as structured clinical care.

- Continued work to embed trauma informed care.
- Development of pharmacy services, streamlining medicines ordering processes.
- Development of quality assurance process through clinical audits.
- Development of evidence based care and treatment.
- Elimination in use of daytime confinement.
- Continued work to progress Excellence in Care.
- Continue to embed new process for the care and treatment plan (CPA) process.

TSH recently launched its updated Clinical Quality Strategy 2024 to 2029 with an associated action plan. This will be monitored and reported through Clinical Governance Group over 2025/26.

Realistic Medicine (RM) is the Scottish Government's approach to delivering Value Based Health and Care (VBH&C) in Scotland. VBH&C is defined as "the delivery of better outcomes and experiences for the people we care for through the equitable, sustainable, appropriate and transparent use of available resources".

TSH develops a Realistic Medicine Action Plan annually to outline the key projects associated with the approach. TSH continue to link with national networks to share practice. Priorities in 2025/26 will be to continue to champion RM, and VBH&C, embedding Shared Decision Making and championing the use and adaptation of BRAN questions (benefits, risks, alternatives and no action) within a secure setting. Each project in the RM action plan has also been aligned with the relevant commitment from the Scottish Government's VBH&C action plan

Physical Health of patients

People with severe mental health conditions often have higher rates of physical ill health such as cardiovascular disease, respiratory disease, diabetes, obesity, digestive diseases, and cancer (John et al, 2018), and also their physical problems can be made worse by effects of their mental health problems. People with severe and enduring mental illness may have their expected lives shortened by 15 to 20 years, a large part of which is because of physical ill-health. (Rees and Thomson, 2021). This is largely due to preventable physical health problems.

TSH continues to recognise the importance of health improvement and disease prevention programmes that target the main causes of morbidity and premature mortality with particular attention to obesity and reducing cardiovascular risk and recognises that physical activity is an extremely important part of overall physical healthcare.

Patients within TSH are offered annual physical health reviews. TSH monitors the uptake of the physical health review and reports it through its corporate KPI report.

TSH has a dedicated group which focuses predominately on improving physical health outcomes. This is further supported by the Supporting Healthy Choices Implementation Group that aims to create an environment that best supports patients to engage in behaviours that support their physical health and healthy weight. Focus over 2025/26 will include:

- Implementation of practice change in the Admissions service to limit weight gain for patients on admission.
- Improvement in practice to support patients' decision making when making purchases in the shop.
- Monitoring the time patients spend on meaningful activity.

Unscheduled Care

Patients in TSH at times require care from other NHS Board's, predominately, but not exclusively from NHS Lanarkshire. In 2024/25 TSH reviewed its arrangement for unscheduled care outings of patients to identify areas for improvement. The review identified areas to further test which include use of the Flow Navigation Centre (FNC), which also connects to the current system used,

Consultant Connect. The FNC would provide a single point of contact for emergency outings with the ability to time ambulance arrivals at TSH with the receiving hospital appointment to lessen time waiting for TSH patients and staff at external venues. The recommendations from the unscheduled care group will be taken forward in 2025/26 and improvements, where found, adopted.

Board actions in 2025/26 to improvement patient outcomes

No	Planning Commitment	TSH Board Action	Delivery timescale
4.1	Continue to embed the clinical model.	Each service will review the Clinical guidance and update as required. Each service will review its 3 year plan at end Y1, Y2, Y3 and take part in forward planning as appropriate. Service development activities will be taken forward to develop each service.	2025/26 Q3 2025/26
4.2	The Intellectual Disability service will develop its care approach using positive behaviour support planning.	Develop staff skills and capabilities on Positive Behaviour Support Planning.	2025 /26
4.3	Review of Risk Assessment Process.	TSH will continue to review current risk assessment process and make recommendations and implement change as required. Review process to include information sharing protocol with Police Scotland and improved access to information as well as establishing an MDT risk group.	2025/26 Q4
4.4	Outcomes focus.	Develop approach to measurement of outcomes for patients: • Review of relevant literature for domains. • Establish expert panel. • Identification and development of domains for measurement. • Testing of measurements. • Recommendations for suite of outcomes.	2025/26 Q1 Q1 Q2 Q3/4 Q4
4.5	TSH will review new frameworks of care e.g. Structured Clinical Care/ Relationally Informed Care and develop most appropriate pathway for TSH.	Review the approach to Structured Clinical Care (SCC) and TSH strengths and weaknesses in relation to this. Establish whether SCC is the approach that TSH will take to develop its clinical care.	2025/26 2025/26
4.6	Pharmacy.	Improve efficiency of ordering processes to free up more time for clinical services: • Q1: use QI methodology to reduce frequency of order stock sheet (ward profile) checking.	2025/26 Q1 Q2

No	Planning Commitment	TSH Board Action	Delivery timescale
		• Q2: update Standard Operating Procedures for ward top ups and ward profile changes. • Q3: conduct scoping exercise to determine if processes can be further automated.	Q3
4.7	Day time confinement (DTC) - TSH will work towards elimination of DTC.	TSH have oversight of all episodes of DTC through daily monitoring and reporting from services on actions to avoid DTC use and any episodes of DTC. Governance and management in place to provide oversight. Escalation of DTC to notify at Director level Nursing staff resourcing has been identified as a significant contributing factor to DTC, actions have been taken to increase nurse resourcing and the impact of these actions on DTC is being monitored to identify episodes or emerging trends of DTC. This will be reported to Strategic Planning, Performance and Governance Group and escalated to CMT if required.	2025/26
4.8	Excellence in Care.	Contribution to Excellence in Care assurance framework to ensure forensic mental health nursing appropriately represented.	2025/26
4.9	Quality Assurance.	Review the approach for adopting new evidence, standards and guidelines related to local audits: • Explore current local system to identify the criteria required for a more effective future system. • Scope out with other NHS Boards the current systems and approaches used by peers. • Agree approach to be taken. • Implementing this into practice.	2025/26 Q1 Q1 Q2 Q4
4.10	Quality Assurance.	Explore the development of master improvement plan from audit projects to provide coherence across audit actions and ability to prioritise.	Q3/4
4.11	Development of evidence based care and treatment.	Development of Research and Development Strategy.	2025 Q2
4.12	CPA process.	Embed and monitor new CPA process to ensure it delivers as expected: • Live testing. • Monitor. • Fully embedded.	2025/26 Q1/2 Q3/4 Q4
4.13	Unscheduled care.	Implement recommendations from the Unscheduled Care Short Life Working Group (SLWG) Test Flow Navigation Centre.	2025/26 Q1-4 Q1-2

No	Planning Commitment	TSH Board Action	Delivery timescale
4.14	Reduce weight gain.	Through the Test Admission Collaborative Kick Start group (TACKS) project, TSH will prioritise physical health by implementing practice change within the admissions service, local target in place to limit weight gain following admission to 5% of body weight.	2025/26
4.15	Reduce weight gain.	The TSH patients shop SLWG will implement and evaluate improvements in practice to support patient's decision making for shop purchases and support focus on health and wellbeing.	2025/26
4.16	Increase uptake of activity for patients.	Service Leadership Team's developed tailored approaches to improve uptake of activity.	2025/26 Q3
4.17	Progress RM and VBH&C principles.	Update annually and implement Realistic Medicine Action Plan. Submit RM Action Plan 2025/26 to Scottish Government.	2025/26 Q1
4.18	Progress RM and VBH&C principles.	Embed Shared Decision Making by increasing the uptake of the learning module.	2025/26
4.19	Progress RM and VBH&C principles.	Champion the use and adaptation the BRAN questions through the nursing care plans.	2025/26
4.20	Build capacity for QI.	Deliver and support QI training. Deliver QI Essential Training. Champion leadership training in QI.	2025 /26 Q3/4
4.21	Champion quality improvement.	Establish Team Based Quality Review (TBQR): • Provide training for TBQR panels on Human Factors. • Establish panels. • Review process.	2025/26 Q1 Q1/2 Q4
4.22	TSH3030 – Organisational approach to QI.	• Plan and implement a cycle of TSH3030. • Support sustainability of projects started through TSH3030.	2025/26 Q1 Q2-4
4.23	Champion quality assurance and improvement.	Monitor and implement actions from the Clinical Quality Strategy Action Plan.	2025/26

Risks

Risks emerging form the above actions will be reviewed regularly throughout the management group structure of CMT/OMT and Service Leadership Teams. If required risks will be added to either Local Risk Registers or escalation to the Corporate Risk Register to manage risks and mitigate potential impacts.

Performance Measures to evidence impact of plan on service delivery

TSH has a set of Corporate KPI's which are reported quarterly to TSH Board and management groups.

TSH has ten key performance indicators reported through its corporate KPI report to the Board these focus on delivery of clinical care, physical activity and healthy weight:

1) 25% of patients will have a healthier BMI.
2) 70% of patients will undertake 150 minutes of moderate exercise each week.
3) 90% of patients will be engaged in off hub activities.
4) 100% of patients will have their care and treatment plans reviewed at 6 monthly intervals.
5) 100% of patients will be transferred / discharged using the CPA process.
6) 85% of patients will be engaged in psychological treatments.
7) 100% of patients will commence psychological therapies within 18 weeks from referral date.
8) 100% of patients will have their clinical risk assessment reviewed annually.
9) 100% of patients will have an annual health review by the practice nurse.
10) 100% of patients requiring primary care services will have access within 48 hours.

There is an ongoing process to review and where appropriate replace/update KPI's to ensure they accurately reflect the improvements TSH are keen to develop.

Performance in these areas are tracked through established internal monitoring and reporting processes, including, but not limited to quarterly Directorate Performance Meetings which provide an opportunity to review and discuss the performance of each directorate and its unique contribution and challenges. Performance is also reviewed throughout the management group structure of CMT/OMT, and quarterly through the Strategic Planning, Performance and Governance Group. The Service Leadership teams and the Activity Oversight Group also review performance in these areas. There are also corporate governance mechanisms of the Board and sub committees' structure.

CONTINUOUS REVIEW OF PROCEDURAL, RELATIONAL AND PHYSICAL SECURITY TO REDUCE RISK AND HARM AND ENSURE RESILIENCE

Security

The purpose of security in forensic mental healthcare is to provide a safe and secure environment for patients, staff, volunteers and visitors which facilitates appropriate treatment for patients and protects the wider public. This involves maintaining a secure environment where mental health care can be delivered, mitigating risks, preventing violence or self-harm and responding effectively to incidents. There are unique challenges posed within a high secure setting and security measures require to be both effective and respectful of people's dignity and mental health needs.

All patients in TSH have been assessed as requiring high security care. As such, all areas within TSH are maintained at a level to meet the criteria set by the Forensic Network Matrix of Security.

The specific features of high security are categorised into three domains: physical, procedural, and relational. These are interdependent and essential for the delivery of safe and secure care:

1) Physical security - Prevents access/egress to a facility or resource through specific measures e.g. locks, alarms, CCTV.
2) Procedural security - The range of policies and procedures that control access/egress, movement across the hospital site, patient communication, patient possessions and visits, etc.
3) Relational security - The ability of staff to develop therapeutic relationships with patients, leading to trust and engagement between staff and patients.

In addition to the measures in place across the site, all patients are subject to a range of security measures tailored to their clinical and risk evaluation needs and the stage of their treatment journey.

TSH has implemented a complex project to upgrade security on site. The Perimeter Security and Enhanced Internal Security Systems project was completed in 2025. Following completion of the project, TSH is in the process of the development of an underpinning security framework by standardising procedures, training staff and implementing quality assurance measures to monitor and maintain the advanced security technology installed. The security framework and associated standards will align with other high secure hospitals within the UK, taking into account Scottish legislation and the Forensic Network Matrix of Security. This will enable TSH to measure and audit performance in line with set criteria. Going forward and in line with TSH development, TSH will refine policies to ensure that security interventions are trauma informed and carry out proactive threat assessment and tailored security planning.

Risk Management

The focus of risk management in TSH is to learn from and reduce risks to all staff and patients, with an aim to maintain a positive risk culture within TSH. The current Incident Management and Health and Safety System used within TSH is at this time under review with an option to upgrade the current recording platform. If the intention is to move to new platforms then these activities will be followed-up with staff training to enable effective use of new platforms. Staff will feel supported to take positive risks through a greater understanding of risk assessment and management.

Strategic Infrastructure Planning

Scottish Government have introduced a new approach to strategic infrastructure planning and investment across NHS Scotland. Each NHS Board are required to submit a Programme Initial Agreement which sets out a deliverable whole system service and infrastructure change plan for the next 20-30 years. The first phase of this new approach to planning is the development and submission of a maintenance only business continuity plan (BCP) based on the risk assessment of the boards existing infrastructure.

TSH has carried out a risk- based assessment of essential maintenance, which is prioritised as part of the completed BCP. Each risk has been considered through their probability and impact in the key areas of Business/Financial, Staff/Health and Safety/Injury, Clinical/Service and Reputational/Adverse Publicity/Complaint and Claims. Following submission of the BCP to Scottish Government in early 2025, TSH will commence work on the implementation of this plan in 2026/27, following agreement from Scottish Government on the funding allocations and associated timescales. It is important to note that actual funding allocations from Scottish Government will be made on the basis of need and risk and so may not follow the same distribution as planning principles.

The work incorporated in TSH BCP investment programme will support the work identified within the existing Capital Allocation. The BCP investment will allow TSH to maintain a good standard of accommodation to support the clinical demand.

Due to the unique security measures at TSH, 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 TSH. The existing capital allocation budget of £269K for 2025/26 will support projects to replace IT hardware, vehicles, digital inclusion and digital platforms.

Board Actions for 2025/26 to enhance security, reduce risk and harm

No	Planning Commitment	TSH Board Action	Delivery timescale
5.1	Security.	Development of security standards and framework.	2025/26 Q1/2

No	Planning Commitment	TSH Board Action	Delivery timescale
		Audit of TSH security processes, procedures and practice against new security standards.	Q3/4
5.2	Security.	Development of quality assurance framework to maintain and audit the new security technology installed across site.	2025/26 Q2/3
5.3	Risk Management.	Review and upgrade the current incident management and Health and Safety recording platform.	2025/26 Q3/4
5.4	Strategic Infrastructure Planning.	Business Continuity Planning/ Programme Initiation Assessment submitted to Scottish Government. Capital budget for 2025/26 will support projects to replace IT hardware, vehicles, digital inclusion and digital platforms.	2025/26 Q3/4

Risks

Risks emerging from the above actions will be reviewed regularly throughout the management group structure of CMT/OMT and Security, Risk and Resilience and Health and Safety Group. TSH will establish a Tactical Tasking and Co-ordination Group to address and assess threats and risks associated with security, resilience and health and safety. The group will ensure that a tactical assessment is developed to identify issues and risks and ensure these are managed through a dynamic responsive approach. If required risks will be added to either Local Risk Registers or escalation to the Corporate Risk Register to manage risks and mitigate potential impacts.

Performance Management to evidence impact of plan on service delivery

There are no specific Corporate KPIs relevant to above area. Performance in these areas are tracked through established internal monitoring and reporting processes, including, but not limited to the Security, Risk and Resilience and Health and Safety Group and the quarterly Directorate Performance Meetings which provide an opportunity to review and discuss the performance of each directorate and its unique contribution and challenges. Performance is also reviewed throughout the management group structure of CMT/OMT. There are also corporate governance mechanisms of the Board and sub committees' structure.

LEARNING FROM THE VIEWS OF OUR PATIENTS, CARERS AND STAKEHOLDERS

Hearing from, and learning about the views of our patients, carers and stakeholders is an important aspect of designing and delivering care and treatment for TSH. Engagement and feedback help to develop an awareness and understanding of the impact of care and treatment on patients, their carers, friends and family members. Understanding the views and experiences of patients and carers also enables TSH to identify areas for improvement.

A detailed overview of the activities and processes in place across TSH to support effective engagement with patients, carers and stakeholders can be found in the MTP. A specific focus and area for developing in 2024 was the development of the Carers Strategy, implementation of this in 2025/26 will be a key priority together with the ongoing engagement activities already embedded.

Carer Strategy

TSH is required under Section 31 of the Carers (Scotland) Act 2016 to prepare a local Carer Strategy. TSH has developed a Carer Strategy 2025-2028 to meet the specific needs of carers

involved in a high secure forensic setting. It is essential to recognise the unique experiences of carers navigating the judicial and forensic health settings, to understand their needs and respond appropriately.

Following the Visitor Experience audit and subsequent engagement with carers carried out in 2024, we have identified the following four priority areas for development:

1) The Triangle of Care self-assessment tool will enable us to identify ways that we can support our carers to navigate and understand what the standard of care is beyond 'the gate' to enable them to better understand our policies and procedures. Due to the high secure nature of our environment they are unable to walk in and look for themselves.
2) Carer communication and sharing of information. Providing good quality, appropriate, and timely information and advice to carers has dual benefits of improving the health and wellbeing of carers, and the cared-for person, reducing the potential need for, and costs of, crisis management.
3) Improve the Carers visiting experience. Continue to work with patients and carers to continue to improve the visiting experience. Offer visitors a check-in following visits.
4) Carer Pathway – it is an important aspect of our patients' journey through the hospital to ensure our carers are linked with the wider Forensic Network. Establishing and maintaining good partnerships with third sector organisations will also play an important part in 'delivering effective local personalised support to carers, which meets their personal outcomes and helps them continue in their caring role'.

Person Centered Improvement Group Improvement Group will devise a detailed delivery plan with at least three improvement activities under each of our priority areas, and assurances that what our carers told us they wanted improved will be included in these actions.

In addition to developing our strategy we will also consider the carer pathway through the forensic estate along with how we engage with Local Authorities to ensure that we are addressing our statutory responsibilities a defined in the Act.

Board Actions for 2025/26 to support learning form the views of patients and carers

No	Planning Commitment	TSH Board Action	Delivery timescale
6.1	Implementation of the Carers Strategy.	Develop delivery Plan for the Carers Strategy.	2025/26
6.2	Communication with Carers.	Review carer information packs and Carer page on website, include the child friendly literature in relation to TSH to support child visits. Establish carer's support group.	2025/26 2025/26
6.3	Stakeholder awareness and skills development.	Carer and Workforce Training and Development. Developing relationships with Partner Agencies.	2026/27 2025/26

Risks

Risks emerging from the above actions will be reviewed regularly throughout the management group structure of CMT/OMT and Person Centered Improvement Group. If required risks will be added to either Local Risk Registers or escalation to the Corporate Risk Register to manage risks and mitigate potential impacts.

Performance Management to evidence impact of plan on service delivery

There are no specific Corporate KPIs relevant to the above area. Performance in these areas are tracked through established internal monitoring and reporting processes, including, but not limited to the Clinical Governance Group, Person Centered Improvement Group and the quarterly Directorate Performance Meetings which provide an opportunity to review and discuss the performance of each directorate and its unique contribution and challenges. Complaints and feedback are specifically reviewed at the Directorate Performance Meetings to ensure management and oversight. Performance is also reviewed throughout the management group structure of CMT/OMT. There are also corporate governance mechanisms of the Board and sub committees' structure.

WORKING IN PARTNERSHIP TO PRIORITISE ORGANISATIONAL HEALTH, SUPPORT STAFF WELLBEING AND DEVELOP AN ENGAGED SUSTAINABLE WORKFORCE

Workforce

Scottish Government's Mental Health and Wellbeing Workforce Action plan 2023-25 outlines the vision and principles that underpin the support and development of the mental health workforce. It details the five pillars of Workforce Planning that are the basis for action to secure sufficient workforce to support recovery, growth and transformation, these are:

1) Plan.
2) Attract.
3) Train.
4) Employ.
5) Nurture.

TSH Workforce accounts for 624 WTE. Just over two thirds of the workforce are in clinical roles, with the remainder providing key support and board wide services.

TSH has developed its Workforce Plan 2025-2028 aligned to delivery and financial planning. The TSH Workforce Plan aims to evolve and align services which will directly support TSH to meet our service objectives, our transformational aims and to ensure sustainability and Value for Money. The five pillars of workforce planning continue to provide a structure to themes TSH actions in the Workforce Plan 2025-2028.

Despite the relative scale of our Board, there is an opportunity to ensure that 'our people' are at the forefront of everything we do, that we are closely aligned to our service objectives and that our focus in these areas will be demonstrated by the levels of patient care offered.

The key strategic themes for the Workforce Directorate over this 3 year period will be:

1) Organisational Health

TSH has historically demonstrated a strong commitment to staff health and wellbeing, reflecting the value of our workforce and their impact on excellent patient care. Our prioritisation of Organisational Health will initially focus in 2025/26 on direction, leadership and work environment. The areas of focus will change over the next three years as we develop our approach and bring a balance between a focus on protective approaches to staff health through management practices that can promote a positive culture and being proactive in offering staff wellbeing activities, both of which will be led by the needs of staff.

2) Sustainable Workforce

We remain committed to ensuring that we have the right people with the right skills and training in the right place at the right time to support our services. This strategic theme will cover:

- Approach to Recruitment and Retention.
- Employability/Career Pathways/Anchor organisation.

- Building resilience in our community/Succession Planning.
- Focused approach to Learning and Education which meets service needs.
- Effective and Efficient Workforce Planning.

3) Strategically Aligned

A key evolution within our service will see the change in approach from transactional to Business Partner model, across all services. This will allow the workforce team to become more involved and more integrated in the delivery of key service, adding value in all of our key activities.

4) Data Driven

A key theme to support the strategic evolution will be improvement in how we use and utilise our data. TSH has significant data available in multiple formats, but the refinement of this data, principally through Performance and Health Dashboards will be key. Reliable real time data will also be key in driving sustainability and value for money, along with moving to a more proactive approach and reliance on data.

Workforce Equalities

TSH have established Workforce Equalities Group in early 2025 to take forward an action plan to progress workforce equalities initiatives and embed these in TSH practices. The group will also review progress on TSH Equalities Monitoring Outcomes for 2025/29

Board Actions for 2025/26 to support TSH workforce

No	Planning Commitment	TSH Board Action	Delivery timescale
7.1	Strategic Planning.	Development and implementation of Workforce plan.	2025/26 Q1
7.2	Workforce Action Plan.	Annual Action plan associated with Workforce strategy.	2025/26 Q1
7.3	Organisational Health	Continue to raise awareness of Organisational Health, increase profile and focus.	2025/26 Q1/2
7.4	Sustainable workforce.	Revised Maximising Attendance Approach.	2025/26 Q2
7.5	Organisational Health.	Launch of OD Strategy, with focus on three key areas: 1) Direction. 2) Leadership. 3) Working Environment.	2025/26
7.6	Data driven.	Establish data dashboards and opportunities to influence decision making.	2025/26 Q3
7.7	Strategic Alignment.	Implement business partner model across TSH teams to align workforce with departments.	2025/26
7.8	Anchors Strategy.	Review employability agenda, with community focus.	2025/26 Q3
7.9	Workforce Equalities.	• Through the Workforce Equalities Group, develop the workforce equalities action plan including anti-racism plans. • Identification of training requirements.	2025/26 Q1 Q2
7.10	Sustainable workforce.	• Support Reduced Working Week (RWW) to 36 hours. • Support teams to develop plans for RWW. • Support implementation of RWW plans.	2025/26 Q3 2026/27 Q1

Workforce Planning Priorities for 2025/26

Scottish Government have set out a range of planning priorities for Workforce and asked NHS Boards to set out how they will deliver against them. Below are the planning priorities that relate to TSH and the associated action.

Scottish Government Planning Priority	TSH action/comment
Achieve further reductions in agency staffing use and to optimise staff bank arrangements.	TSH does not utilise agency staff, the internal Supplementary Staffing Register (SSR) register is used.
Achieve reductions in medical locum spend.	TSH does not use medical locums.
Increasing efficiencies across administrative and support services.	The Workforce Governance Group has oversight of all vacancies and control processes are in place.
Encourage attendance and support employees, where health issues impact on their ability to be at work, through implementing the NHSScotland Attendance Policy.	A priority action for TSH over 2024/25 has been to support managers to implement the attendance management policy and focused support has been given to managers to support this. This will continue into 2025/26.
An implementation plan for eRostering (Safe Care, Allocate, Health Medics Optima and loop) in 2025/26 with a view to implementing across all Services and professions by 31 March 2026.	Safe Care – all rosters will use Phase 1 by Q4 2025/26, Phase 2 will be rolled out for Nursing Hub rosters by Q4 2025/26. Allocate - the impact of the RWW will enable review of the digitalised system and enable it to be used to fuller potential. TSH will move from a centralised resource management approach to a ward based approach, giving the Senior Charge Nurse (SCN) overview and management of rosters via allocate. Q3/4 2025/26. Health Medics Optima – continue to explore the opportunities around this. Loop - Management of annual leave for all non-nursing rosters to be fully embedded in this approach Q2 2025/26.
How are the NHS Board working with Further/Higher Education Institutions to improve the way they plan the education needs of their workforce, and what collaboration takes place to ensure education curriculums offered can respond to the changing population health needs both locally and nationally.	As part of the TSH approach to recruitment outreach to Higher and further education is now an integrated part of recruitment.
Plans to ensure that all relevant staff are face fit tested to an FFP3 respirator to support business as usual patient care and in the event of responding to an incident such as Mpox Clade1 and Measles.	TSH, through its Health and Safety Group and Infection Prevention and Control Committee will review the needs for FFP3 respirator requirements to support business as usual and ensure sufficient staff are tested based on needs and risk assessments.

Risks

Risks emerging form the above actions will be reviewed regularly throughout the management group structure of CMT/OMT and Workforce Governance Group. If required risks will be added to either Local Risk Registers or escalation to the Corporate Risk Register to manage risks and mitigate potential impacts.

Performance Management to evidence impact of plan on service delivery

TSH has a set of Corporate KPI's which are reported quarterly to TSH Board and management groups. TSH has two key performance indicators reported through its corporate KPI report to the board these focus on:

1) 5% sickness absence rate.
2) 80% of staff will have an approved Performance Development Review (PDR).

Performance in these areas are tracked through established internal monitoring and reporting processes, including, but not limited to the Workforce Governance Group, the Workforce, Well-being and Organisational Development Delivery Group, Workforce Equalities Group and the quarterly Directorate Performance Meetings which provide an opportunity to review and discuss the performance of each directorate and its unique contribution and challenges. Absence Management and PDR completion are specifically reviewed at the Directorate Performance Meetings to ensure management and oversight. Performance is also reviewed throughout the management group structure of CMT/OMT, and quarterly through the Strategic Planning, Performance and Governance Group. There are also corporate governance mechanisms of the Board and sub committees' structure.

VALUE FOR MONEY AND ACHIEVING FINANCIAL BALANCE

Financial Balance

Scottish Government continues to highlight the challenging national financial position for NHS Scotland. All Boards have been instructed to achieve breakeven, with no brokerage option available and the Support and Intervention Framework now in operation. The requirement for recurring savings on baseline budgets is increasingly challenging given the ongoing national financial position.

TSH has developed its three year finance plan to outline the high level Revenue and Capital budget spending plans with known budget pressures outlined. The TSH Finance Plan is subject to review and approval by Scottish Government and will align with both the Delivery and Workforce plans.

TSH has consistently achieved financial balance, however this has become increasingly challenging and forecast to remain so with the requirement to achieve recurring savings. It is noteworthy that only 14% of TSH budget of costs are non-pay related.

TSH has in place a range of approaches to support managers to have oversight and management of budgets. A consistent pressure for TSH has been costs associated with staffing. A review of the requirements for staffing within nursing, which has the biggest pressure, has been carried out and high level oversight in place to better understand and deploy resource for this budget.

Digital and e-health

There has been significant focus on developing the organisations digital and e-health function over the last few years. TSH remains fully committed to digital development and enablement, however the significant financially challenging position will impact on TSH ability to deliver its digital inclusion ambitions. The hospital aims to make the best use of digital technologies in the design

and delivery of services delivering greater access, better insight and improved outcomes for patients.

TSH continues to support the development of digital capability and will promote nationally developed learning resources to support the development of staff digital capability. Digital and Data Capability Framework | Turas | Learn and the Self-Assessment Tool | Turas | Learn

TSH has invested in a Business Intelligence Team who continue to develop a suite of dashboards to inform both clinical and managerial decision making and ensure fit for purpose data is readily available. The focus for 2025/26 will be to develop business intelligence financial dashboards for clinical staff to support financial planning and decision making.

TSH is committed to ensuring fit for purpose data is readily available and accessible. The focus for e-health teams is to equip staff with the ability to understand and interrogate data-driven recommendations and decision support tools. Through involving staff in the design of these tools and supporting them to improve patient outcomes we aim to empower those delivering services to have confidence and ability to gather, safely use, and share data to sustainably improve services. We aim to expand our specialist digital data design and technology professional workforce ensuring there's appropriate level of leadership, skills and capacity. TSH will progress infrastructure systems, ensuring that regulations, standards and governance are in place to ensure robust and secure delivery. We aim to move to a digital system for all records.

Cyber security continues to be recognised as a high risk and concern for all Boards, with significant focus for TSH. The Network Information and Security Regulations (NIS) is at the fore front of everything we do. TSH was audited against the NIS standards in 2023 and achieved a high standard, which we have sought to improve on. A second audit was carried out in Oct 2024. TSH will continue to work towards improvement in network security, the next full review from NIS is due in 2026.

TSH has invested in the development of the electronic patient record (RiO). This requires regular updates and internal redesign to meet the needs of those delivering services to ensure that reporting and recording of patient care is accurate and useable. TSH has developed bespoke modules on RiO to support improved observation practice, psychological service referrals, CPA process review and Variance Analysis Tool redesign.

TSH has engaged with the adoption and implementation of national digital programmes including M365, SharePoint and e-roster. TSH will continue to link in with the national programmes as they develop with the requirement to ensure preparatory work in track for these systems.

Digital Inclusion

TSH is keen to progress digital inclusion for patients, both to improve the patients' experience and also to support care and treatment. Presently, patients within the TSH are at a disadvantage in terms of digital inclusion compared to patients being cared for within other forensic settings across NHSScotland. In November 2018, the Forensic Network produced a key report "Supporting Communication and Technology Use in Mental Health Settings", and post pandemic this was updated in May 2021. In January 2024, Scottish Government indicated that they will engage with the Forensic Network to develop a Delivery Plan based on the recommendations from the above reports.

Within TSH, a digital inclusion strategy was prepared, with stakeholder engagement during 2023/24. However, this is now on hold due to financial constraint. Funding for both capital and revenue (staffing/resourcing) support is required. In the meantime, all other potential funding options continue to be reviewed and investigated; and consideration is given to any elements of the overall programme which can be addressed within existing resources and budgets.

In Q4 2024/25 TSH was offered an electronic platform, Made Purple Operating system equipment and software at no initial cost to provide 'proof of concept' testing to be taken forward. The aim of this would be evaluate the systems effectiveness in enhancing patient engagement and digital inclusion, and contribute to strengthening the business case for consideration for future funding opportunities. This will be taken forward in 2025/26 and recommendations from this built into future funding opportunities.

Board action 2025/26 for Finance and e-health/digital developments

No	Planning Commitment	TSH Board Action	Delivery timescale
8.1	3 year finance plan 2025 - 2028.	Action plan associated with 3 year finance plan.	2025-2028
8.2	Financial management.	Development of local dashboards to support financial analysis and management.	2025/26
8.3	Financial Compliance.	Making Tax Digital.	2025/26
8.4	Patient digital Inclusion/patient funds.	Patient digital inclusion / patient funds.	Depend on funding
8.5	Digital Inclusion.	Test Made Purple equipment and software in the Transitions service to provide proof of concept for further roll out.	2025/26 Q2/3
8.6	Digital Infrastructure.	Ensuring that regulations, standards and governance are in place to ensure robust and secure delivery.	2025-2028
8.7	Business Service Transformation.	Development and support implementation of systems for HR, payroll, Finance and Procurement.	2026/27 2027/28
8.8	Business Service Transformation.	Support implementation of the public contracts tender portal and any new DI system.	2026/27
8.9	National digital programmes.	TSH has engaged with the adoption and implementation of programmes including M365, SharePoint and e-roster. TSH will continue to link in with the national programmes as they develop. **e-roster** - Safe Care – all rosters will use phase 1, with phase 2 will be rolled out for Nursing Hub rosters. **Allocate** - the impact of the RWW will enable review of the digitalised system and enable it to be used to fuller potential. TSH will move from a centralised resource management approach to a ward based approach, giving the SCN overview and management of rosters via allocate. **Health Medics Optima** – continue to explore the opportunities around this. **Loop** - Management of annual leave for all non-nursing rosters to be fully embedded in this approach.	2025-2028 2025/26 Q4 2025/26 Q3/4 2025/26 Q2
8.10	Network security.	NIS audit – preparation for next audit scheduled in 2026.	2025/26

Risks

Risks emerging form the above actions will be reviewed regularly throughout the management group structure of CMT/OMT and Finance, e-health and Audit Group. If required risks will be added to either Local Risk Registers or escalation to the Corporate Risk Register to manage risks and mitigate potential impacts.

Performance Management to evidence impact of plan on service delivery

There are no other specific Corporate KPIs relevant to above area. Performance, with a particular emphasis on finance is tracked through established internal monitoring and reporting processes, including, but not limited to the Finance, e-health and audit Group, e-health sub group, Capital Group, Policy Approval Group, and the quarterly Directorate Performance Meetings which provide an opportunity to review and discuss the performance of each directorate and its unique contribution and challenges. Financial management is also specifically explored in monthly meetings with budget holders and reviewed at the Directorate Performance Meetings to ensure management and oversight. Performance is also reviewed throughout the management group structure of CMT/OMT, and quarterly through the Strategic Planning, Performance and Governance Group. There are also corporate governance mechanisms of the Board and sub committees' structure, specifically the Audit committee

CLIMATE AND SUSTAINABILITY

TSH recognises the role it plays in NHS Scotland's approach to the climate emergency as set out in DL (2021) 38. TSH operates from 15 buildings including patient accommodation, off ward therapy areas, offices, carers' facilities, security buildings and estates buildings. TSH also manages land and buildings covering an area of 63 hectares.

As a relatively modern hospital, TSH does not require an extensive plan of works to reach national targets on climate change. However, TSH continues to develop and implement work to reduce the hospital's impact on climate and improve sustainability. TSH buildings will also need lifecycle maintenance. Maintenance costs will inevitably increase as the facility ages. These costs now need to be planned for to maintain standards of building quality for patients and staff to enable a level of care. TSH will require to develop a planned maintenance programme to ensure that buildings continue to be fit for purpose.

The State Hospitals Board for Scotland is obliged to meet decarbonisation targets set by NHS Scotland Assure. The most critical targets are:

- 75% reduction in emissions by 2030.
- Decarbonised heat by 2038.
- Net Zero by 2040.

TSH has already reduced emissions by 83.7% against the baseline year 1993/94, which is within the five year 1990 Kyoto window. Therefore, TSH is well-ahead of the 2030 target. However, without targeted decarbonisation measures the health board would not meet the other two key targets. In the medium term a feasibility study will be commissioned to explore use of new technologies to meet the decarbonisation target.

TSH will also develop and implement a high-level waste route map, move forward with an active travel agenda, including active business travel, increase biodiversity/greenspace awareness to contribute towards achievement Net Zero by 2040.

Recent development has included Electric Vehicles (EV) which have now been added to the Fleet, with further EV's planned. EV charging points have now been extended to the Car Park for staff

use and additional points are being added internally for future EV's. New LED lighting is also being introduced across the hospital.

Board action 2025/26 for climate

No	Planning Commitment	TSH Board Action	Delivery timescale
9.1	Net zero target.	• Develop and implement a high-level waste route map. • Progress an active travel agenda. • Increase biodiversity/greenspace awareness. • Fully implement an EMS for TSH.	2025/26
9.2	Planned maintenance programme.	TSH will develop a planned maintenance programme to ensure that building continue to be fit for purpose	2025/26

Climate Planning Priorities

Scottish Government have set out a range of planning priorities and asked NHS Boards to set out how they will deliver against them. Below are the planning priorities that relate to TSH and the associated action.

Scottish Government Planning Priorities	TSH action/comment
Greenhouse gas emission reduction in line with national targets with focus on building energy use reduction, transport and travel and medical gases.	TSH does not report on the inhaler propellant and nitrous oxide use as these are not aspects of our clinical care. TSH will continue to explore small gains of reducing energy building use whilst creating a longer-term net zero plan.
Adapting to the impacts of climate change, enhancing the resilience of healthcare assets and services of NHS Boards.	The climate change risk assessment report identified that weather fluctuations are the key risk across the site. Work over the year will identify mitigation to address risks
The achievement of national waste targets, local targets for clinical waste, and engagement with local procurement, waste leads and clinicians to progress Circular Economy programme within Boards	TSH will develop and implement a high-level waste route map. The Anchors Strategy references the focus on local procurement where possible. This will continue to be a developmental aspect of TSH procurement.
Implementation of the sustainable travel approach for business travel, commuting and patient and visitor travel, linking to other strategy areas such as greenspace and adaptation.	TSH will progress an active travel agenda.
Environmental management and use of EMS, including increasing biodiversity and improving greenspace across NHS Scotland estate.	As part of the sustainability work plan, TSH will increase biodiversity/greenspace awareness through creating a local biodiversity action plan.
Improving environmental performance through improved stewardship of capital and	This is addressed in the Business Continuity Planning Process with oversight through the Climate Change and Sustainability Group.

Scottish Government Planning Priorities	TSH action/comment
assets and identified opportunities through the Business Continuity Planning process.	
Reducing environmental impact through adopting the National Green Theatre Programme actions, supporting the implementation of the Quality Prescribing Guides and adoption of the sustainability in quality improvement approach.	TSH does not report on the National Green Theatre Programme as this is not an aspect of our clinical care.

Governance for the Climate Change and Sustainability agenda is through the newly established Climate Change and Sustainability Group which has the lead responsibility and is accountable to the Security, Resilience, Health and Safety Oversight Group. The Group ensures an integrated approach to sustainable development, harmonising environmental, social and economic issues.

Appendix 3

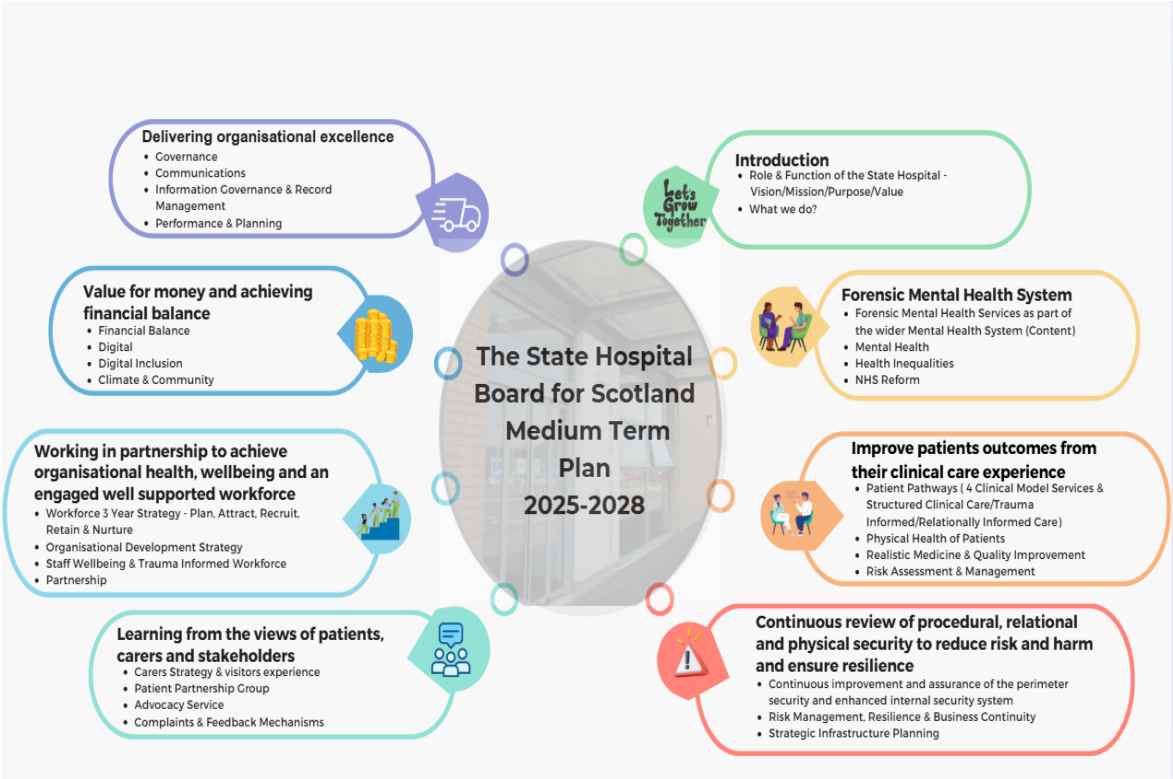
Medium Term Plan 2025-2028

NHS Board: The State Hospital

CONTENTS

STRUCTURE AND CONTENT

The State Hospital (TSH) has developed the Medium Term Plan (MTP) following extensive engagement in 2024/25 across all staff groups. Each Directorate and all Heads of Service have developed local three year plans, these plans have been used to develop the overall MTP. All directorates also discussed and reflected on the vision/mission of TSH, which has been revised following the consultation. The critical success factors which are central to the achievement of TSH vision and mission have been used as pillars to structure the MTP. Through the engagement process, and over the delivery of this MTP, the focus has been on delivering effective care and treatment through the balance of organisational performance and health.



INTRODUCTION

This medium term plan details the high level priority actions that TSH Board for Scotland will progress over the years 2025 to 2028. The plan forms part of NHS Scotland's planning framework and has been developed in tandem with the Financial Plan and the Workforce Plan and is set within the wider NHS reform framework. It also reflects that financial challenge and pressures felt across the whole of NHS Scotland health system.

TSH is the national high secure forensic mental health care provider for Scotland and Northern Ireland. The organisation provides specialist individualised assessment, treatment and care in conditions of high security for patients with major mental disorders and intellectual disabilities. 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.

An extensive consultation exercise was carried out in 2024/25 with staff, stakeholders and patients. This activity supported the development of the Medium Term Plan 2025-28 and the revised vision, mission and critical success factors that are required to deliver excellent forensic mental health care and treatment. The following was agreed:

The vision is to be a leader in delivering relationally informed, person-centred, high-secure mental health care that enables recovery whilst ensuring the safety and wellbeing of staff, patients, and the public.

The mission of the hospital is to assess and treat major mental disorders in a secure and person centred care environment that manages risks, supports recovery, rehabilitation and onward progression.

Critical success factors are the central things we do to achieve our mission and focus on:

- Improving patient outcomes from their clinical care experience.
- Continuous review of procedural, relational and physical security to reduce risk and harm and ensure resilience.
- Learning from the views of patient, carers, and stakeholders.
- Working in partnership to achieve organisational health well-being and an engaged well supported workforce.
- Value for money and achieving financial balance.

The values of TSH align with NHSScotland, they are:

- Care and compassion.
- Dignity and respect.
- Openness, honesty and responsibility.
- Quality and teamwork.

The core clinical focus of TSH is to deliver forensic mental health care as part of normal business. Oversight and governance of care and treatment metrics is monitored through the Clinical Governance Committee. Governance of workforce is through the Staff Governance Committee, with the Risk and Audit Committee having oversight of finance and risk issues. All committees report through the Board. An overview of the governance structure for TSH as detailed later in the document.

ROLE AND FUNCTION OF THE STATE HOSPITAL

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 is one of the 22 NHS Boards within NHS Scotland. It is a national board with responsibility for the provision of high secure Forensic Mental Health Services in Scotland and Northen Ireland, working from a single site in Carstairs, South Lanarkshire. The site is in a rural location. TSH has 120 beds available for male patients, 108 beds for patients with Major Mental Illness and 12 beds for patients with Intellectual Disabilities. In 2025 TSH will open an interim high secure inpatient service for women. TSH site also has protected patient space on site as a resilience and contingency measure if patients were required to move from their current wards.

MENTAL HEALTH

The Mental Health and Wellbeing Strategy was launched in 2023 and outlines the legislative background and strategic ambition and focus for Mental Health and Wellbeing in Scotland. The associated Mental Health and Wellbeing Workforce Action Plan 2023-25, and the Mental Health and Wellbeing Strategy Delivery Plan 2023-25 were launched in November 2023. These documents

outline priorities for Scottish Government which include strategic planning and governance of Forensic Mental Health Services and the provision of a high secure female service in Scotland.

The provision of the Mental Health (Care and Treatment) (Scotland) Act 2003 allows for detention in hospital and compulsory medical treatment on the grounds of mental disorder. Rigorous safeguards apply which include the right to independent advocacy, an independent mental health tribunal for Scotland and the independent Mental Welfare Commission (MWC). Scottish Government have committed to consider changes to practice and legislation to improve or simplify the delivery of forensic mental health services. There are two recent publications of particular relevance to Mental Health direction for Scotland, these are:

1) The Independent Review of Forensic Mental Health Services.
2) The Scott Review.

TSH are aware and aligned to the ongoing development and delivery of relevant recommendations from these reports.

TSH support and participate with safeguarding approaches and will engage with discussions regarding any changes to legislation. Regular reviews are held by the Mental Welfare Commission within TSH. Mental Welfare Commission visits provide a rigorous assessment of care quality and safety for patients and identify any areas for improvement. TSH secured a Service Level Agreement (SLA) with an independent advocacy service through a procurement process in 2024. The Advocacy service have full access to patients and continue a programme of development to provide support to patients.

Healthcare Improvement Scotland will recommence Safe Delivery of Care inspections of Adult Inpatient Mental Health services from January 2025. These unannounced inspections will provide focus on infection prevention and control and wider determinants of safety and quality of care in accordance with the Safe Delivery of Care inspection methodology. This approach will provide robust public assurance and support services to identify and reduce risks. TSH will engage with and support this new approach to care inspections as part of its approach to ensuring excellent care and treatment for patients.

FORENSIC MENTAL HEALTH SERVICES AS PART OF WIDER MENTAL HEALTH SYSTEM

TSH operates as the high security provider within a wider Forensic System and connects with a range of partners in health, criminal justice, policy, and resilience. TSH links with the Forensic Network and wider NHS and independent providers of health care. TSH is an active collaborator in system leadership and NHS Reform. TSH have provided leadership in the Healthcare and Custody Oversight Group, collaborate on National Executive Leads and participate in the national Strategic Planning Board with a focus on Mental Health. It is recognised that the forensic system is a dynamic landscape, and that the emerging strategic direction of forensic services for Scotland is evolving. TSH will continue to review its cross-boundary collaboration and seek areas for improvement in cross system leadership where appropriate.

To facilitate further collaboration in Forensic Mental Health Services, the Scottish Government commissioned the Forensic Network to carry out further work on capacity across the estate in September 2024. The Forensic Network brought together NHS Boards and forensic mental health services to develop a plan to improve access to services and reduce variation between services. The focus was to reduce variation in referral criteria, minimise differences in management of waiting lists, achieve greater cohesion in the delivery of secure in patient services, and streamline escalation and dispute resolution processes. The Forensic Network reported findings to the Scottish Government. TSH will contribute to achieving improvements outlined in this plan, including exploring regional agreements to enhance cohesion in service delivery.

Forensic Mental Health Board for Scotland

The Scottish Government, in response to recommendation one of the Independent Review into the Delivery of Forensic Mental Health services has committed to develop plans to establish a Forensic Mental Health Board for Scotland. This Board would be established with the aim of delivering a national approach to the planning and governance of forensic mental health inpatient services.

A Forensic Governance Advisory Group was established in October 2024 to advise ministers on operational and practical changes needed to transition from the existing governance arrangements for adult mental health services to a Forensic Mental Health Board for Scotland by exploring options detailed in their Terms of Reference. The group will provide a report to advise on how best to improve integration of existing national and local pathways of care providing adult forensic service. The group are due to report in May 2025

NHS SCOTLAND REFORM

As part of NHS Scotland, TSH has a contribution to the strategic priorities that will support delivery of public service reform. The NHS requires major reform to ensure that it is a sustainable health service that is fit for the current and future population needs. In June 2024 the Cabinet Secretary for Health and Social Care set out a new vision for health and social care services in Scotland to address the challenges and provide focus on reform. These challenges include threats from infectious diseases, life expectancy stalling and widening health inequalities. The demand on and utilisation of health and social care services continues to increase, and the climate emergency requires us to adapt behaviours and embrace new technologies to reduce carbon. Scottish Government vision is to enable people to live longer healthier and more fulfilling lives and is supported by four key areas of work: improving population health, a focus on prevention and early intervention, providing quality services and maximising access, all underpinned by person centred approach.

Scottish Government is committed to developing a transformation programme to deliver a number of related change projects and activities, detailed in the Mental Health and Well-being Strategy Delivery Plan 2023-2025. TSH will engage and collaborate to support this transformation and reform agenda.

No	Planning Commitment	TSH Board Action	Delivery timescale
1.1	TSH will engage with the emerging strategic direction for the Forensic Mental Health Board for Scotland.	TSH will engage with the recommendations from the Forensic Governance Advisory Group and work with Scottish Government and other stakeholders to progress these.	2025-2028
1.2	Forensic Network recommendations to improve access to Forensic Mental Health Services.	TSH will contribute to achieving improvements outlined in this plan which is aimed at exploring regional agreements to enhance cohesion in service delivery.	2025/2026
1.3	Public service reform and cross system collaboration.	Engage and collaborate to support public service reform and transformation.	2025-2028

WOMEN'S HIGH SECURE FORENSIC SERVICE DEVELOPMENT IN SCOTLAND

The Scottish Government, in response to recommendation three of the Independent Review into the Delivery of Forensic Mental Health services has committed to the development of a plan to deliver services in Scotland for woman who need high secure care and treatment in the short and long term. There is currently no provision for high secure forensic mental health care and treatment for women in Scotland. TSH have been working alongside stakeholders to support this commitment. Discussions with legal and ministerial colleagues in November 2024 resulted in an agreement to develop an interim service model of female high secure patients at TSH.

A high secure female service in Scotland is an additional service, separate from the current funding TSH receives to deliver a male high secure service. A female service requires both capital and revenue funding to be taken forward as a separate funding stream from Scottish Government. In January 2025, funding was confirmed by the Mental Health Directorate to progress with both Phase 1 and 2 aspects of the female high secure service in TSH. A project team was then established to take forward planning.

In early 2025, the project team commissioned a feasibility study on Phase 2 of the development of a medium to long term female high secure service. They also commenced development of plans for the interim service in collaboration with key stakeholders. A Project Initiation Document was agreed by Corporate Management Team (CMT) and TSH Board in February 2025. A project governance and reporting structure is in place to receive regular reports on progress and risks. A Project Oversight Board will be established to oversee the work programme.

The development of the high secure female service will be taken forward in two interconnected phases.

Phase 1 – Interim and Outreach Service Model

TSH will progress a High Secure Female Service development in Q1/2 2025 with the objective to:

- Develop and implement an interim woman's service model for patients who have been clinically assessed as requiring high security care and treatment.
- Develop and implement an outreach service model from high security to medium security providers and Scottish Prison Service, based on the Rampton outreach model. The outreach service will aim to work in partnership with service teams to support the management of patients who may require referral and admission to TSH.

Phase 2 Medium – Long Term Service Model for high secure female inpatient services.

Oversee the development and implementation of a capitol development following the outcome from a professional design team feasibility report. This will create a dedicated care and treatment centre. Timelines and project milestones will be agreed following the outcome of the design team's feasibility study, it is anticipated it is likely to be circa 36 months.

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 TSH.

A female high secure service would be segregated from the male service to protect patients and support recovery. This is in line with how similar services are delivered in England. A female high secure service will require segregated arrangements to provide:

- Access to Activity
- Grounds / Outdoor access
- Dedicated therapeutic and recreational physical environment
- Activities Centre

- Access to Healthcare Services

Women in secure services can have a background of extreme adverse childhood events, low self-esteem, poor assertiveness, extreme vulnerability and are likely to lack the interpersonal resources to deal with a largely male population. Evidence from England and Wales reveals that sexual incidents are commonplace in mixed gender mental health environments, ranging from sexualised language, to harassment and sexual assault. There is also a lack of dignity for women in mixed gender environments. There is a risk that women are unlikely to move beyond 'safety and stabilisation' in their clinical treatment journey if they are within a mix gender environment.

There are distinct difference between providing care for high secure forensic male and female patients, some of the unique needs of female patients are detailed below.

- Most females have a diagnosis of Post Traumatic Stress Disorder (PTSD).
- Over half of female patients will have experienced childhood physical and sexual abuse – this is predictive of health harming behaviours. Aggression is displayed differently in women and men.
- Managing behaviours are complex often demonstrated through disruptive interpersonal relationships. Fear of abandonment can be overwhelming and lead to very extreme behavioural incidents.
- There is a higher incidence of challenging behaviour and self-harm in females resulting in higher interventions with rapid tranquilisation, seclusion and intense interventions. This is demonstrated in data from Rampton Hospital on their intervention rates when compared to the TSH male population.

To provide care and treatment for female high secure patients a specialist workforce would be required. Staff will need specific training to create a safe therapeutic environment that works for women. In Rampton, Trauma Informed Care is embedded into staff practice and clinical care is structured into three domains: 1) Safety and Stabilisation 2) Insight and Processing 3) Treatment and Recovery. There is a higher staff burn out rate on women's high and medium secure wards. Given the complex, and very distinct needs and risks of this population, service developments need to be strongly underpinned by relational and trauma informed principles

Options to Develop the High Secure Female Medium - Longer term service model

To advise on phase 2 of the project to develop a female high secure service, TSH commissioned a Lead Advisor to develop and produce an Initial Design Assessment proposal for a National High Secure Healthcare Service for Women in Scotland. The Initial Assessment proposal for the project will be presented Q1 2025/26.

The initial design assessment will consider four options for the development of the service on site in TSH and make recommendations on the feasibility, costs and benefits of each option for full consideration. The project will require to be compliant with all current statutory standards and regulations

Following this approach future work will be required to develop the following:

- Outline Business Case for National High Secure Service for Women.
- Full Business Case for National High Secure Service for Women.
- Construction Phase for National High Secure Service for Women.

The timeline for completion and go live for the medium to long term service model is dependent on the outcome of the design team feasibility study, and agreement from NHS Assure. 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.

No	Planning Commitment	TSH Board Action	Delivery timescale
2.1	Phase 1 - TSH to establish an interim high secure forensic mental health service for women.	TSH develop infrastructure for establishment of an interim model for women, this will include: • Clinical operating model. • Ward modifications. • Admission criteria and process. • Workforce model including recruitment and training.	Q1/2 2025/26
2.2	Phase 1 – Forensic Female Outreach Service.	Scope and develop an outreach service model. The aim will be to support medium secure units and Scottish Prison Service to assist in managing patients who may require referral and admission to TSH female service, or who are displaying behaviours that necessitate a high secure referral.	2025/26 Q2
2.3	Phase 2 - TSH will develop an initial design feasibility assessment for a Medium – Longer term Forensic Female High Secure Service.	Planning proposal detailing the options, risks, financial and capital investments will be submitted to Scottish Government.	2025/26 Q1
2.4	Phase 2 - TSH will develop required planning and governance approaches to achieve development of Forensic Female High Secure Service	Outline Business Case.	2025/26 Q3
2.5	Phase 2 - TSH will develop required planning and governance approaches to achieve development of Forensic Female High Secure Service.	Full Business Case.	2025/26 Q4
2.6	Phase 2 - TSH will develop required planning and governance approaches to achieve development of Forensic Female High Secure Service.	Construction phase.	2026-28

HEALTH INEQUALITIES

There are many, diverse and interacting determinants of mental health and wellbeing, with these being driven by structural factors such as unequal distribution of income, power and wealth, global, national and local economic and political forces and priorities, and societal attitudes. The impact of poverty, along with stigma and the pervasive nature of adverse childhood experiences and trauma are seen to be impacting on wellbeing and mental health at an individual and population level in Scotland, and the evidence of how inequalities are being exacerbated by the ongoing effects of the pandemic and cost of living increases continues to emerge.

Evidence Narrative to inform the Scottish Government Mental Health and Wellbeing Strategy (www.gov.scot)

Within TSH individual health inequalities and health behaviours is addressed later in this plan though the supporting healthy choices and physical health projects. The more structural elements of population health and health inequalities are addressed in this section with a focus on improving health through supporting a circular economy via the TSH Anchors strategy.

TSH Anchors strategy 2023- 25

Scottish Government commissioned all NHS Boards to produce an Anchors Strategic Plan as an initial three year strategy to demonstrate how TSH plans to take action to contribute to community wealth. The initial themes include:

- Progressive Procurement - TSH can direct investment into the local region through procurement practices. It may be possible to consider giving local suppliers greater weight in procurement processes, which in turn can create new employment locally.
- Employment - TSH is a relatively large local employer within an area of deprivation. Development of recruitment practices to encourage community members to consider employment in TSH would be useful to consider.
- Sustainable use of land and property - consideration given to the use of land and sustainable practices.

The Anchors strategy has a range of commitments in each of the initial themes. TSH have developed an action plan to ensure that key commitments are taken forward. Reporting is through the Audit and Risk Committee and onwards to TSH Board and Scottish Government through the Anchors Strategy baseline metrics report. As Scottish Government evolve their approach to Anchors institutions and organisations TSH will adapt the strategy to reflect requirements.

No	Planning Commitment	TSH Board Action	Delivery timescale
3.1	Anchors implement strategy 2023-2025.	Continue with implementation of action plan with focus on: • Progressive procurement. • Employment. • Land and assets.	2025/26
3.2	Develop Anchors Strategy 2026-2028.	Develop revised strategy based on learning from previous strategy and in line with SG commission.	2025/26 Q3
3.3	Anchors Strategy 2026-2028.	Implement Actions associated with Anchors strategy 2026-2028.	2026-28

IMPROVED PATIENT OUTCOMES FROM THEIR CLINICAL CARE EXPERIENCE

Patient Pathways

A new Clinical Model was introduced in July 2023 to provide patients with a recovery pathway through TSH and address issues raised by staff around feelings of safety. The new clinical model saw the establishment of four new services: Admissions and Assessment, Treatment and Recovery, Transitions, and Intellectual Disability. Service Leadership Teams were also established for each service, with an overarching leadership group overseeing the implementation of the model, (Clinical Model Oversight Group). Clinical Model Guidance was developed to guide and support implementation with detailed sections on the four new services. Referral between services is now expected with all major mental illness patients being admitted into Admission and Assessment wards, then progressing, if required, though the Treatment and Recovery and onwards to Transitions service. Patients with an Intellectual Disability are admitted directly to the Intellectual Disability service.

Each service has developed a three-year implementation plan to outline what they seek to achieve. All four clinical model services in 2025/26 plan to continue to embed the clinical model and support team development. Service identity is also evolving, and each Service Leadership Team will continue to embed their specific part of the patient recovery pathway. The clinical guidance document will be reviewed as part of the maturation of each service. Any updates to the clinical guidance will be received through the Clinical Governance route with the Clinical Model Oversight Group having oversight of the patient pathway and overall effectiveness of the clinical model.

Intellectual Disability Service

TSH has a specialist Intellectual Disability service which provides expert multidisciplinary assessment and management of needs of patients with intellectual disabilities. The service aims to develop its approach to Positive Behaviour Support (PBS) Implementation Plan. This will require improved communication support, clarifying the sensory environmental needs of patients and a training needs analysis for staff. The aim will be for patients to have PBS plans in place over 2026/27 This will require a focus on staff training and development as well as team development.

Structured Clinical Care/Relational Informed Approaches to Care

The aim of structured clinical care (SCC) is to create an environment that places the understanding of people and their relationships at the heart of care, treatment and well-being at TSH. TSH will review this new framework of care, and if following review, it is agreed to be developed and implemented in this setting, then the aim would be to become the first evidence based responsive structured and psychologically informed high secure relational care environment. To progress this ambition in 2025/26 TSH will review its strengths and weaknesses in relation to SCC, establish a group of stakeholders to develop a plan for delivering structured clinical care and begin to work with engaging others. A training pathway for staff and patients will be developed to implement it. If SCC is taken forward, there will also be a need to establish the measurement approach required to monitor progress of this. TSH would then work to embed compliance the training and to continuously improve the quality of structured clinical care.

Risk Assessment and Management

Completion of risk assessments and risk management plans are integral to the patient's journey. TSH standards are that each patient within the hospital will have an up to date, appropriate, structured professional judgment-based risk assessment and management plan. A review of the current risk assessment process is underway, which has included a peer review of TSH process and best practice with Scottish Government and medium secure units. Improvements to the risk assessment process have been developed as a result and shared across the Multidisciplinary Team. The process for completion of risk assessment will continue to be developed and refreshed over 2025/26 to improve information gathering and assessment of risk.

Trauma informed Care

TSH is currently working towards embedding trauma informed approaches to care. TSH has a trauma champion and implementation coordinator. The champion role is to provide senior level support for transforming psychological trauma informed care. TSH delivers trauma informed and trauma responsive training this is delivered at three levels:

1) Level 1 trauma informed practise.
2) Level 2 trauma skilled practise.
3) Level 3 trauma enhanced practise.

As TSH develops its approach to understanding patients' behaviours and formulating care and treatment plans which are informed by trauma sensitive practise. We will continue to understand the trauma needs of our patients through trauma needs analysis and will continue to develop this practise.

Daytime Confinement Monitoring

Daytime confinement (DTC) has been identified as a recent phenomenon in TSH since 2022. DTC is a practice of patients being locked in their bedroom out with the normal voluntary time in room after lunch and dinner, it has been used as a short-term solution to manage increased clinical activity and staff shortfalls. This is a suboptimal clinical practice and runs the risk of being considered as an element of Type 2 seclusion when the patient has not activity chosen this. TSH has been working towards making this practice a never event. Monitoring of DTC occurs daily, and resource decisions are made to minimise any possibility of DTC being utilised. An escalation process is in place to ensure Director oversight of any DTC episodes. DTC has reduced markedly, however still occurs.

TSH has had an improvement programme in place (2023/24) to reduce the use of DTC. Actions from this programme have been integrated into standing groups with the Clinical Governance Committee having oversight. To ensure that TSH staffing model is evidence based and aligned to safe staffing legislation, a detailed review of the current funded establishment and minimum staffing requirements to support safe daily operations across each of the wards was carried out in 2024. The outcome of this resulted in TSH Board agreement to recruit and additional ten whole time equivalent Band 3 Healthcare Support Workers on fixed term contracts until 2026. This is to reduce reliance on overtime for staffing wards and provide ongoing workforce resource to wards. It is expected this will have a positive impact on the use of DTC. Monitoring and reporting of the impact of the additional staff on DTC and use of nursing staff overtime will be carried out to assess impact.

Patient outcomes

TSH carried out an initial consultation and literature review on the potential development of a suite of outcomes for patients. This is in the early stages of development in 2024/25 with initial scoping having been carried out. This work will progress to identify, develop and test a suite of new outcome measures for patients over the 2025/26 period with the expectation of recommendations being made following this work for adoption of new patient outcome measures for TSH.

Care Plan Approach process

All patients who are admitted to TSH will have their care and treatment planned using the Care Plan Approach (CPA). Guidance for the application of CPA for restricted patients is contained in the Scottish Government CEL 13 (2007) and the Memorandum of Procedure on restricted patients CEL 20 (2010). The CPA process was reviewed to be more patient centered and to embed parity of input from the multidisciplinary team. Thie new system was develop in 2023/24 and then tested over 2024/25. The new system will provide assurance around the CPA process and will require embedding and monitoring in 2025/26 to ensure it delivers as expected.

Multidisciplinary Clinical Teams

Central to the care delivery approach in TSH is effective multidisciplinary team working. Whilst each profession within the teams has their own specialised evidence based approaches to contribute to the delivery of forensic mental health care, the overall team combines to provide multi-dimensional care and treatment approaches.

TSH will continue to evolve and develop its approach to supporting clinical team development through the service leadership teams as well as specific professions within the clinical team. TSH will support staff to feel empowered to practice as accountable, confident and capable practitioners. We will embed a process of reflexion and review to achieve continuous improvement. Leadership skills and capabilities will also be supported through training and development opportunities. TSH is also assessing the clinical and managerial leadership structure to ensure continuous improvement in this area.

Duty to Collaborate - work as part of a wider system

TSH will work to progress and support a collaborative ethos across NHS Scotland through active participation in the national governance arrangements of the NHS Scotland Executive Group. This group will progress the renewal and reform agenda, focusing NHS Boards' efforts on supporting population health needs and delivery of care beyond geographical boundaries.

TSH have SLA's with other NHS Boards and Local Authorities to deliver key services. The staff from these services are integrated into the Service Leadership Teams and are members of the multidisciplinary teams.

Social work service staff are employed by South Lanarkshire Council and deliver a key service within TSH. The social work service within TSH is person centred and works with patients and their families to promote rights, recovery and mental well-being. Key objectives of the service are to develop stakeholder engagement, develop child contact information in line with UNCRC directives, deliver training to meet the needs of the wider hospital staff and the team, carry out peer reviews visits

The onsite Pharmacy team are employed by NHS Lothian and provide a clinical service through a SLA. Medicines supply is via Area Stores, St John's Hospital Pharmacy. The Pharmacy team aim to ensure that the right medicines are available in the right doses for patients at the right time. Service developments will include streamlining and improving efficiency of the medicines ordering process and developing the role of the Pharmacy Technician. This in turn will allow pharmacists to spend more patient facing time: on education, reducing unnecessary polypharmacy and introducing chronic disease reviews in conjunction with and to complement the annual health checks undertaken by the Primary Care service.

TSH aims to deliver evidence-based care. TSH will develop its research and development strategy in 2025. The hospital will promote ongoing research activity. Systems and protocols for research and development will be reviewed and implemented in preparation for work across the wider forensic system.

Clinical Quality will review the cycle for publication and adoption of new evidence. The aim is to ensure that new evidence is successfully embedded through the audit projects, clear pathway information will be generated from an electronic system and a master action list to ensure all actions from clinical audits are being implemented. The care pathway data collection process will be reviewed and recommendations made for update to this.

Unscheduled Care

Patients in TSH at times require care from other NHS Board's, predominately, but not exclusively from NHS Lanarkshire. In 2024/25 TSH reviewed its arrangement for unscheduled care outings of patients to identify areas for improvement. The review identified aeras to further test which include use of the Flow Navigation Centre, which also connects to the current system used, Consultant Connect. The Flow Navigation Centre would provide a single point of contact for emergency outings with the ability to time ambulance arrivals at TSH with the receiving hospital appointment to lessen time waiting for TSH patients and staff at external venues. The recommendations from the unscheduled care group will be taken forward in 2025/26 and improvements, where found, adopted.

Excellence in Care

The Excellence in Care (EiC) programme is a collaborative piece of work commissioned by Scottish Government in response to the Vale of Leven Hospital enquiry.

TSH have been working alongside national partners and NHS Boards to establish processes that allow the measurement, assurance and improvement of the quality of care provided by nursing and midwifery staff.

The EiC Programme has four key deliverables:

1) A nationally agreed (small) set of clearly defined key measures/indicators of high-quality nursing and midwifery.
2) A design of local and national infrastructure, including an agreed national framework and dashboard.
3) A framework document that outlines key principles/guidance to NHS Boards and Health and Social Care Partnerships on development and implementation of local care assurance systems/processes.
4) A set of NHS Scotland record-keeping standards.

No	Planning Commitment	TSH Board Action	Delivery timescale
4.1	Continue to embed the clinical model.	Each service will review the Clinical guidance and update as required. Each service will review its three year plan at end Y1, Y2, Y3 and take part in forward planning as appropriate. Service development activities will be taken forward to develop each service.	2025/26 2025-28 during Q3 2025/26
4.2	The Intellectual Disability service will develop its care approach using positive behaviour support planning.	Develop staff skills and capabilities on PBS. Ensure that PBS planning is built into care planning Training staff in its use.	2025/26 2026/27 2026/27
4.3	Review of Risk Assessment Process.	TSH will continue to review current risk assessment process and make recommendations and implement change as required. Review process to include information sharing protocol with Police Scotland and	2025/26 Q4

No	Planning Commitment	TSH Board Action	Delivery timescale
		improved access to information as well as establishing a multidisciplinary risk group.	
4.4	Outcomes focus	Develop and test approach to measurement of outcomes for patients. Recommend suite of new outcomes following testing	2025/26 2026/27
4.5	TSH will review new frameworks of care e.g. Structured Clinical Care/ Relationally Informed Care and develop most appropriate pathway for TSH.	Review the approach to SCC and TSH strengths and weaknesses in relation to this. Establish whether SCC is the approach that TSH will take to develop its clinical care. If this is taken forward then establish a group of stakeholders to develop a plan for delivering structured clinical care and begin to work with engaging others. Develop a training pathway for staff and patients will be developed to implement it.	2025/26 2025/26 2026/27 2027/28
4.6	Pharmacy	Improve efficiency of ordering processes. Develop the role of technicians. Increase patient education. Develop chronic disease reviews and reduce poly pharmacy.	2025/26 2026/27 2026/27 2027/28
4.7	TSH will work towards elimination of DTC as a practice.	TSH have oversight of all episodes of DTC through daily monitoring and reporting from service on actions to avoid DTC use and any episodes of DTC. Governance and management in place to provide oversight. Escalation of DTC to notify at Director level Nursing staff resourcing has been identified as a significant contributing factor to DTC, actions have been taken to increase nurse resourcing and the impact of these actions on DTC is being monitored to identify episodes or emerging trends of DTC. This will be reported to Strategic Planning, Performance and Governance Group and escalated to Corporate Management Team if required.	2025/26
4.8	Excellence in Care.	Contribution to Excellence in Care assurance framework to ensure forensic mental health nursing appropriately represented.	2025/26

No	Planning Commitment	TSH Board Action	Delivery timescale
4.9	Quality Assurance.	Review and implement a new approach to adopting new evidence, standards and guidelines related to local audits.	2025/26
4.10	Quality Assurance.	Develop a master improvement plan from all clinical audits to provide coherence across audit actions.	2025-28
4.11	Development of evidence based care and treatment.	Development of Research and Development Strategy.	2025
4.12	CPA process	Embed and monitor new CPA process to ensure it delivers as expected.	2025/26
4.13	Unscheduled care	Implement recommendations from the Unscheduled Care Short Life Working Group (SLWG). Test Flow Navigation Centre.	2025/26 Q1-4 Q1-2

PHYSICAL HEALTH OF PATIENTS

People with severe mental health conditions often have higher rates of physical ill health such as cardiovascular disease, respiratory disease, diabetes, obesity, digestive diseases, and cancer (John et al, 2018), and also their physical problems can be made worse by effects of their mental health problems. People with severe and enduring mental illness may have their lives shortened by 15 to 20 years, a large part of which is because of physical ill health. A 20 year follow up of former patients in TSH, it is known that this patient cohort died approximately 16 years earlier than the general population as a whole (Rees and Thomson, 2021). This is largely due to preventable physical health problems. People with severe mental illness can find it extremely difficult to manage their physical health condition, and therefore personalised support taking into account their needs and circumstances is essential.

TSH continues to recognise the importance of health improvement and disease prevention programmes that target the main causes of morbidity and premature mortality with particular attention to obesity and reducing cardiovascular risk and recognises that physical activity is an extremely important part of overall physical healthcare.

Patients within TSH are offered annual physical health reviews. TSH monitors the uptake of the physical health review and reports it through its corporate Key Performance Indicator (KPI) report. TSH has a dedicated health centre where patients have access to a full primary care service including a practice nurse, specialist practitioners and a General Practitioner. TSH patients are offered all routine screening services and also have access to vaccinations and chronic disease management through the health centre. TSH will continue to develop its approach to physical health care and health improvement interventions. This is supported by a health psychologist who provides input to enable patients to understand their physical health conditions.

The Skye Centre within TSH is a dedicated resource of multidisciplinary professionals working collaboratively to deliver a range of therapeutic interventions together with the clinical service teams. The staff within the Skye Centre are engaged in supporting physical activity, health and well-being and learning, recreational and vocational activities for patients. The aim is to create a therapeutic recovery focused environment that supports progression of patients through the hospital. It also offers vocational opportunities for patients to volunteer and supports peer learning.

Supporting Healthy Choices

The work of the Physical Health Steering Group and Supporting Healthy Choices Implementation Programme (SHCIP) within TSH focuses predominately on improving physical health outcomes. The

SHCIP aims to create an environment that best supports patients to engage in behaviours that support their physical health and healthy weight.

In 2024 TSH adapted the Public Health England practice guidance 'Managing a healthy weight in secure settings' (PHE, 2021) for TSH. This practice guidance, titled *"Moving towards a healthier state hospital: A whole systems approach":* this was supported by Public Health Scotland. TSH also developed an action plan linked to the practice guidance. A key focus is preventing weight gain in the period after admission. In March 2024, work began to create the Test Admission Collaborative Kick Start (TACKS) group. Work is continuing through this group on a tailored approach from the SHC action plan, concentrating on assessing current practice within the admission service and providing support for the admission and assessment activity plan.NIS

The SHC programme will focus on the following key areas of work:

- Through the TACKS project, TSH will prioritise physical health by implementing practice change within the admissions service, local target in place to limit weight gain following admission to 5% of body weight.
- The TSH patients shop SLWG will implement and evaluate improvements in practice to support patient decision making for shop purchases and support focus on health and wellbeing.

Patient Activity

The Activity Oversight Group (AOG) was established in August 2022 to actively monitor the amount of time patients spend on both physical and meaningful activity. This is a key priority for TSH. The AOG meets bimonthly and receives reports from the four Clinical Model services and the Skye Centre around the levels of patient activity. The Clinical Quality Department supports the Service Leadership Teams to review data monthly and monitor levels of activity. This area of work will continue to be informed by evidence based approach to patient engagement in activities in a high secure setting. Services identify local activity targets and tailored approaches to improve uptake of activity throughout the year.

No	Planning Commitment	TSH Board Action	Delivery timescale
4.14	Reduce weight gain.	Through the TACKS project, TSH will prioritise physical health by implementing practice change within the admissions service, local target in place to limit weight gain following admission to 5% of body weight.	2025/26
4.15	Reduce weight gain.	The TSH patients shop SLWG will implement and evaluate improvements in practice to support patient's decision making for shop purchases and support focus on health and wellbeing.	2025/26
4.16	Increase uptake of activity for patients.	Service Leadership Teams develop tailored approaches to improve uptake of activity.	2025/26

Performance Measures to evidence impact of plan on service delivery

TSH has a set of Corporate KPI's which are reported quarterly to TSH Board and management groups.

TSH has ten key performance indicators reported through its corporate KPI report to the Board these focus on delivery of clinical care, physical activity and healthy weight:

1) 25% of patients will have a healthier BMI.
2) 70% of patients will undertake 150 minutes of moderate exercise each week.
3) 90% of patients will be engaged in off hub activities.
4) 100% of patients will have their care and treatment plans reviewed at 6 monthly intervals.
5) 100% of patients will be transferred / discharged using the CPA process.
6) 85% of patients will be engaged in psychological treatments.
7) 100% of patients will commence psychological therapies within 18 weeks from referral date.
8) 100% of patients will have their clinical risk assessment reviewed annually.
9) 100% of patients will have an annual health review by the practice nurse.
10) 100% of patients requiring primary care services will have access within 48 hours.

There is an ongoing process to review and where appropriate replace/update KPI's to ensure they accurately reflect the improvements TSH are keen to develop.

REALISTIC MEDICINE AND QUALITY IMPROVEMENT

Realistic Medicine (RM) is the Scottish Government's approach to delivering Value Based Health and Care (VBH&C) in Scotland. VBH&C is defined as "the delivery of better outcomes and experiences for the people we care for through the equitable, sustainable, appropriate and transparent use of available resources". VBH&C seeks to reduce the waste, harm and unwarranted variation that exist across our health and care system. It is by practising RM that we will deliver VBH&C.

TSH develop a RM action plan annually to outline the key projects associated with the approach. TSH continue to link with national networks to share practice. Priorities in 2025/26 will be to continue to champion RM, and VBH&C, embedding Shared Decision Making and championing the use and adaptation the BRAN questions (benefits, risks, alternatives and no action) within a secure setting. Each project in the RM action plan has also been aligned with the relevant commitment from the Scottish Government's VBH&C action plan.

TSH recently launched its updated Clinical Quality Strategy 2024 to 2029 with an associated action plan. This strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. The vision of the strategy is to improve the experiences of care and treatment provided to our patients by working together to deliver quality care and support that is person centred and free from harm.

Championing quality improvement (QI) is an integral part of the Clinical Quality Strategy. TSH has delivered a wide range of quality improvement projects, initiatives and training for staff over recent years. This will continue over the period of this plan, with the aim to:

- Deliver a minimum of one cycle of TSH 3030 which is our quality improvement initiative to progress an organisational approach to QI.
- Continue to provide QI training.
- Continue to establish and progress Team Based Quality Review (TBQR). These are service based panels who identify areas/themes with the most potential for learning and improvement to be discussed at regular TBQR meetings. This approach supports learning from local practice.

No	Planning Commitment	TSH Board Action	Delivery timescale
4.17	Progress RM and VBH&C principles.	Update annually and implement RM Action Plan.	2025-28
4.18	Progress RM and VBH&C principles.	Embed shared decision making by increasing the uptake of the learning module.	2025-28

No	Planning Commitment	TSH Board Action	Delivery timescale
4.19	Progress RM and VBH&C principles.	Champion the use and adaptation the BRAN questions through the nursing care plans.	2025-28
4.20	Build capacity for QI.	Deliver and support QI training.	2025-28
4.21	Champion quality improvement	Establish TBQR.	2025-28
4.22	Champion QI.	Deliver one cycle of TSH3030.	2025/26
4.23	Champion quality assurance and improvement.	Monitor and implement actions from the Clinical Quality Strategy Action Plan.	2025-28

CONTINUOUS REVIEW OF PROCEDURAL, RELATIONAL AND PHYSICAL SECURITY TO REDUCE RISK AND HARM AND ENSURE RESILIENCE

Security

The purpose of security in forensic mental healthcare is to provide a safe and secure environment for patients, staff, volunteers and visitors which facilitates appropriate treatment for patients and protects the wider public. This involves maintaining a secure environment where mental health care can be delivered, mitigating risks, preventing violence or self-harm and responding effectively to incidents. There are unique challenges posed within a high secure setting and security measures require to be both effective and respectful of people's dignity and mental health needs.

All patients in TSH have been assessed as requiring high security care. As such, all areas within TSH are maintained at a level to meet the criteria set by the Forensic Network Matrix of Security.

The specific features of high security are categorised into three domains: physical, procedural, and relational. These are interdependent and essential for the delivery of safe and secure care:

1) Physical security - Prevents access/egress to a facility or resource through specific measures e.g. locks, alarms, CCTV.
2) Procedural security - The range of policies and procedures that control access/egress, movement across the hospital site, patient communication, patient possessions and visits, etc.
3) Relational security - The ability of staff to develop therapeutic relationships with patients, leading to trust and engagement between staff and patients.

In addition to the measures in place across the site, all patients are subject to a range of security measures tailored to their clinical and risk evaluation needs and the stage of their treatment journey.

TSH has implemented a complex project to upgrade security on site. The Perimeter Security and Enhanced Internal Security Systems project was completed in 2025. Following completion of the project, TSH is in the process of the development of an underpinning security framework by standardising procedures, training staff and implementing quality assurance measures to monitor and maintain the advanced security technology installed. The security framework and associated standards will align with other high secure hospitals within the UK, taking into account Scottish legislation and the Forensic Network Matrix of Security. This will enable TSH to measure and audit performance in line with set criteria. Going forward and in line with TSH development, TSH will refine policies to ensure that security interventions are trauma informed and carry out proactive threat assessment and tailored security planning.

RISK, RESILIENCE AND BUSINESS CONTINUITY

Risk and Resilience

The focus of risk management in TSH is to learn from and reduce risks to all staff and patients, with an aim to maintain a positive risk culture within TSH. The current Incident Management System used within TSH is currently under review with an option to upgrade the current recording platform. An ongoing review of the Health and Safety management platform is also underway. If the intention is to move to new platforms then these activities will be followed up with staff training to enable effective use of new platforms. Staff will feel supported to take positive risks through a greater understanding of risk assessment and management.

Resilience of TSH is fundamental to ensure safety and security for staff, patients and visitors onsite and also for the wider community and general public. TSH has developed its resilience function and has a renewed focus on testing of plans, collaboration with external partners and training of staff to ensure they have the necessary capabilities to ensure and maintain staff, patient and visitor safety.

TSH, although not a Category 1 or 2 Responder, does have a responsibility to ensure that emergency procedures are planned, and staff are trained in core aspects in line with the Scottish Government “Preparing Scotland” guidance and the NHSScotland Resilience “Preparing for Emergencies” guidance and standards.

TSH will establish a Tactical Tasking and Co-ordination Group to address and assess threats and risks associated with security, resilience and health and safety. The group will ensure that a tactical assessment is developed to identify issues and risks and ensure these are managed through a dynamic responsive approach.

Business Continuity

Level 3 Plans

Partnership working is key to the resilience of TSH. As a stand-alone site TSH aims to maintain resilience and have further developed staff skills and sustainability in times of crisis. However, TSH will still require assistance from other agencies in times of extremis. Close relationships exist with partner agencies, and this will continue to develop and grow. TSH collaborates with partner agencies through joint training and familiarisation activities to ensure interoperability is maintained. Joint exercising is key, and plans are again in place to deliver a multi-agency exercise this year following the success of last year’s event.

TSH level 3 plans align to the multi-agency joint working model. These plans involve input from partner agencies, Police Scotland, Scottish Fire and Rescue, Scottish Ambulance Service, South Lanarkshire Council and the West of Scotland Regional Resilience Partnership. Work continues to develop and refresh level 3 plans to a standardised format.

A Multi-Agency Incident Response Guide has been developed as a short but informative overview of a multi-agency response for TSH. A multi-agency Memorandum of Understanding, aligned to the level 3 Plans has been developed to further define roles and responsibilities.

Level 2 Plans

TSH level 2 plans are primarily Loss of Service Plans and are led by internal operational structures. Ordinarily, a return to normal operations is swift and is controlled within normal service functions and operations.

Work has been ongoing to develop these plans into a consistent format, with each of the plans being fully reviewed and refined. TSH will prioritise a testing regime for these plans, this will ensure that departmental plans are tested and remain fit for purpose.

Strategic Infrastructure Planning

Scottish Government have introduced a new approach to strategic infrastructure planning and investment across NHS Scotland. Each NHS Board are required to submit a Programme Initial Agreement which sets out a deliverable whole system service and infrastructure change plan for the next 20-30 years. The first phase of this new approach to planning is the development and submission of a maintenance only Business Continuity Plan (BCP) based on the risk assessment of the Boards existing infrastructure.

TSH has carried out a risk- based assessment of essential maintenance, which is prioritised as part of the completed Business Continuity Plan. Each risk has been considered through their probability and impact in the key areas of Business/Financial, Staff/Health and Safety/Injury, Clinical/Service and Reputational/Adverse Publicity/Complaint and Claims. Following submission of the BCP to Scottish Government in early 2025, TSH will commence work on the implementation of this plan in 2026/27, following agreement from Scottish Government on the funding allocations and associated timescales. It is important to note that actual funding allocations from Scottish Government will be made on the basis of need and risk and so may not follow the same distribution as planning principles.

The work incorporated in TSH BCP investment programme will support the work identified within the existing capital allocation. The BCP investment will allow TSH to maintain a good standard of accommodation to support the clinical demand.

Due to the unique security measures at TSH, 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 TSH. The existing capital allocation budget of £269K for 2025/26 will support projects to replace IT hardware, vehicles, digital inclusion and digital platforms.

Corporate Risk Register

The Risk Management Team continue to review and refresh the risk management strategy and processes and align the Corporate Risk Register to the corporate objectives, KPI's and organisational risk appetite.

No	Planning Commitment	TSH Board Action	Delivery timescale
5.1	Security.	Development of security standards and framework. Audit of TSH security processes, procedures and practice against new security standards.	2025/26 Q1/2 Q3/4
5.2	Security.	Development of quality assurance framework to maintain and audit the new security technology installed across site.	2025/26 Q2/3
5.3	Risk Management.	Review and upgrade the current incident management recording platform and review the Health and Safety management platform. Support staff to use new platforms through awareness and training activities.	2025/26 Q3/4 2026/27
5.4	Strategic Infrastructure Planning.	BCP submitted to Scottish Government, implementation of the BCP for deliverable whole system infrastructure change - local implementation plan will be developed following feedback.	2025/26

No	Planning Commitment	TSH Board Action	Delivery timescale
5.5	Security.	Refine policies to ensure that security interventions are trauma informed.	2026/27

LEARNING FROM THE VIEWS OF OUR PATIENTS, CARERS AND STAKEHOLDERS

Hearing from, and learning about the views of our patients, carers and stakeholders is an important aspect of designing and delivering care and treatment for TSH. Engagement and feedback help to develop an awareness and understanding of the impact of care and treatment on patients, their carers, friends and family members. Understanding the views and experiences of patients and carers also enables TSH to identify areas for improvement.

Within TSH many of our patients will have carers who support them throughout their recovery. There are over 340 individuals identified as carers, from two key groups: Approved Visitors and Key Carers. Approved Visitors are able to visit in-person, while Key Carers, though not approved for visits, have a significant role to play in patient care. Our carers' insights are invaluable for developing effective carer support strategies.

Carer Strategy

TSH is required under Section 31 of the Carers (Scotland) Act 2016 to prepare a local Carer Strategy. TSH has developed a Carer Strategy 2025-2028 to meet the specific needs of carers involved in a high secure forensic setting. It is essential to recognise the unique experiences of carers navigating the judicial and forensic health settings, to understand their needs and respond appropriately. Carers for our patient group may have experienced trauma and distress and may experience stigma as a consequence of their loved ones association with TSH. We aim to ensure that the carers we work with are recognised, feel valued, and included. As a national service, our carers are geographically spread and there is a need to understand how this impacts on them, as well as on patients.

Currently, TSH:

- Has identified all our carers and updated our data base.
- Supports face to face contact with carers through social work.
- Has dedicated visiting facilities in the Family Centre.
- Implemented Triangle of Care.
- Provide a Visitors Information Pack.
- Has a dedicated page on TSH website for carers and visitors.
- Carries out an annual carer engagement questionnaire.

Following the Visitor Experience audit and subsequent engagement with carers, we have identified the following four priority areas for development:

1) The Triangle of Care self-assessment tool will enable us to identify ways that we can support our carers to navigate and understand what the standard of care is beyond 'the gate' to enable them to better understand our policies and procedures. Due to the high secure nature of our environment they are unable to walk in and look for themselves.
2) Carer communication and sharing of information. Providing good quality, appropriate, and timely information and advice to carers has dual benefits of improving the health and wellbeing of carers, and the cared-for person, reducing the potential need for, and costs of, crisis management.
3) Improve the Carers visiting experience - continue to work with patients and carers to continue to improve the visiting experience. Offer visitors a check-in following visits.
4) Carer Pathway - it is an important aspect of our patients' journey through the hospital to ensure our carers are linked with the wider Forensic Network. Establishing and maintaining good partnerships with third sector organisations will also play an important part in 'delivering effective local personalised support to carers, which meets their personal outcomes and helps them continue in their caring role'.

The Person Centre Improvement Group will devise a detailed delivery plan with at least three improvement activities under each of our priority areas, and assurances that what our carers told us they wanted to improve will be included in these actions.

In addition to developing our strategy we will also consider the carer pathway through the forensic estate along with how we engage with Local Authorities to ensure that we are addressing our statutory responsibilities a defined in the Act.

The Patient Partnership Group

The Patient Partnership Group (PPG) is a weekly patient forum that meets face to face as a planned partnership group. This group is supported by the Person Centred Improvement Team and enables patients to share experiences, plan activities and engage with TSH. The PPG is chaired by a patient and consists of patients' representatives from each of the wards. PPG members are tasked with cascading information from the group to their peers as well as gaining feedback to support the views of patients to be heard. The group is consulted on any changes suggested to the patient day or service delivery such as the Clinical Model implementation. A representative from the Complaints Team attends the PPG every month to seek discussion and feedback around complaints. Patient views are also sought through newly developed community groups who meet on the wards and raise local issues in relation to ward/service activity.

Patient Advocacy Service

The Patient Advocacy Service (PAS) is an independent advocacy service, based within TSH to be accessible and available for patients. The PAS aims to provide an independent, highly skilled, responsible, and professionally run service. The service provides 1:1 support to patients to help ensure that patients are empowered to engage in their care and treatment and also to raise concerns or complaints. The PAS works closely with the clinical teams and the complaints service to advocate on patient issues. The contract for the advocacy service was tendered for in 2024, this SLA will run for three years with an option to extend.

Complaints and Feedback

The NHS Model Complaints Handling Procedure (MCHP) is designed to encourage NHS organisations to learn from complaints and feedback with the aim of continuous improvement. The focus is on the resolution of individual complaints within a wider framework of taking learning and identifying areas for service improvement. Complaints outcomes are highlighted to the relevant Director and Heads of Department who have responsibility to effect change within their own remit. Complaints are also highlighted through directorate performance reviews to ensure effective oversight. In addition, TSH actively monitors all complaints and ensures reporting on complaints activity each quarter through the Clinical Governance Committee and Organisational Management Team.

Given the high secure nature of the hospital, additional support is provided to help patients to make complaints including face-to-face access to the Complaints Officer when attending the Skye Centre, as well as a confidential telephone line, and the use of facilities within the Patient Learning Centre to make a written complaint. Patients are also supported through PAS to engage in the complaints process. Carers can make complaints by telephone, web form or by email and/or post.

NHS Boards are required to ask complainants their views about the complaints process. Presently, the most valuable feedback from patients is gained through discussion at the PPG. A local feedback pro-forma has been used to try and encourage feedback. The challenge in this area was highlighted during a recent internal audit, and this is subject to review about how to obtain meaningful feedback.

No	Planning Commitment	TSH Board Action	Delivery timescale
6.1	Implementation of the Carers Strategy.	Develop delivery Plan for the Carers Strategy.	2025/26
6.2	Communication with Carers.	Review carer information packs and Carer page on website, include the child friendly literature in relation to TSH to support child visits. Establish carer's support group.	2025/26 2025/26
6.3	Stakeholder awareness and skills development.	Carer and Workforce Training and Development. Developing relationships with Partner Agencies.	2026/27 2025/26
6.4	Recovery progression.	Supporting transition within TSH Preparation for discharge.	2026/27

WORKING IN PARTNERSHIP TO PRIORITISE ORGANISATIONAL HEALTH, SUPPORT STAFF WELLBEING AND DEVELOP AN ENGAGED SUSTAINABLE WORKFORCE

Workforce

Scottish Government's Mental Health and Wellbeing Workforce Action plan 2023-25 outlines the vision and principles that underpin the support and development of the mental health workforce. It details the five pillars of Workforce Planning that are the basis for action to secure sufficient workforce to support recovery, growth and transformation, these are:

1) Plan.
2) Attract.
3) Train.
4) Employ.
5) Nurture.

TSH Workforce accounts for 624 WTE. Just over two thirds of the workforce are in clinical roles, with the remainder providing key support and board wide services.

TSH has developed its Workforce Plan 2025-2028 aligned to delivery and financial planning. The TSH Workforce Plan aims to evolve and align services which will directly support TSH to meet our service objectives, our transformational aims and to ensure sustainability and Value for Money.

Despite the relative scale of our Board, there is an opportunity to ensure that 'our people' are at the forefront of everything we do, that we are closely aligned to our service objectives and that our focus in these areas will be demonstrated by the levels of patient care offered.

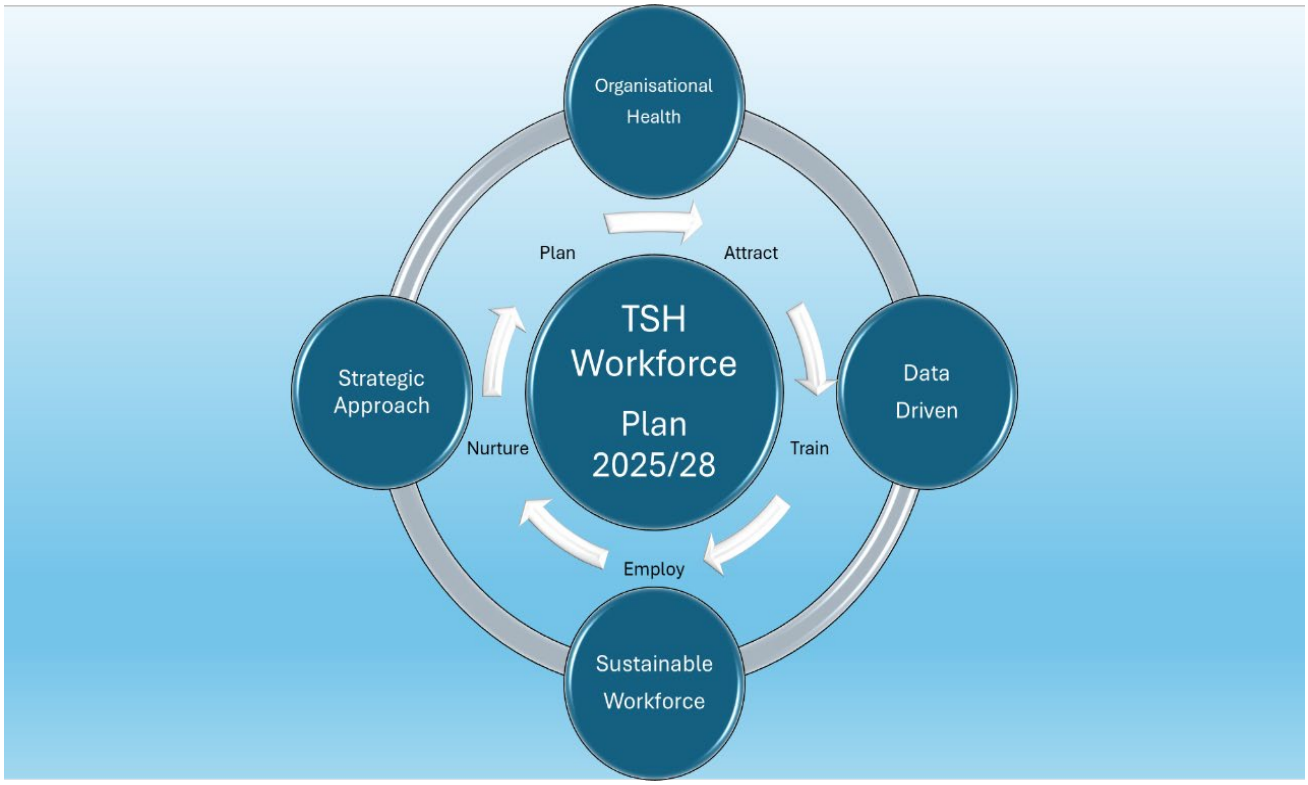
We are committed to the broad vision of the Health and Social Care National Workforce Strategy. 'A sustainable, skilled workforce with attractive career choices and fair work where all are respected and valued for the work they do.'

This vision is underpinned by the following values:

- Continual Improvement.
- Engagement.
- Honesty.
- Co-Design.
- Accountability.

Alongside our Workforce Plan 2025-28, we have recognised the need to evolve our approach to build on the foundations of our 2022-25 workforce plan, but more importantly to support the delivery of our Medium Term Plan and beyond.

The key strategic themes for the Workforce Directorate over this three year period will be:



1) Organisational Health

TSH has historically demonstrated a strong commitment to staff health and wellbeing, reflecting the value of our workforce and their impact on excellent patient care.

Our key vision of 'Prioritising Health, enhancing Performance' signifies the slight change in focus to organisational health, signifying that we recognise the value of our staff, we understand how important their work and their manager can be and we, as employers, have a duty and obligation to prioritise and maximise areas in which we can support health and wellbeing.

This approach extends significantly beyond staff health and wellbeing, and is in fact intertwined in everything we do throughout the employee journey.

Our prioritisation of Organisational Health will begin with a focus on Direction, Leadership and Work environment. The areas of focus will change over the next three years and bring a balance between a focus on protective approaches to staff health through management practices that can promote a positive culture and being proactive in offering staff wellbeing activities, both of which will be led by the needs of staff.

2) Sustainable Workforce

We remain committed to ensuring that we have the right people with the right skills and training in the right place at the right time to support our services.

This strategic theme will cover:

- Approach to Recruitment and Retention.
- Employability/Career Pathways/Anchor organisation.
- Building resilience in our community/Succession Planning.
- Focused approach to Learning and Education which meets service needs.
- Effective and Efficient Workforce Planning.

3) Strategically Aligned

A key evolution within our service will see the change in approach from transactional to Business Partner model, across all services. This will allow the workforce team to become more involved and more integrated in the delivery of key service, adding value in all of our key activities.

4) Data Driven

A key theme to support the strategic evolution will be improvement in how we use and utilise our data. TSH has significant data available in multiple formats, but the refinement of this data, principally through performance and health dashboards will be key.

Reliable real time data will also be key in driving sustainability and value for money, along with moving to a more proactive approach and reliance on data.

5) FOCUS ON CONTINUOUS IMPROVEMENT

In recognising the requirement for change and transformation, TSH Workforce Directorate require to provide real focus on sustainability, value for money and the opportunity for transformational change.

This focus should be a key priority in day to day actions, but aligned to being more strategically linked to organisational business need, with more relevant real time data, it will a key activity area over the coming years.

These strategic aims recognise that the importance of our employees in our success: employee health and well-being is a key component in workforce productivity and organisational effectiveness and crucial for the delivery of high-quality services and patient care.

Our focus on Organisational Health will facilitate more of a focus on the fundamentals in terms of a positive culture, energising environment, effective managers and strong working relationships.

These themes will also support TSH in developing an open, inclusive culture which engages all staff, encouraging feedback and providing ways through which they can help to further improve the quality of care for our patients.

Workplace health and well-being is multifaceted, and many factors can impact and influence the health and well-being of individuals and teams. Mental and physical health, and a healthy lifestyle all contribute to an individual's health and wellbeing however, other factors such as work relationships, leadership and management support, and the work environment are also important for workforce wellbeing and health.

Our journey and evolution, along with our progress on the Workforce Plan 2025-28, will be reviewed through our Staff Governance Committee, which provides the oversight and governance of workforce related KPI's.

The Workforce Governance Group (WGG) provides reporting to Staff Governance Committee via the CMT. WGG oversees the governance around decision making processes, update on the three year workforce plan and associated strategies for example recruitment and retention and well-being, as well as ensuring TSH meets the various Workforce policies and terms and conditions of service.

Workforce Equalities

Scottish Government requires NHS Boards to embed anti-racism objectives within Senior Executives for the year 2024/25. These should include a commitment that the Board will develop and deliver their own anti-racism plan, covering both the workforce and racilalised health care inequalities. Further guidance on this request was provided in DL23 (2024) which included the document intended to support the development of each NHS Board's own anti-racism plan. Scottish Government confirmed that the development and delivery of anti-racism plans would not be within annual delivery plan reporting, but in a flexible format with the first report provided by 31 January 2025.

TSH have established a Workforce Equalities Group in early 2025 to take forward an action plan to progress workforce equalities initiatives and embed these in TSH practices. The group will also review progress on TSH Equalities Monitoring Outcomes for 2025-29

No	Planning Commitment	TSH Board Action	Delivery timescale
7.1	Strategic Planning.	Development and implementation of Workforce plan.	2025/26 Q1
7.2	Workforce Action Plan.	Annual Action plan associated with Workforce strategy.	2025/26 Q1
7.3	Organisational Health	Continue to raise awareness of Organisational Health, increase profile and focus.	2025/26 Q1/2
7.4	Sustainable workforce.	Revised Maximising Attendance Approach.	2025/26 Q2
7.5	Organisational Health.	Launch of OD Strategy, with focus on three key areas:	2025/26

No	Planning Commitment	TSH Board Action	Delivery timescale
		1) Direction. 2) Leadership. 3) Working Environment.	
7.6	Data driven.	Establish data dashboards and opportunities to influence decision making.	2025/26 Q3
7.7	Strategic Alignment.	Implement business partner model across TSH teams to align workforce with departments.	2025/26
7.8	Anchors Strategy.	Review employability agenda, with community focus.	2026/27 Q2
7.9	Workforce Equalities.	• Establish Workforce Equalities Group. • Development of workforce equalities action plan including anti-racism plans. • Identification of training requirements.	2025/26 Q1 Q2
7.10	Sustainable workforce.	• Support Reduced Working Week (RWW) to 36 hours. • Support teams to develop plans for RWW. • Support implementation of RWW plans.	2025/26 Q3 2026/27 Q1
7.11	Strategic Alignment.	Review annual action plan associated with Workforce Strategy.	2026/27 Q1
7.12	Organisational health.	Focus on Manager and Leadership Development.	2026/27
7.13	Continuous Improvement.	Embed Organisational Health Approach.	2026/27
7.14	Strategic Alignment.	Annual Action Plan with Workforce Strategy.	2027/28 Q1

VALUE FOR MONEY AND ACHIEVING FINANCIAL BALANCE

Financial Balance

Scottish Government continues to highlight the challenging national financial position for NHS Scotland. All Boards have been instructed to achieve breakeven, with no brokerage option available and the Support and Intervention Framework now in operation. The requirement for recurring savings on baseline budgets is increasingly challenging given the ongoing national financial position.

TSH has developed its three year finance plan to outline the high level Revenue and Capital budget spending plans with known budget pressures outlined. The TSH Finance Plan is subject to review and approval by Scottish Government and will align with both the Delivery and Workforce plans.

TSH has consistently achieved financial balance, however this has become increasingly challenging and forecast to remain so with the requirement to achieve recurring savings. It is noteworthy that only 14% of TSH budget of costs are non-pay related.

TSH has in place a range of approaches to support managers to have oversight and management of budgets. A consistent pressure for TSH has been costs associated with staffing. A review of the requirements for staffing within nursing, which has the biggest pressure, has been carried out and high level oversight in place to better understand and deploy resource for this budget.

Internally to support financial management and oversight, TSH have regular reviews to assess savings plans within each area and identify specific initiatives in order that these can be achieved. TSH aims to achieve financial stability, with a key element of this being to empower managers to manage budgets and to automate as many processes and reporting to aid effective oversight.

Business transformation and innovation are also import elements of the collaboration across national Boards. TSH will engage with and take forward modernisation systems for HR, payroll, Finance and Procurement.

Procurement

TSH aims to provide the best value for money, benefits for patients and ensuring sustainable goods and services by maximising procurement technologies and digital innovation. TSH will continue to collaborate with the wider NHS Scotland procurement community and extend contract management to maximise performance. TSH will support the implementation of the replacement PECOS system, and also implement the new business system (Public Contracts Tender Portal) and support implementation of any new digital innovation (DI) systems.

TSH reviews its SLA's and contracts on a regular basis, taking action to update these and ensure value for money where required. TSH will continue to work with stakeholders to identify waste and inefficiency. The Procurement Reform (Scotland) Act 2014 requires authorities to comply with the Sustainable Procurement Duty where applicable. The Scottish Government Sustainability Toolkit is used in all regulated tenders to identify opportunities to ensure sustainable contracts. TSH will also ensure governance and regulated procurement compliance in all activity to reduce risk and maximise value. TSH will also seek to embed sustainability, support the climate change targets and support initiatives and projects which lead to continuous improvement.

Digital and e-health

There has been significant focus on developing the organisations digital and e-health function over the last few years. TSH remains fully committed to digital development and enablement, however the significant financially challenging position will impact on TSH ability to deliver its digital inclusion ambitions. The hospital aims to make the best use of digital technologies in the design and delivery of services delivering greater access, better insight and improved outcomes for patients.

TSH has invested in a Business Intelligence Team who continue to develop a suite of dashboards to inform both clinical and managerial decision making and ensure fit for purpose data is readily available. The focus for 2025/26 will be to develop business intelligence financial dashboards for clinical staff to support financial planning and decision making.

TSH continues to support the development of digital capability and will promote nationally developed learning resources to support the development of staff digital capability. Digital and Data Capability Framework | Turas | Learn and the Self-Assessment Tool | Turas | Learn.

TSH is committed to ensuring fit for purpose data is readily available and accessible. The focus for e-health teams is to equip staff with the ability to understand and interrogate data-driven recommendations and decision support tools. Through involving staff in the design of these tools and supporting them to improve patient outcomes we aim to empower those delivering services to have confidence and ability to gather, safely use, and share data to sustainably improve services. We aim to expand our specialist digital data design and technology professional workforce ensuring there's appropriate level of leadership, skills and capacity. TSH will progress infrastructure systems, ensuring that regulations, standards and governance are in place to ensure robust and secure delivery. We aim to move to a digital system for all records.

Cyber security continues to be recognised as a high risk and concern for all Boards, with significant focus for TSH. The Network Information and Security Regulation (NIS) is at the fore front of everything we do. TSH was audited against the NIS standards in 2023 and achieved a high standard, which we have sought to improve on. A second audit was carried out in October 2024. TSH will continue to work towards improvement in network security, the next full review from NIS is due in 2026.

TSH has invested in the development of the electronic patient record (RiO). This requires regular updates and internal redesign to meet the needs of those delivering services to ensure that reporting and recording of patient care is accurate and useable. TSH has developed bespoke modules on RiO to support improved observation practice, psychological service referrals, CPA process review and Variance Analysis Tool redesign.

TSH has engaged with the adoption and implementation of national digital programmes including M365, SharePoint and e-roster. These programmes are complex and have a variety of products e.g. e-roster has Safe care, Allocate, Health Medics Optima and Loop. TSH will adopt and adapt elements of these products to meet its needs. TSH will continue to link in with the national programmes as they develop with the requirement to ensure preparatory work in track for these systems.

Digital Inclusion

TSH is keen to progress digital inclusion for patients, both to improve the patients' experience and also to support care and treatment. Presently, patients within the TSH are at a disadvantage in terms of digital inclusion compared to patients being cared for within other forensic settings across NHSScotland. In November 2018, the Forensic Network produced a key report "Supporting Communication and Technology Use in Mental Health Settings", and post pandemic this was updated in May 2021. In January 2024, Scottish Government indicated that they will engage with the Forensic Network to develop a Delivery Plan based on the recommendations from the above reports.

Within TSH, a digital inclusion strategy was prepared, with stakeholder engagement during 2023/24. However, this is now on hold due to financial constraint. Funding for both capital and revenue (staffing/resourcing) support is required. In the meantime, all other potential funding options continue to be reviewed and investigated; and consideration is given to any elements of the overall programme which can be addressed within existing resources and budgets.

In Q4 2024/25 TSH was offered an electronic platform, Made Purple Operating system equipment and software at no initial cost to provide 'proof of concept' testing to be taken forward. The aim of this would be evaluate the systems effectiveness in enhancing patient engagement and digital inclusion, and contribute to strengthening the business case for consideration for future funding opportunities. This will be taken forward in 2025/26 and recommendations from this built into future funding opportunities.

No	Planning Commitment	TSH Board Action	Delivery timescale
8.1	Three year finance plan 2025-2028.	Action plan associated with 3 year finance plan.	2025-2028
8.2	Financial management.	Development of local dashboards to support financial analysis and management.	2025/26 2026/27
8.3	Financial Compliance.	Making Tax Digital.	2025/26 2026/27
8.4	Patient digital Inclusion/patient funds.	Patient digital inclusion / patient funds.	Depend on funding
8.5	Digital Inclusion.	Test Made Purple equipment and software in the Transitions service to provide proof of concept for further roll out.	2025/26 Q2/3
8.6	Digital Infrastructure.	Ensuring that regulations, standards and governance are in place to ensure robust and secure delivery.	2025-2028
8.7	Business Service Transformation.	Development and support implementation of systems for HR, payroll, Finance and Procurement.	2026/27 2027/28

No	Planning Commitment	TSH Board Action	Delivery timescale
8.8	Business Service Transformation.	Support implementation of the public contracts tender portal and any new DI system.	2026/27
8.9	TSH will continue to link in with the National Digital Programmes as they develop.	TSH has engaged with the adoption and implementation of programmes including M365, SharePoint and e-roster. **e-roster** - Safe Care – all rosters will use phase 1, with phase 2 will be rolled out for Nursing Hub rosters. **Allocate** - the impact of the RWW will enable review of the digitalised system and enable it to be used to fuller potential. TSH will move from a centralised resource management approach to a ward based approach, giving the Senior Charge Nurse overview and management of rosters via allocate. **Health Medics Optima** – continue to explore the opportunities around this **Loop** - Management of annual leave for all non-nursing rosters to be fully embedded in this approach	2025-2028 2025/26 2025/26 2025/26
8.10	Network security	NIS audit	2026

CLIMATE AND SUSTAINABILITY

TSH recognises the role it plays in NHS Scotland's approach to the climate emergency as set out in DL (2021) 38. TSH operates from 15 buildings including patient accommodation, off ward therapy areas, offices, carers' facilities, security buildings and estates buildings. TSH also manages land and buildings covering an area of 63 hectares.

As a relatively modern hospital, TSH does not require an extensive plan of works to reach national targets on climate change. However, TSH continues to develop and implement work to reduce the hospital's impact on climate and improve sustainability. TSH buildings will also need lifecycle maintenance. Maintenance costs will inevitably increase as the facility ages. These costs now need to be planned for to maintain standards of building quality for patients and staff to enable a level of care. TSH will require to develop a planned maintenance programme to ensure that buildings continue to be fit for purpose.

The State Hospitals Board for Scotland is obliged to meet decarbonisation targets set by NHS Scotland Assure. The most critical targets are:

- 75% reduction in emissions by 2030.
- Decarbonised heat by 2038.
- Net Zero by 2040.

TSH has already reduced emissions by 83.7% against the baseline year 1993/94, which is within the five year 1990 Kyoto window. Therefore, TSH is well-ahead of the 2030 target. However, without targeted decarbonisation measures the health board would not meet the other two key targets. In

the medium term a feasibility study will be commissioned to explore use of new technologies to meet the decarbonisation target.

In September 2023, 'Jacobs Carbon and Energy Consulting' published the *'NHS The State Hospital Net Zero Route Map Report*' following a number of site visits, and the hospital continues to progress the recommendations, to support movement towards the 2040 target wherever possible.

The bulk of carbon savings in 2030 are proposed to be delivered by deployment of on-site renewable generation, whereas in 2040 it is the decarbonisation of heat that drives the health board towards Net Zero.

To meet the decarbonising of heat sources target, TSH will require to commission a feasibility study to explore the use of new technologies such as ground source/air source heat pumps, and any emerging technologies that would be suitable for the site.

With the target year being 2038, this will require to be completed over the next 5/6 years.

Electrical renewable technology to be explored for the site includes wind (turbine) and solar PV. This work will coincide with the feasibility study for the decarbonising of heat sources over the next 5/6 years.

TSH will also develop and implement a high-level waste route map, move forward with an active travel agenda, including active business travel, increase biodiversity/greenspace awareness to contribute towards achievement Net Zero by 2040.

Recent development has included Electric Vehicles (EV) which have now been added to the fleet, with further EV's planned. EV charging points have now been extended to the car park for staff use and additional points are being added internally for future EV's. New LED lighting is also being introduced across the Hospital.

The tables below contain the current modelling report for TSH's Net Zero performance on a business-as-usual scenario.

NHS State Hospital							
CO2e Emissions Targets		**1993/94**	**2023/24 Reported Figures**	**2025 Interim Target**	**2030 Interim Target**	**2035 Interim Target**	**2040 Net Zero Target**
The New % Pathways to a 2040 Net Zero Outcome.	CO2e Emissions Targets	Baseline	-63.6%	-65.5%	-75%	-87.5%	-100%
Target – Our Current Usage Trend will have to follow these trajectories.	Tonnes	10,678	3,887	3,684	2,670	1,335	0
Actual and Predicted CO2e Emissions from now to 2040.	Tonnes	10,678	1,739	1,653	1,446	1,332	1,264
CO2e Emissions – Current Pathway based on current	Based on 1993/94 usage levels	-	-83.7%	-84.5%	-86.5%	-87.5%	-88.2%

NHS State Hospital							
CO2e Emissions Targets		**1993/94**	**2023/24 Reported Figures**	**2025 Interim Target**	**2030 Interim Target**	**2035 Interim Target**	**2040 Net Zero Target**
anticipated energy use.							
Potential Shortfall			-20.1%	-19.0%	-11.5%	0.0%	11.8%

Governance for the Climate Change and Sustainability agenda is through the newly established Climate Change and Sustainability Group which has the lead responsibility and is accountable to the Security, Resilience, Health and Safety Oversight Group. The Group ensures an integrated approach to sustainable development, harmonising environmental, social and economic issues.

No	Planning Commitment	TSH Board Action	Delivery timescale
9.1	Net Zero Target	• Develop and implement a high-level waste route map. • Progress an active travel agenda. • Increase biodiversity/greenspace awareness. • Fully implement an EMS for TSH.	2025/26
9.2	Planned maintenance programme.	TSH will develop a planned maintenance programme to ensure that building continue to be fit for purpose	2025/26
9.3	Decarbonisation of heat sources.	Commission a feasibility study to explore the use of new technologies such as ground source/air source heat pumps, and any emerging technologies that would be suitable for the site	2028

DELIVERING ORGANISATIONAL EXCELLENCE

Governance

There are three statutory governance strands for NHS Boards in Scotland.

The TSH structure is aligned through the:

1) Clinical Governance Committee.
2) Staff Governance Committee (which sponsors the Remuneration Committee).
3) Audit and Risk Committee.

Each committee meets quarterly and has a structured workplan to support active oversight within its remit. The committees review their terms of reference annually; and each will provide an annual report to the Board as assurance that the terms of reference have been met and that the committee has fulfilled its remit

Additionally, the Board will stand up additional governance structures when required - the project Oversight Board for the Perimeter Security and Enhanced Internal Security Systems Project will be finalised within 2024/25 with final reporting to the Board by June 2025.

The Board also supports a structure of Professional Advisory Committees (PACS) under the umbrella of the Clinical Forum. The forum was paused during 2024 and scheduled to re-start in January 2025. The structure of the PACS is under active review of their terms of reference and

membership. This is to align this structure to practice in this area across NHS Scotland, providing a structured route for engagement with professional colleagues to raise clinical views outwith the existing management structure.

The Board works actively to review its corporate governance arrangements, taking direction from the NHSScotland Blueprint for Good Governance. This is a process of continuous improvement, with the key focus in 2025/26 being continued implementation of the Board Improvement Plan as well as supporting the next phase of self-assessment, expected to be rolled out through NHS Education for Scotland in early 2025.

TSH continues to review its management reporting systems and organisational groups actively, to embed a streamlined linear approach, and to underpin assurance reporting for the Board. This structure is led by the Chief Executive.

Information Governance

The aim of information governance service within TSH is to ensure that the hospital handles information legally, securely, efficiently and effectively. Governance structure for information governance is through the Information Governance Group, chaired by the Senior Risk Information Owner who is responsible for progression of attainment levels in relation to Information Governance Standards - reporting to the Finance, eHealth and Audit Group, then onto TSH Board.

The Caldicott Guardian principles are integrated within the initiatives and standards required by NHS QIS for Information Governance and attainment levels are recorded via the Information Governance Toolkit.

TSH seeks to continue to work to improve Information Governance standards and practices across the hospital. TSH encourage staff to adopt good Information Governance standards through a number of measures, and to complete mandatory online Information Governance learning modules. TSH will review baseline tasks required for the organisation for information governance to ensure that we deploy the most efficient approaches. Information Governance is reviewed by Information Commissioners audit (ICO), TSH was last audited against the ICO standards in 2023 and achieved a ‘high’ rating, however work continues to ensure we sustain this levels and also make improvements.

Records Management

The Information Governance Group also has oversight of Records Management (RM). In TSH there has been recent changes in the structure of the records management department with improvements noted in RM within the organisation. An overarching RM Policy was approved in 2024 and a formal Retention and Destruction Policy was agreed in 2023, and work is ongoing with regard to guidance on version control and naming conventions. The RM department has contributed to the development of the national Records Management Code of Practice and will continue to support ongoing updates to this document as well as the national Business Classification Schedule.

A full resubmission of the Records Management Plan (RMP) was completed and submitted to the Keeper of the Records in the National Records of Scotland in December 2024. Feedback on the RMP will form part of the actions for the RM team going into 2025-2028.

Communications

TSH has a well-established Communications Service that connects the organisation with its stakeholders, including staff, the local community, the general public, professional bodies, and local/national government. The services provided include consultancy, electronic communications,

video production, media and social media management, marketing materials, corporate publications, and stakeholder engagement.

The Communications Strategy 2025-30 shapes communication efforts over the next five years, aligning with organisational priorities and capitalising on emerging tools and trends to maximise impact and engagement. Internally, the service is committed to meeting the needs of the 'Well Informed' strand of the Staff Governance Standard. Externally, focus is on increasing TSH's visibility and raising awareness of severe and enduring mental illness. The aim is to reduce stigma by fostering a better understanding of mental illness, promoting open dialogue, and enhancing the hospital's role in high-secure care through targeted communication efforts. The strategy builds on existing communication strengths, refining organisational messaging while leveraging a diverse range of communication tools to deliver a unified narrative to stakeholders.

Focus also remains on building capacity for the future, with a particular emphasis on enhancing resilience, succession planning, and fostering sustainable growth.

Equally important is the need to stay current with and embrace digital technologies and advancements, ensuring that communication channels remain innovative and effective in meeting the needs of stakeholders.

Performance

TSH is a Special Health Board serving the population of Scotland and Northern Ireland and is part of NHS Scotland. TSH has a sponsorship agreement with Scottish Government which has been reviewed by the Public Bodies Unit. This framework sets out how TSH will operate and defines key roles and responsibilities which underpin the relationship between the TSH and Scottish Government. TSH retains its functional independence, and its executive directors are accountable to TSH Board through the Chief Executive. TSH sponsorship agreement is a key part of the accountability and governance framework. Legislative provisions shall take precedence over any part of the document.

As part of the sponsorship agreement, TSH is held accountable for the delivery of its planned commitments through quarterly Sponsorship Meetings with Scottish Government where the Boards performance against delivery commitments is monitored and discussed. TSH also has an annual review with Scottish Government as part of the NHS Scotland Review process.

TSH has both internal and external auditors who provide an objective audit function to monitor both business as usual activities and specific projects. Internal audit cycles are agreed and monitored through the Audit and Risk Committee and the Board. The external auditor provides an annual review of data and activity to provide an analysis and reporting on TSH functions.

External monitoring is also carried out by the Mental Welfare Commission.

Internally, quarterly Directorate Performance Meetings have been established. These provide an opportunity to review and discuss the performance of each directorate and its unique contribution and challenges. Performance is also reviewed throughout the management group structure of CMT/Organisational Management Team and Service Leadership Teams. There are also corporate governance mechanisms of the Board and sub committees' structure.

TSH has an established programme of Strategic Planning, Performance and Governance Meetings. These take place quarterly and provide the opportunity to review in detail performance, planning and governance issues.

No	Planning Commitment	TSH Board Action	Delivery timescale
10.1	Blueprint for Good Governance.	Implementation of Board Improvement Planning Cycle.	2025/26

No	Planning Commitment	TSH Board Action	Delivery timescale
10.2	Information Governance.	Implementation of ICO audit actions.	2025/26
10.3	Records Management Plan.	Implement key actions from the National Records of Scotland feedback on the RMP.	2025-28
10.4	Communications.	Delivery of the Communications Action Plan.	2025-28

Paper No 25/63

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 25
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning, Performance & Quality Corporate Planning, Performance & Quality Project Support
Title of Report:	Performance Report 2024/25 and Annual Comparative Figures
Purpose of Report:	For Noting

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1 April 2024 until 31 March 2025. Trend data is 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 Key Performance Indicators (KPIs) 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) and Delivery Plan Framework

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator performance as well as an Annual Overview of performance and a Year-on-Year comparison at the Board meeting each June.

3 ASSESSMENT

The following section contains the KPI data for 2024/25 and highlights any areas for improvement through a deep dive analysis for KPI's that have missed their targets.

There are seven updated KPIs for 2024/2025 that have achieved target,
these are:

- Patients will be engaged in psychological treatment.
- Patients will be engaged in off-hub activities.
- Patients will undertake an annual health review.
- Staff have an approved PDR.
- Patients Transferred/ Discharged using CPA.
- Patients required primary care will have access within 48 hours.
- Patients will commence psychological therapies ,18 weeks from referral date

There are five KPIs that have missed their target this year, these are:

- Patients will have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will have a healthier BMI.
- Sickness absence
- Patients will undertake 150 minutes of exercise each week.
- Patients have their clinical risk assessment reviewed annually

Item	Performance Indicator	Target	RAG	24/25	23/24	22/23	21/22	20/21	19/20		LEAD
1	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	**A**	91.01%	87.92%	91.70%	92.67%	94.40%	91.73%	Average figure from April 2024 – March 2025. There has been an improvement within this KPI over the year moving the RAG from Red to Amber	**LT**
2	Patients will be engaged in psychological treatment	85%	**G**	94.11%	82.21%	83.2%	85.56%	86.74%	87.93%	Average figure from April 2024 – March 2025.	**KMcC**
3	Patients will be engaged in off-hub activity centres	90%	**-**	-	-	-	-	-	83%	This indicator was closed in June 2020 to accommodate engagement during restrictions (see 3.1).	**KMcC**
3.1	Patients will be engaged in off-hub activity centres	90%	**G**	95.25%	94.50%	90.92%	92.47%	83.33%	-	Average figure from April 2024 – March 2025.	**KMcC**
4	Patients will be offered an annual physical health review.	90%	**-**	-	-	-	51.78%	56.67%	98.48%	This indicator was closed in March 2022 with restructured reporting commencing in April 22 (see 4.1).	**LT**

4.1	Patients will undertake an annual physical health review	90%	**G**	100%	100%	98.2%	-	-	-	Average figure from April 2024 – March 2025.	**LT**
5	Patients will undertake 90 minutes of moderate exercise each week (Annual Audit)	80%	**-**	-	-	-	78.75%	75.00%	60.70%	This indicator was closed in March 2022 to accommodate new guidance with reporting commencing in April 2022 (see 5.1).	**KMcC**
5.1	Patients will undertake 150 minutes of moderate exercise each week (Annual Audit)	60%	**-**	-	-	63.35%	-	-	-	This indicator was closed in March 2023 as the target was increased (See 5.2)	**KMcC**
5.2	Patients will undertake 150 minutes of moderate exercise each week (Annual Audit)	70%	**R**	60.09%	61.48%	-	-	-	-	Average figure from April 2024 – March 2025.	**LT**
6	Patients will have a healthier BMI	25%	**R**	9.75%	8.92%	9.5%	10%	10.50%	8.75%	Average figure from April 2024 – March 2025.	**LT**
7	Sickness absence	5%	**R**	7.51%	7.81%	7.68%	6.39%	5.30%	5.92%	Average figure from April 2024 – March 2025.	**SW**
8	Staff have an approved PDR	80%	**G**	88.78%	85.93%	83.35%	85.25%	80.58%	86.68%	Average figure from April 2024 – March 2025.	**SW**
9	Patients transferred/discharged using CPA	100%	**G**	100%	100%	100%	100%	100%	100%	Average figure from April 2024 – March 2025.	**LT**
10	Patients requiring primary care services will have access within 48 hours	100%	**G**	100%	100%	100%	100%	100%	100%	Average figure from April 2024 – March 2025.	**LT**
11	Patients will commence psychological therapies <18 weeks from referral date	100%	**G**	99.91%	99.12%	91.43%	98.66%	97.66%	99.78%	Average figure from April 2024 – March 2025.	**KMcC**
14	Patients have their clinical risk assessment reviewed annually.	100%	**A**	94.03%	93.79%	95.42%	96.49%	95.35%	97.68%	Average figure from April 2024 – March 2025.	**LT**

15	Attendance by all clinical staff at case reviews	Individual	-	70.3%	66.9%	60.8%	69.7%	70.5%	72.7%	Average figure from April 2023 – March 2024.	**All Leads**

No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals
Target: 100%

Data for 2024/25: 91.01%

Performance Zone: Amber

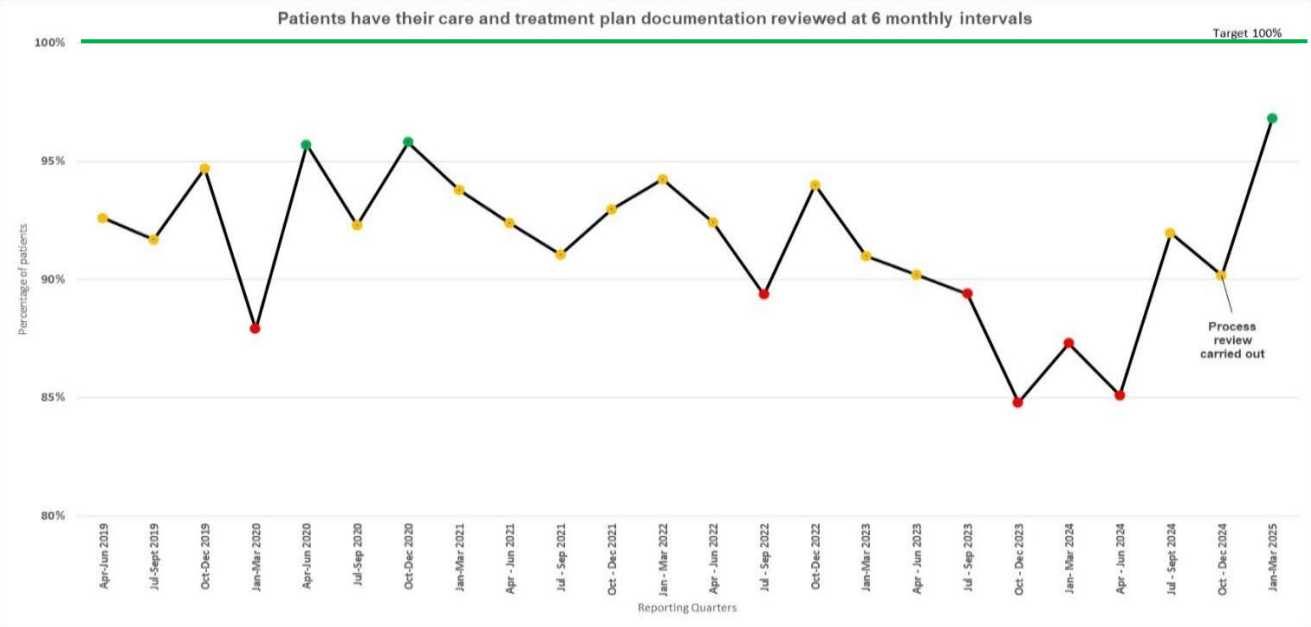
The Mental Health Act 2003 requires the preparation of documented care plans for people who are subject to compulsion. The Scottish Government CEL 13 (2007) identifies that the CPA is the appropriate tool for all restricted patients. The Code of Practice for the 2003 Act gives guidance on the RMO's responsibilities and required content of the care plans.

This indicator measures the assurance of patients receiving intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	R	A	A	G	91.01%	87.92%	91.7%	92.67%	94.40%	91.73%

Performance has improved in 2024/25, with the annual data increasing by 3.09% in comparison to the 2023/24 figure, moving from the red to amber RAG. A review of the process for preparing, reviewing and uploading of documents was completed between June and August 2024 where a process map was developed by the Clinical Admin Co-ordinator. The process map illustrated the steps within the process and identified potential bottlenecks within the system. Since this review the process has been circulated to relevant parties to ensure that the correct system is followed and relevant timescales met. Monitoring of CPA documentation that has been out of date for over 8 weeks has been feedback to the Medical Director to raise awareness with relevant individuals, this has resulted in improvements in outstanding uploading of documentation.

Chart 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals



No 2: Patients will be engaged in Psychological Treatment

Target: 85%

Data for 2024/25: 94.11%

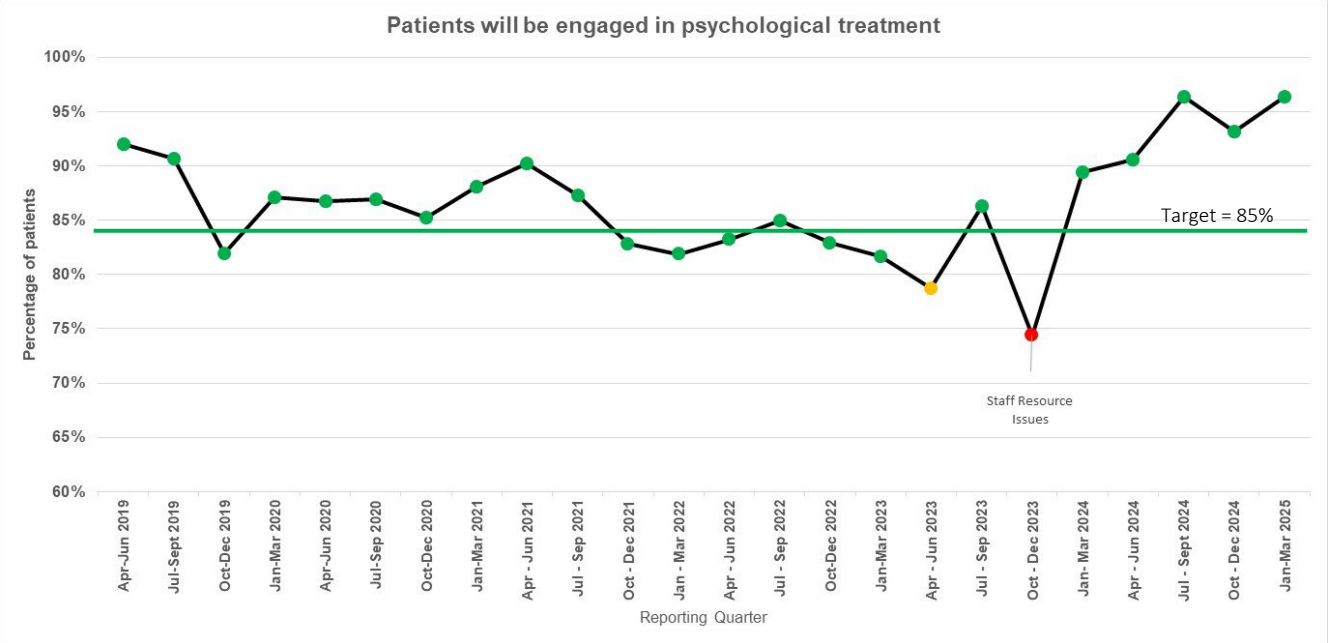
Performance Zone: Green

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

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Patients will be engaged in psychological treatment	85%	G	G	G	G	94.11%	82.21%	83.2%	85.56%	86.74%	87.93%

Performance has stabilised over the course of this year. The annual average of 94.11% which is a 11.9% increase from last year's annual report. There are a few factors contributing to this: successful recruitment leading to improved staffing, which resulted in more patients been seen individually. In addition, assistance from the link nurse role has resulted in an increased number of groups being offered, resulting in an increase in patient accessing treatment sooner. Psychology have also put measures into place to ensure more accurate recording and reporting of data.

Chart 2: Patients will be engaged in Psychological Treatment



No 3.1: Patients will be engaged in Off-Hub Activity Centres

Target: 90%

Data for 2024/25: 95.25%

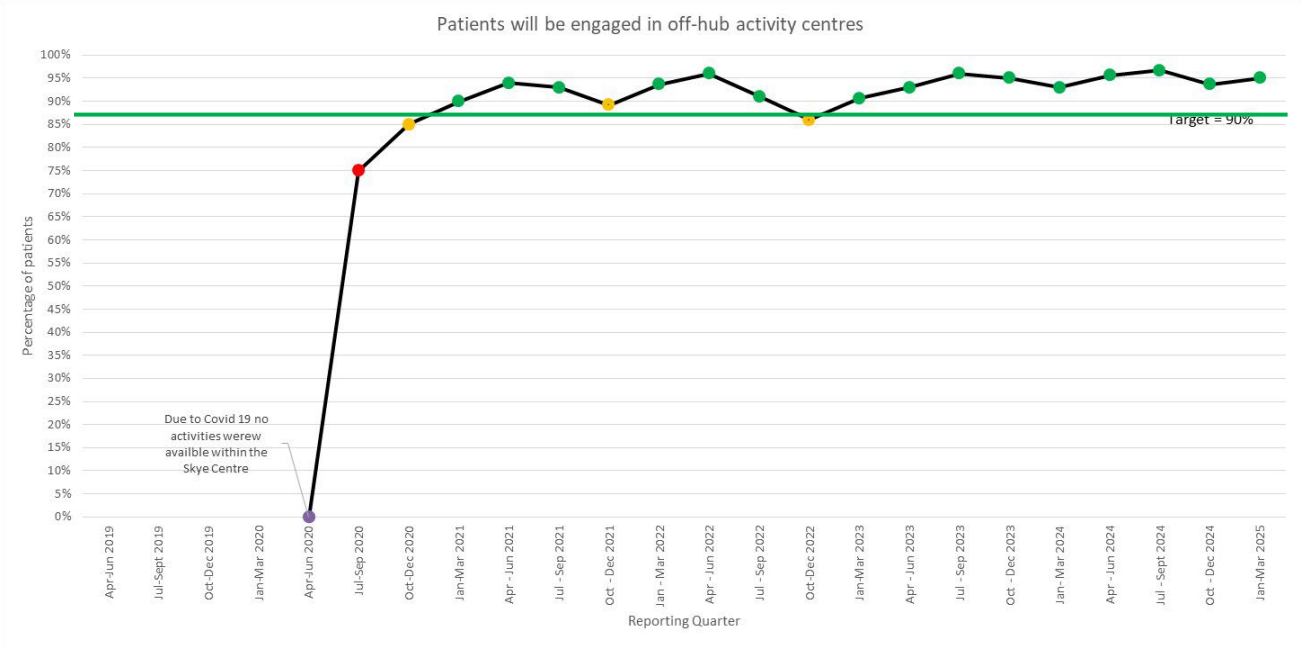
Performance Zone: Green

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 relate to the objectives in their care plan however are recognised as therapeutic activities. Work has started to explore amending this KPI to include all forms engagement in activity not just off hub.

Performance Indicator	Target	RAG Q1 23/24	RAG Q2 23/24	RAG Q3 23/24	RAG Q4 23/24	24/25	23/24	22/23	21/22	20/21	19/20
Patients will be engaged in off-hub activity centres	90%	G	G	G	G	95.25%	94.5%	90.92%	92.47%	83.33%	-

This indicator averaged at 95.25% for this reporting year and remains above target.
The Activity Oversight Group (AOG) is responsible for monitoring this data and commissioned a review of this KPI to include all activity within the hospital not just off hub activity. Clinical Quality have carried out an analysis of the data to review data quality, with the first phase completed, a revised timetable is now with the developers with a completion date expected in Q1/2 2025/26.

Chart 3: Patients will be engaged in Off-Hub Activity Centres



No 4.1: Patients will undertake an Annual Physical Health Review

Target: 100%

Data for 2024/25: 100%

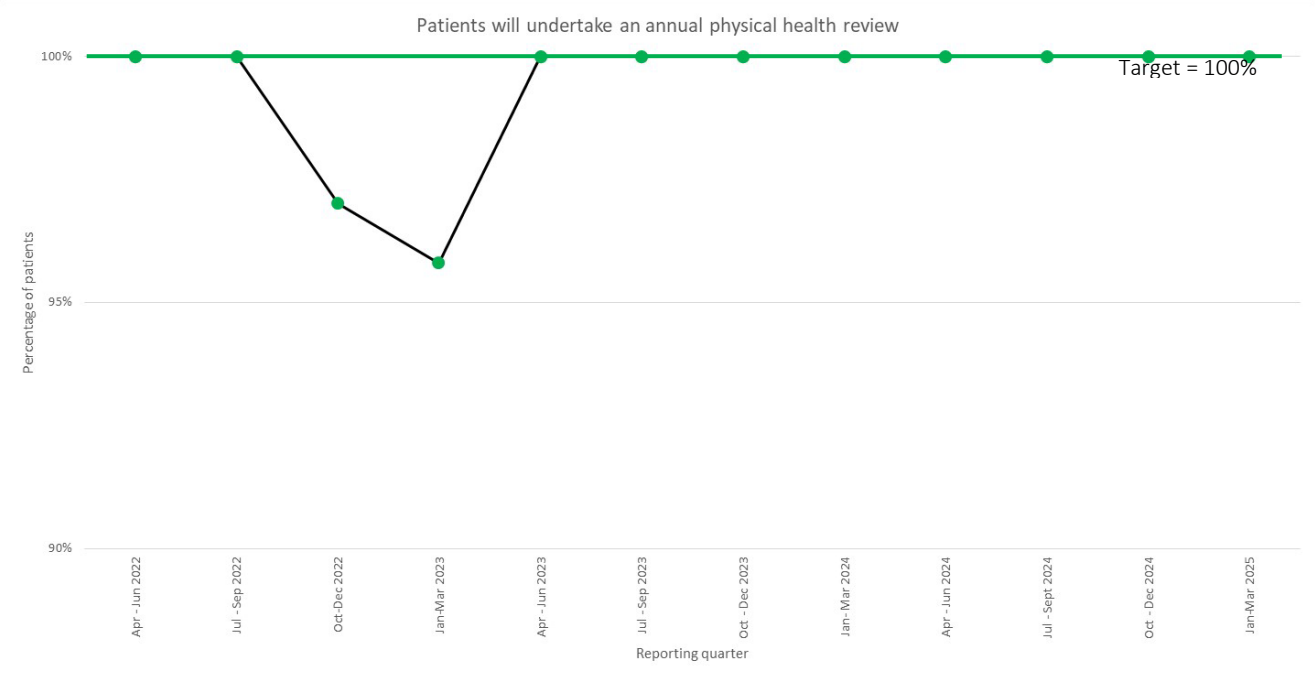
Performance Zone: Green

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS).

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23
Patients will undertake an annual physical health review	100%	G	G	G	G	100%	100%	98.2%

This KPI charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse will identify any patients that require to be reviewed face-to-face by the GP and these reviews will be conducted during the normal clinic sessions.

Chart 4: Patients will undertake an Annual Physical Health Review



No 5.2: Patients will undertake 150 Minutes of moderate exercise each week

Target: 70%

Data for 2024/25: 60.09%

Performance Zone: Red

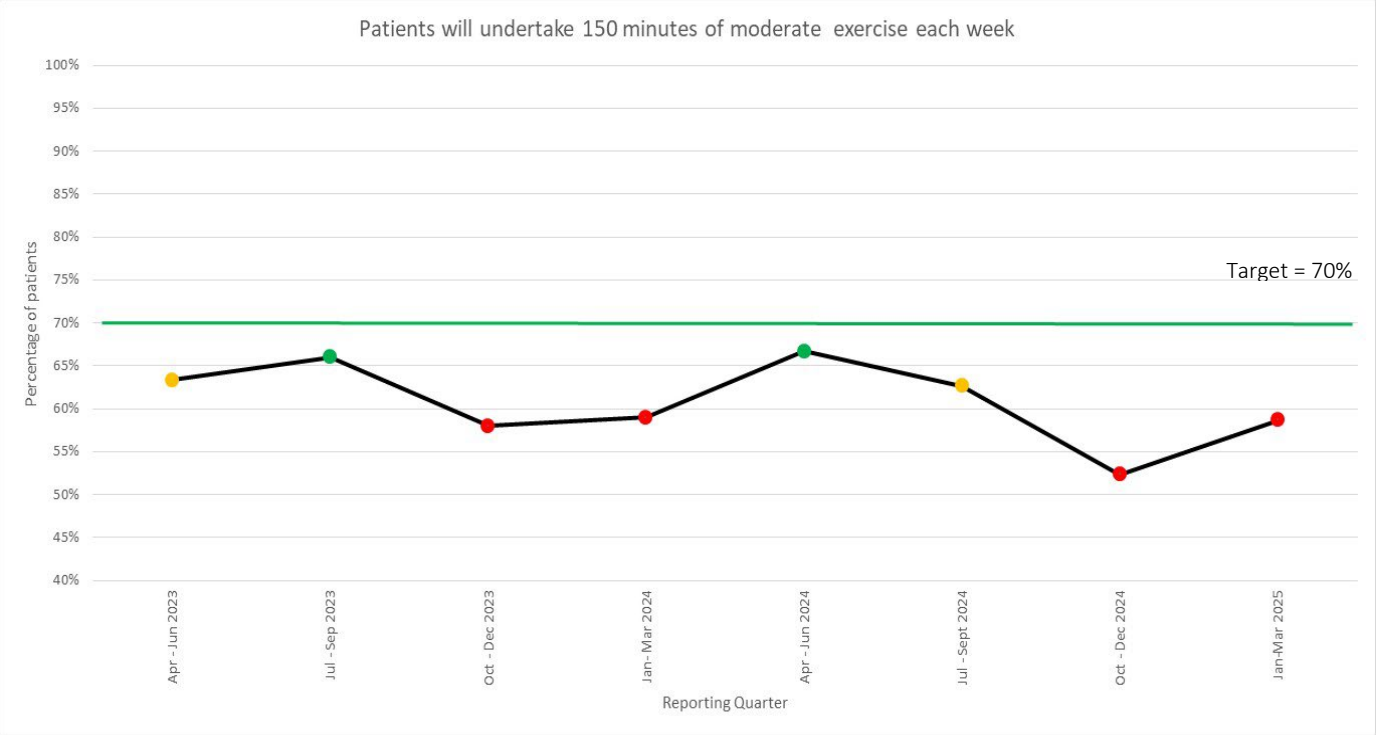
This links with national activity standards for Scotland. This measures the number of patients who undertake 150 minutes of moderate exercise each week.

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24
Patients will undertake 150 minutes of moderate exercise each week	70%	G	A	R	R	60.09%	61.48%

Seasonal variation is noted across all services for this target. Q1 & Q2 activity is consistently higher in each service with a drop in Q3 and Q4, with increases in activity beginning to be noticeable in latter part of Q4. Each service has its progress against the target measured and reported to the Service Leadership Team.

There is variation across the services in their performance against this target. The Transition service has consistently met the target over the year with a service median of 87%, the ID service has a median of 53% and the Treatment and Recovery service median have changed from summer to winder months with 56% Q1&Q2 then reducing to 47% later in the year. Similarly, the Admissions service Q1&2 median is 47% drooping to 29% in Q3 then increasing over Q4
Reductions in performance against the target is associated with poor weather, festive events in Q3, public holidays and staffing levels across disciplines. Supporting Health Choices are progressing small scale projects to increase compliance.

Chart 5: Patients will undertake 150 Minutes of moderate exercise each week



No 6: Patients will have a Healthy BMI

Target: 25%

Data for 2024/25: 9.75%

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 our patient group.

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Patients will have a healthier BMI	25%	R	R	R	R	9.75%	8.92%	9.5%	10%	10.50%	8.75%

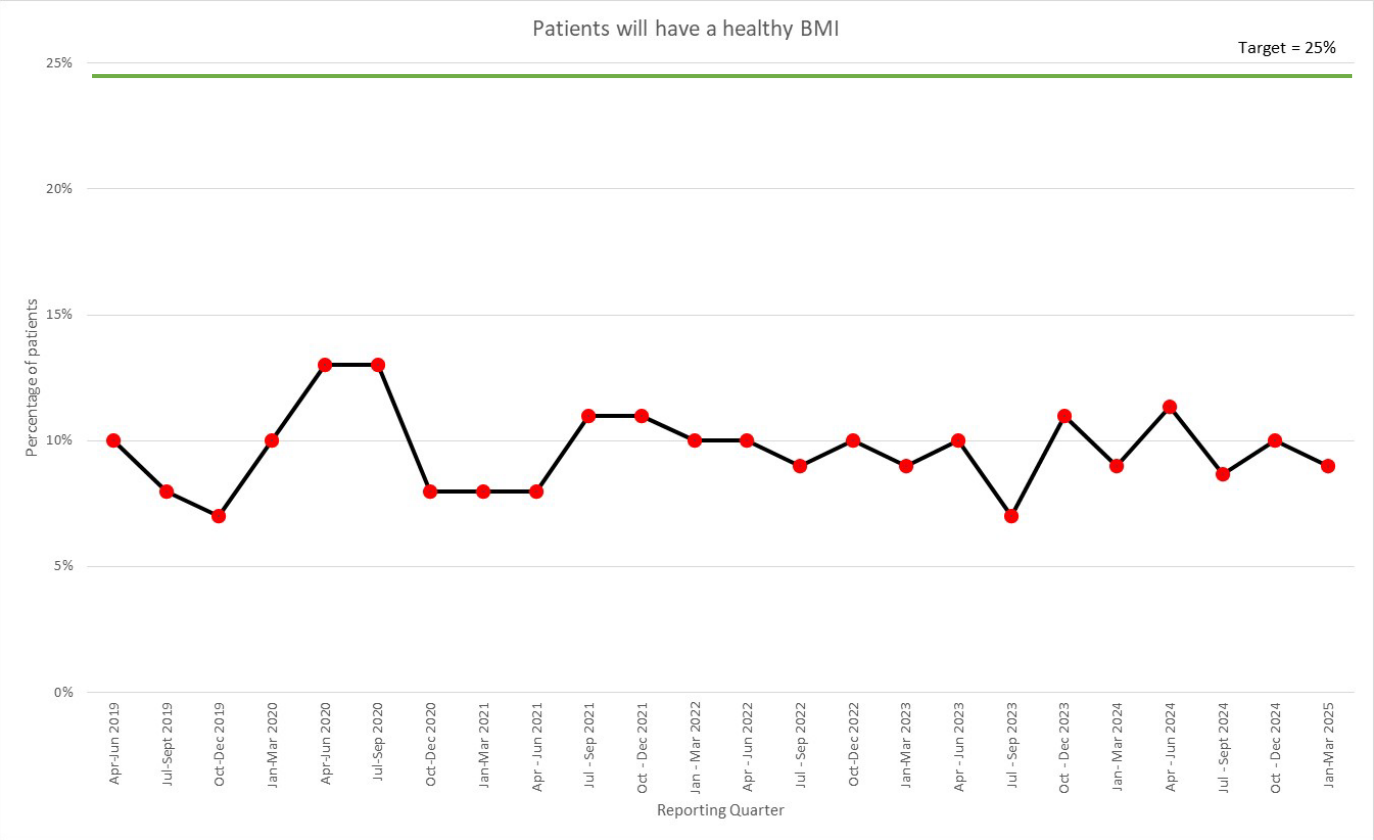
The average percentage of patients who have a healthier BMI increased to 9.75% from 8.92% in the previous reporting year.
As at the end of March 2025, 6% of patients are within a healthy BMI banding and 94% of patients are overweight or obese. These are the highest levels for some considerable time. Work is ongoing with the sub-group which concentrates on the journey for Admission patients and the various ways practices impacts has on weight gain and how these can be improved and patients better supported. Further to the recent development of a BMI Tableau dashboard, data will be shared monthly with each SLT via a data report in the anticipation of better highlighting concerns across wards/services and encouraging further discussions and actions.

In relation to the monitoring of 5% of patient weight gain across the first 12 months following admission, for the year April 2023 to March 2024, of 21 admissions 13(62%) patients completed a

12 month stay. Of these 13 patients, 3 (23%) remained within the 5% weight gain limit. One patient gained 4.5% of their admission body weight during the 12 months and the remaining 2 patients lost weight (2.8% and 7.2% reduction of their admission body weight).

It should be noted that discussions are ongoing with the Supporting Healthy Choices Oversight Group to review and replace this measure. The Group met in May to review the risk status and the actions necessary to mitigation the risk. They continue to review the risk regularly in alignment with risk management policy.

Chart 6: Patients will have a Healthy BMI



No 7: Sickness Absence

Target: 5%

Data for 2024/25: 7.51%

Performance Zone: Red

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Sickness absence rate (National HEAT standard is 4%)	5%	R	R	R	R	7.51%	7.81%	7.68%	6.39%	5.30%	5.92%

In the reporting period 1 April 2024 to 31 March 2025, the rate of absence was 7.51% compared to 7.81% in the previous year - this is a decrease of sickness absence levels by 0.3%, against a 5% target. TSH remains in the red performance zone for this reporting year.

Chart 7: Sickness Absence

Levels of absence across NHS Scotland have escalated significantly since COVID and a key focus and priority for Scottish Government remains reducing levels of absence to 5% in the case of the State Hospital (and 4% across the broader NHS).

During this period, we have continued to focus on 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 have also focused on communication and awareness across our workforce including the impact of absence in terms of days lost and financially.

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. The Staff Governance Committee continue to receive detailed reports on the organisational approach to managing sickness absence.

No 8: Staff have an Approved PDR

Target: 80%

Data for 2024/25: 88.78%

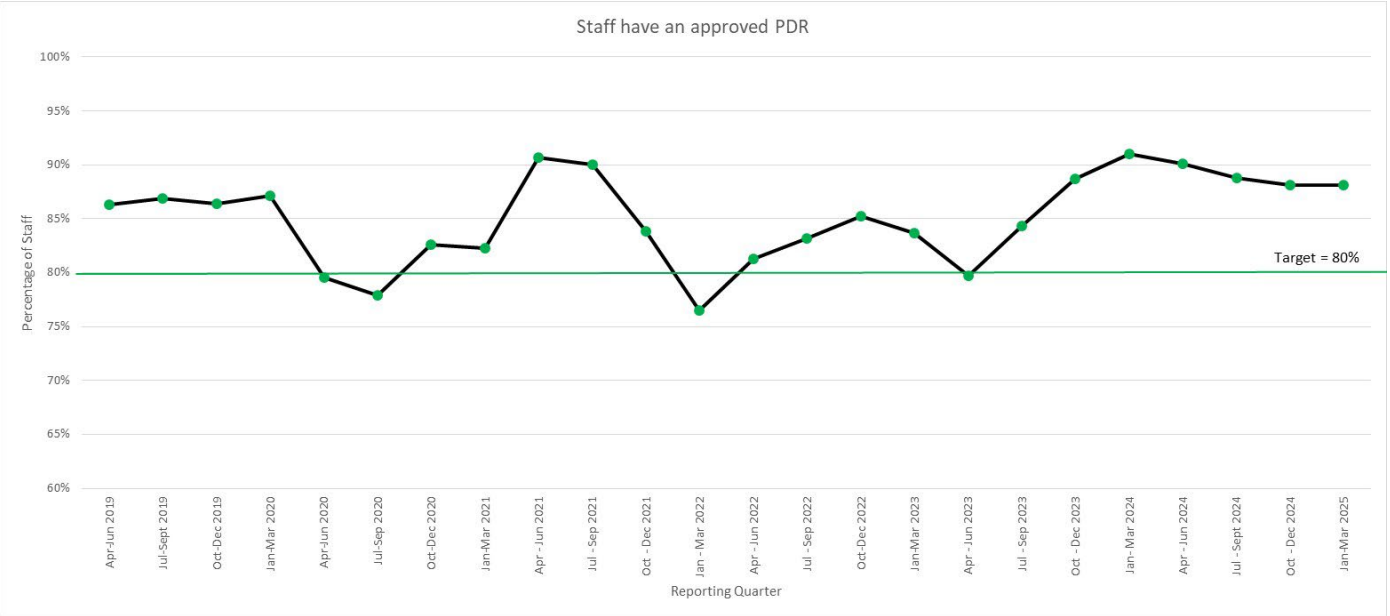
Performance Zone: Green

This indicator relates to the National Workforce Standards, measuring the percentage of staff with a completed PDR within the previous 12 months.

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Staff have an approved PDR	80%	G	G	G	G	88.78%	85.93%	83.35%	85.25%	80.58%	86.68%

The PDR compliance for this reporting year averages at 88.78%. This is an increase of 2.85% from the 2023/24 reporting period and highest annual figure for the last 6 years. This indicator has consistently been within the green zone since March of 2019. Fluctuations have occurred throughout this time however compliance has been maintained.

Chart 8: Staff have an Approved PDR



No 9: Patients are Transferred/Discharged using CPA

Target: 100%

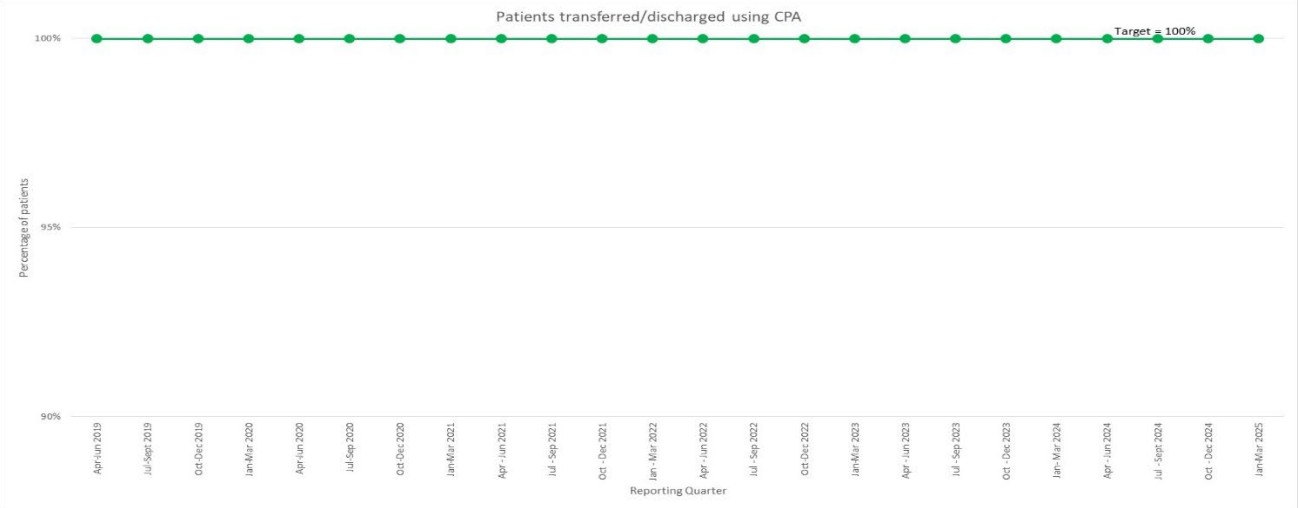
Data for 2024/25: 100%

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.

Performance Indicator	Target	RAG Q2 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	100%	100%	100%	100%	100%

Chart 9: Patients are Transferred/Discharged using CPA



No 10: Patients requiring Primary Care Services will have access within 48 Hours

Target: 100%

Data for 2024/25: 100%

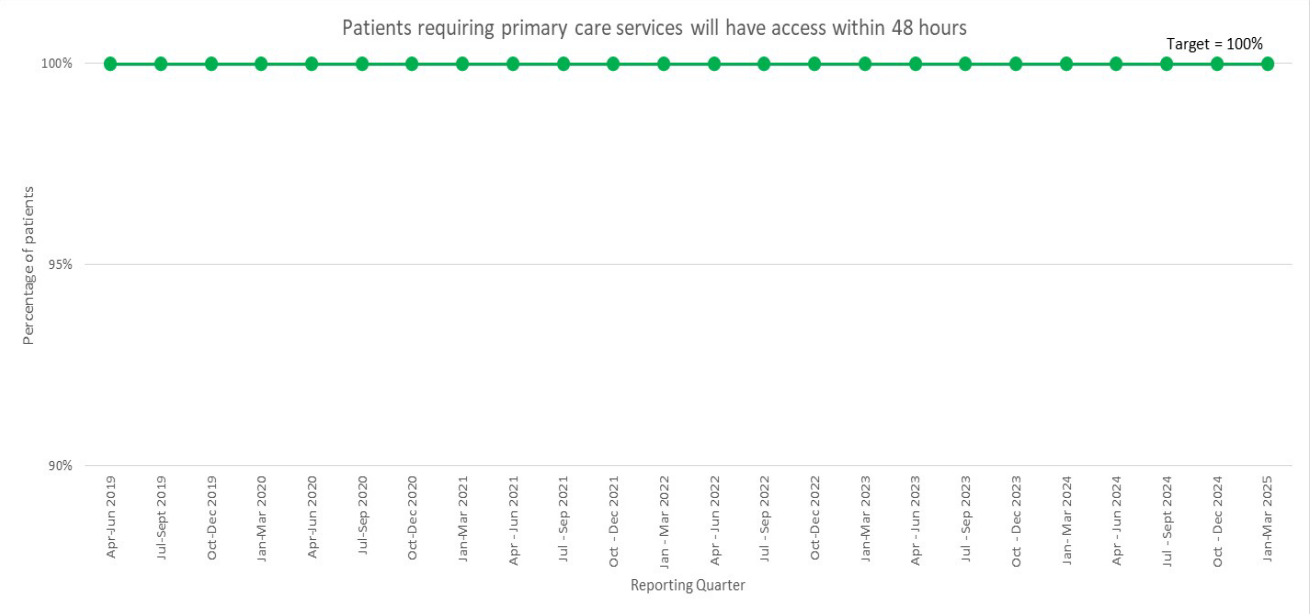
Performance Zone: Green

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 the Health Centre including triage.

Performance Indicator	Target	RAG Q4 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	100%	100%	100%	100%	100%

This indicator has consistently stayed at full compliance since its data collection began.

Chart 10: Patients requiring Primary Care Services will have access within 48 Hours



No 11: Patients will commence Psychological Therapies <18 weeks from referral date

Target: 100%

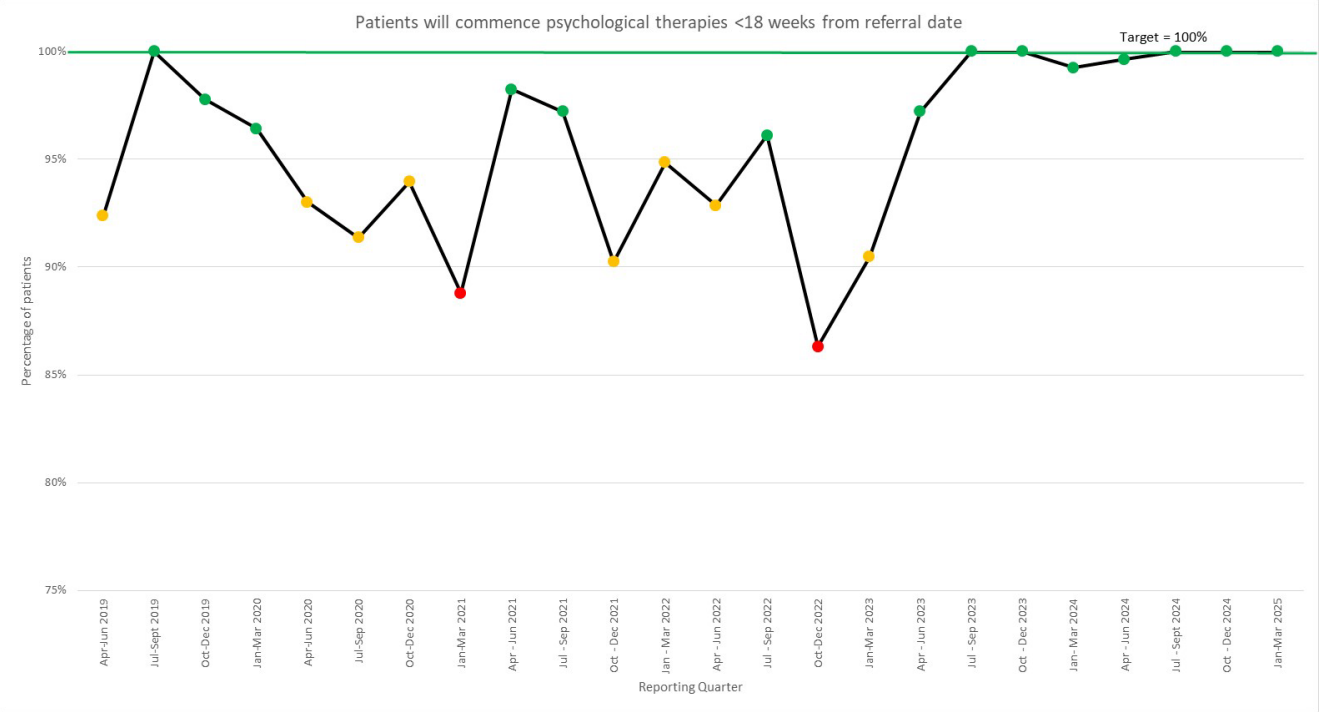
Data for 2024/25: 99.90%

Performance Zone: Green

The indicator correlates with the National Specification for the Delivery of Psychological Therapies and Interventions in Scotland, which outlined the expectation that individuals will be seen within the recommended psychological therapies waiting times standard of 18 weeks referral to treatment. The Scottish Government Target for this KPI is 90%.

Performance Indicator	Target	RAG Q2 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Patients will commence psychological therapies <18 weeks from referral date	100%	G	G	G	G	99.90%	99.12%	91.43%	98.66%	97.66%	99.78%

Chart 11: Patients will commence Psychological Therapies <18 weeks from referral date



TSH have collaborated with Public Health Scotland to work towards submitting data for national collection and analysis on the 18-week treatment target. Work continues with Public Health Scotland to achieve this data submission and local agreement in place to submit data.
TSH have achieved near 100% on this target.

No 13: Patients have their Clinical Risk Assessment reviewed annually

Target: 100%

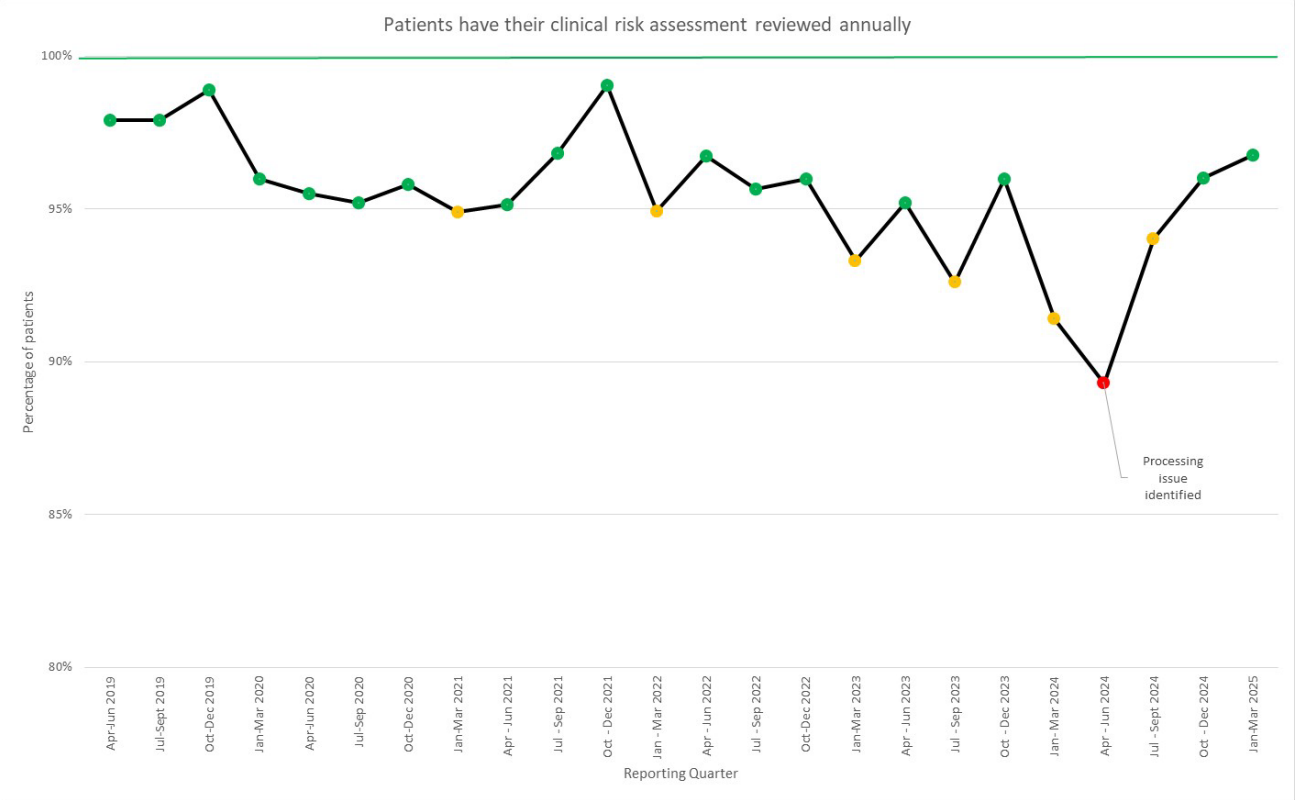
Data for 2024/25: 94.03%

Performance Zone: Amber

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.

Performance Indicator	Target	RAG Q1 24/25	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	24/25	23/24	22/23	21/22	20/21	19/20
Patients have their clinical risk assessment reviewed annually.	100%	R	A	G	G	94.03%	93.79%	95.42%	96.49%	95.35%	97.68%

Chart 12: Patients have their Clinical Risk Assessment reviewed annually



Although the KPI has remained over 90%, there has been a fluctuation in the performance of this KPI through 2024/25. There was a declined in Q1 2024/25 which has been identified as processing issues around uploading or closing off of risk assessment on RiO, that was explored by the Psychology Department. Since the process has been reviewed there has been a significant improvement made through Q2,3 &4 of 2024/25.

No 15: Attendance by clinical staff at case reviews.

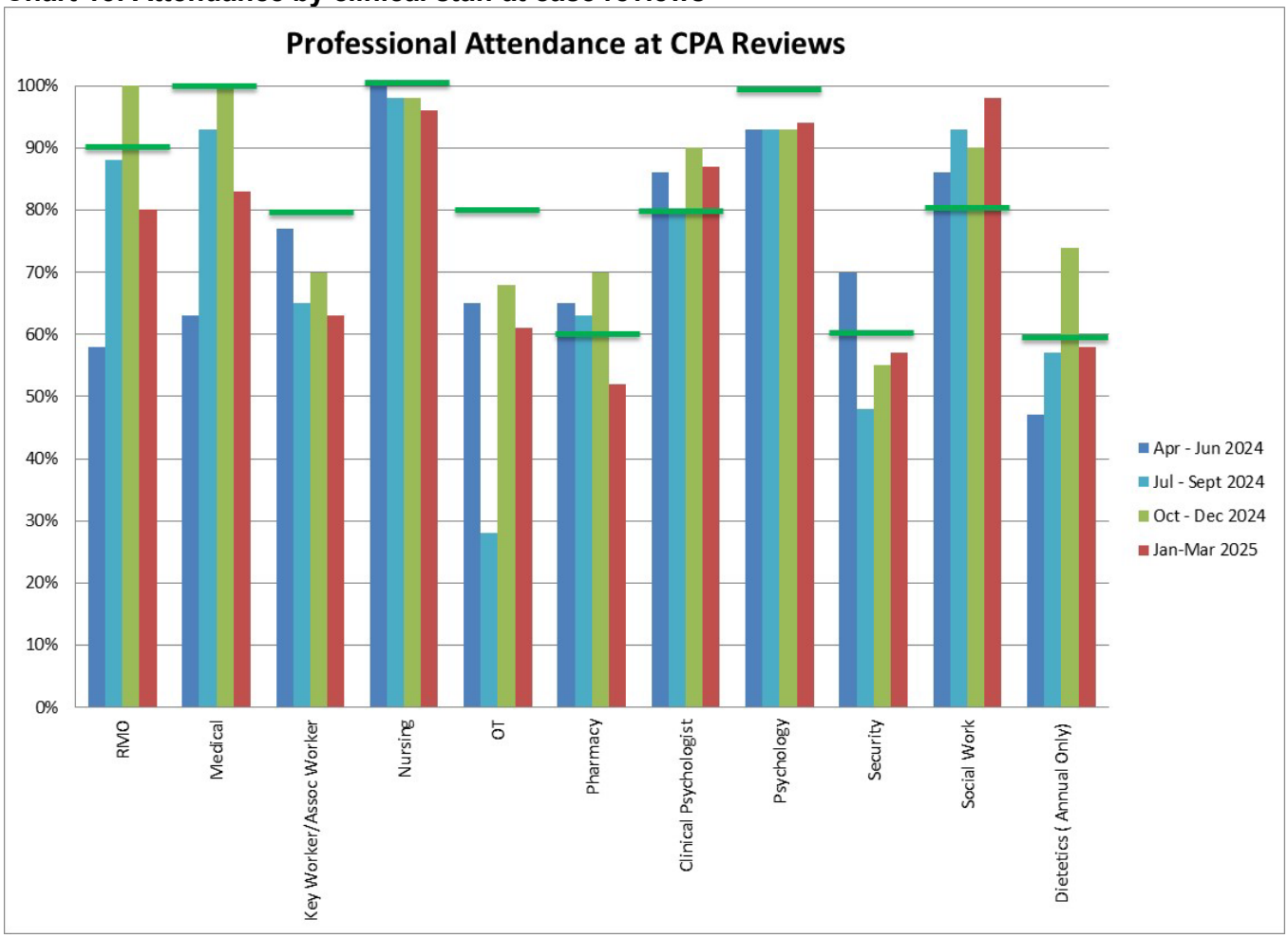
The table below provides comparative data on the extent to which professions met their attendance target. The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over 5 years.

Attendance by clinical staff at case reviews

Professional Group	Target	19/20	20/21	21/22	22/23	23/24	24/25	Increase/Decrease from previous year
RMO	90%	90%	78.5 %	87.25 %	84%	89.5%	81.7%	Decrease of 7.8% on previous year
Medical	100%	96%	79%	90.5%	91.75 %	91.7%	84.3%	Decrease of 2.6% om previous year
KW/AW	80%	78.3%	66%	58.75 %	58.75 %	56.9%	68.6%	Increase of 8.7% on previous year
Nursing	100%	97.8%	92.3 %	97%	97.25 %	96.2%	97.6%	Increase of 1.4% on previous year
OT	80%	86.3%	77.8 %	77.5%	42.25 %	67%	55.6%	Decrease of 11.4% on previous year
Pharmacy	60%	61.3%	63.5 %	81.5%	59%	55%	62.1%	Target met
Clinical Psychologist	80%	71.3%	67.8 %	68.25 %	59.25 %	73%	87%	Target met

Professional Group	Target	19/20	20/21	21/22	22/23	23/24	24/25	Increase/Decrease from previous year
Psychology	100%	87.8%	78.3 %	84.75 %	80%	84.2%	93.3%	Increase of 9.1% on previous year.
Security	60%	52.5%	41.8 %	40.75 %	44.75 %	51.9%	57.4%	Increase of 5.5% on previous year
Social Work	80%	73.8%	87%	86%	80.75 %	81.2%	91.1%	Target met
Dietetics	60%	60.8%	77.3 %	59.75 %	66.25 %	61.9%	59.2%	Decrease of 2.7% on previous year

Chart 13: Attendance by clinical staff at case reviews



RMO* – During 2024/25, there were improvements through Q2 where the RAG moved from Red to Green, which continued through Q3. There has been a decrease in Q4 whereby the RAG moved from Green to Amber.

Medical* – During 2024/25 there this target fluctuated throughout the year, in Q2 this RAG moved from the red to the amber zone, then into the green zone through Q3. There has been a shift in Q4 where the RAG changed from the green to the Red Zone.

Key Worker/Associate Worker – During 2024/25, this target has fluctuated throughout the year there was an increased to 77% in Q1 this was the highest the target has been since Q4 in 2020-21. However, through Q2, Q3 & Q4 the percentage decreased where by in Q4 the target decreased to 63% moving this back into the Red Zone.

Nursing – Attendance from nursing during 2024/25 remains positive remaining in the green zone and above the target of 80% through the four quarters of 2024/25.

Occupational Therapy – during 2024/25, attendance from occupational therapy has remained above the 60% mark within Q1, Q3 and Q4. In Q2 attendance significant drop to below 30% OT attendance target of 80% was never achieved through 2024-25, therefore this profession remains in the red zone for this reporting year.
Pharmacy – During this reporting year this profession met the target of 60% in Q1, Q2 and Q3. There has been a slight decreased in Q4 where the target moved from the Green to the Amber RAG.

Clinical Psychologist – During this reporting year, this profession met the target of 60% and remains in the green zone for this reporting year.

Psychology – During 2024/25 attendance by this profession remains in the Amber RAG with a percentage attendance of over 90%.

Security ** **–** During 2024/25 attendance by this profession has fluctuated throughout 2024-25. One Q1 attendance was within the green zone, then in Q2 attendance decreased to 48%. In Quarter 3 and 4 this has increased slightly to 55% in Q3 and 57 in Q4.

Social Work – During this reporting year, this profession met the target of 80% and remains in the green zone for this reporting year.

Dietetics (Attendance at Annual Reviews only) – during 2024/25, attendance from dietetics has fluctuated whereby the target set for dietetics to attend 80% of patients Annual Review through Q1. It was agreed at the Clinical Governance Group in August 2024 to review the Target and this was reduced to 60%. The new Target of 60% was achieved in Q3 of 2024-25 and continues to meet the target in Q4.

*- It is noted that this is likely to be a recording issues as CPA would not go ahead within a RMO or medical representative present
**- work is ongoing to encourage the Clinical Security Laision Managers to priorities attendance at meetings taking into consideration shift patterns, to continue to improve attendance

4 RECOMMENDATION

The Board are asked to note the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP	Monitoring of TSH Key Performance Indicators links to 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.
Corporate Objectives Please note which objective is linked to this paper	**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 NHS Scotland 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. **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. e- Utilise connections with other health care systems to ensure patients receive a full range of healthcare support. **Better Value;** k - Support quality improvement approaches, embedding a cohesive approach. i - Ensure the continued delivery and development of the organisation's performance management framework. **Better Workforce:** M -Continue to support training and development for all staff at every level across the organisation.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Strategic Planning and Performance Group / CMT
Risk Assessment (Outline any significant risks and associated mitigation)	No implications identified.

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).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	√ 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

Date of Meeting:	19 June 2025
Agenda Reference:	Item No: 26
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 status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the 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 15th May 2025 and the next Project Oversight Board is to take place w/c 23rd June 2025. At the meeting of 15th May 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 essentially complete and all systems are functioning. All quality targets have been met and the projected date for the award of Practical Completion is the 27th June. The projected final cost overspend is contained in Finance – Project Cost below. At the time of writing discussions are ongoing regarding the need for the contractor to address final issues and the timing of those works.

b) Project Timescales

The most recent accepted programme revision is rev 69 with a forecast completion date of 27th June. Practical Completion is expected be awarded on the planned date.

The installation of technology is complete and all systems are functional.

Works to be addressed include:

- F2K Issues previously agreed and known to the Board
- Routinely arising issues that would normally be addressed by BAU (Business As Usual) maintenance and support processes.
- Civil Works that do not have technical implications
- Issues with a known solution that have a date for starting or for completion that takes the works into the MDL (Maintenance, Defects and Liability Period).

c) Progress

At the time of writing all systems are functioning, though as above, some areas require attention to correct faults that create minor performance issues or require attention to ensure that performance or maintenance will not be impaired in the future.

Site Acceptance Testing (SATs) took place between 10th March and 10th April 2025 and retesting of the elements awarded a "C" began on 29th May. Some elements were not able to be tested as works continued to address problems preventing full testing. Remaining tests are expected to be completed in the near future.

d) Finance – Project cost

Practical Completion is projected to be awarded on 27th June 2025. The contract with Securitas will underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by changes in the project timescale and the project has a projected final overspend (exclusive of VAT) of approximately £961k. This is reduced by £5k since the April 2025 report to the Board.

The key project outline at 07th June 2025 is:

Project Start Date:	April 2020
Planned Completion Date:	June 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 07/06/25:	£9,753,396
Total costs to date (exc. VAT & retention) at 07/06/25:	£9,722,671
Total costs to end of project (Exc. VAT & retention)	£ 30,725

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 Scottish Government (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 Rounded breakdown of actual spend to date (Exc. VAT) at 07/06/25 is:

Securitas	£ 7.299m
Thomson Gray	£ 1.276m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 1.058m
Miscellaneous	£ 0.002m
Income	-£ 0.113m
Total	**£ 9.723m**

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 / ADP	Update paper on previously approved project
Corporate Objectives Please note which objective is linked to this paper	**3. Better Value** i) Complete the security upgrade and move towards the development of the core security quality indicators.
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. There are privacy implications, but full DPIA not needed There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **ARC(M) 25/02**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 27 March 2025.

This meeting was conducted virtually by way of MS Teams and commenced at 1pm.

Chair:	
Vice Board Chair	David McConnell
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Pam Radage
In Attendance:	
Business Manager, Corporate Services	Anne Donnelly
Acting Director of Security, Estates, and Resilience	Allan Hardy
Internal Auditor, RSMUK	Asam Hussain
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey (Item 5)
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Corporate Services Team	Bonnie Murphy (minute)
Head of Corporate Governance	Margaret Smith
Medical Director	Lindsay Thomson (Item 5)
Director of Workforce	Stephen Wallace (Item 5)
External Auditor, KPMG	Michael Wilkie

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting and apologies were noted from John Blewett, External Auditor, KPMG.

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 30 January 2025.

The Committee:

1. Approved the minutes held on 30 January 2025.

4 MATTERS ARISING – ROLLING ACTION LIST UPDATE

The Committee received the action list and discussed the progress on action 4, Security Standards.

It was noted that Mr Jenkins had contacted Scottish Government to provide an outline of what NHS Scotland aimed to achieve and obtain approval. It was clarified that the Board had established ownership of the security standards with Scottish Government and so the action was completed. Members agreed that the action could now be closed. It was noted that item 7 (Fraud Update) would remain as an ongoing action.

The Committee agreed that all other actions were either closed or on the meeting agenda.

The Committee:

1. Noted the Action List and agreed to close item 4.

INTERNAL AUDIT

5 INTERNAL AUDIT REPORTS

a) Physical Health - Supporting Healthy Choices

The Committee received the Physical Health - Supporting Healthy Choices Audit Report. Ms Gould outlined the key aspects of the report including the agreed scope of the audit, the outcomes and actions. She highlighted that the opinion was one of 'Reasonable Assurance' with four medium actions noted as detailed within the report.

Ms Gould highlighted that the audit had been focused on patient physical health related to the risk of obesity, and detailed the current steps being taken by the State Hospital (TSH) to address this risk. She noted the importance of documenting expected deliverables and milestones that would be underpinned by the the delivery of the 'Supporting Healthy Choices' plan. Further, there was an opportunity to action governance improvements and ensure the reports would be submitted to the appropriate forums for discussion and scrutiny. Mr McConnell thanked Ms Gould for her overview and invited Professor Thomson to comment on the report and outlined actions.

Professor Thomson thanked Ms Gould for the audit overview and clarified that although 'Supporting Healthy Choices' is part of physical health, the topic had wider considerations and implications. She informed members that a meeting took place with the auditors in January and some recommended actions had already been addressed.

Professor Thomson highlighted that there were no clinical concerns with regard to the overall physical healthcare of TSH patients. It was noted that there was no Physical Health Strategy for mental health services in Scotland currently. Professor Thomson proposed that she could take this forward with the Committee's agreement.

Mr Jenkins thanked Ms Gould for the report and Professor Thomson for her oversight and governance. He reiterated Professor Thomson's point around this report addressing the physical health needs of patients rather than individual dietary requirements. He suggested that it may be beneficial to link with the population health agenda currently promoted by Public Health Scotland which tied into the three core objectives of the Scottish Government. It was noted that the use of this agenda would broaden the proposed strategy and highlight the strategic intentions of the organisation. Professor Thomson agreed with the proposal to develop a high-level strategy aligned with Public Health Scotland.

Mr Currie agreed with the suggestion made by Mr Jenkins and added, in audit terms, it would be good to have have high level input to signpost people to the key issues, highlight any suggested improvements and how these could be monitored. Ms Radage also concurred with the points raised and commented on the utility of using the findings of the audit to inform a Physical Health Strategy.

Mr Jenkins highlighted the level of work being done to address issues and provide assurance through discussions within the relevant groups. He added that these efforts would facilitate the production of a strategy which aligned with national intent.

Mr Hussain noted that the audit reached reasonable assurance due to the demonstrative level of work being done to improve performance related to this risk through the link with 'Supporting Healthy Choices'. He added that although this has been a difficult risk to address, if a scrutiny enquiry was carried out in the future, the work undertaken to explore solutions to these issues could be illustrated and monitored effectively. It was highlighted that the annual report would be a good opportunity to reflect on the strategy and achievements made. Mr McConnell concurred with the points raised by Mr Jenkins and Mr Hussain.

Professor Thomson asked Ms Gould to forward information around the NHS England Physical Health Policies to help inform the new Physical Health Strategy.

Action - V Gould

Mr McConnell thanked everyone for their contributions to the discussion. Professor Thomson left the meeting at this point.

<u>The Committee:</u>

1. Noted the Internal Audit Report on Physical Health - Supporting Healthy Choices.
2. Noted that Professor Thomson would develop a Physical Health Strategy for TSH.

b) Roster Compliance

The Committee received the Roster Compliance Audit Report. Ms Gould outlined the key aspects including the agreed scope of the audit, the outcomes and actions and highlighted that the opinion was one of 'Partial Assurance' with seven medium actions noted as detailed within the report.

Ms Gould highlighted that the Roster Compliance audit had been added to the audit plan by management request as there were some known issues and concerns relating to the protocols around rostering and whether these were being applied in practice. She added that they were unable to test all key aspects planned due to the implications of some of the findings within the audit report. An example was highlighted relating to the recording of shift swaps. It was noted that, after addressing the actions within the report, it would be helpful to review the protocols to reflect the current best practice.

Mr McConnell thanked Ms Gould for the overview of the report and invited Ms McCaffrey and Mr Wallace to comment. Ms McCaffrey explained that she was aware of many actions highlighted and these issues were actively being addressed to make the best use of the available resources. She highlighted the challenges in relation to accommodating the multiple rostering patterns and how to integrate the reduced working week.

Ms McCaffrey noted that it was helpful to understand why there were incidences of non-compliance and explore ways to produce a more simplified process. She highlighted that the Optima system does not currently interface with SSTS and various forums are discussing solutions to mitigate the duplication of work. She added that there was a move from working in a centralised way to providing wards with the autonomy to self roster. It was noted that this would be carefully managed in stages and staff would receive support and training to enable them to successfully assume the responsibility.

Mr Wallace concurred with the points raised by Ms McCaffrey and highlighted the challenge of staff recognising that they need to use the system in its current form and not make adaptations. He noted the importance of reviewing the project plan in terms of how shifts patterns were being recorded. Mr McConnell invited the Committee to comment.

Mr Connor highlighted that on page 5 of the report it stated that the 'Shift Swap Protocol' did not have an approval date; it was suggested that an older version of the document may have been viewed and a date was detailed on the latest version. Ms Gould clarified that the audit commenced in November/December and the document may not have been available. She agreed to update this and close the related action. Mr Connor also noted that the audit suggested that aspects of leave such as special leave could not be recorded on SSTS, but this was not the case. It was agreed that this discrepancy would be reviewed.

Action – V Gould

Mr Connor also expressed concern that it appeared that the protocols and processes agreed were not currently being followed.

Ms McCaffrey assured members that incidences where non-compliance was observed have already been addressed. Mr Jenkins noted it it would be useful to reflect on the reasons for non-compliance and any training needs highlighted. He added that, given the current status, he would expect roster compliance to be included for re-audit in the next cycle.

Ms Radage thanked Ms Gould for the useful report and commented on the difficulties faced at the beginning of a new system roll out. She noted that it was encouraging to hear the acknowledgement of issues and how these were being proactively addressed. Ms Radage suggested it would be helpful to consider whether implementation resources were removed too quickly and extract the learning from this in relation to how change management is executed in future.

Ms McCaffrey explained that there was pressure around timescales to deliver and this posed challenges for TSH as a smaller board with less access to expertise in this area. Mr Wallace noted that a review around the skills and resources in relation to the implementation would be beneficial and he would endeavour to obtain resource to support this. He added that it was imperative to ensure pay was not impacted as the new system did not interface with SSTS and so roster compliance across the organisation was essential to this aim.

Mr Moore acknowledged that this was a national initiative with some inherent issues however, there was advanced awareness of several issues which was highlighted by the audit report. He added that it would be useful to reflect on what factors have inhibited progress. It was noted that previous reporting to the board had indicated a more advanced position and so it would be useful to consider how progress would be reported in future. Mr Moore also concurred with Mr Jenkins point that a well-timed follow up audit would be advisable. He added that staff operating dual systems would not be utilising resources effectively and would add additional pressure to frontline staff.

Mr Wallace commented that TSH were in a favourable position in terms of having implemented the system which was supported by feedback received from the companies responsible for the implementation. However, challenges have arisen in relation to the uptake of the system by staff and the timely realisation of the benefits. He noted the importance of ensuring ongoing progress and establishing what support is available to NHS Boards. It was noted that the 'double keying' issue was being explored at a national level. Ms McCaffrey clarified that work was ongoing to enable staff to have to confidence to input data directly into the system rather than relying on manual processes.

Mr McConnell thanked members for their input to discussions and opened a discussion on what is to be done around reviewing and monitoring going forward. He suggested that it may be beneficial to generate a follow up report in response to the findings of the audit and the action plans. Ms McCaffrey added that she and Mr Wallace would work through the actions ensuring completion.

Mr Hussain agreed that a follow up audit would be useful where negative assurance had been received and noted that regular updates on actions would be received by this Committee as well as the Staff Governance Committee. He added that Roster Compliance would be scheduled for re-

audit in the 2026-2027 audit plan. Mr Jenkins concurred with Mr Hussain on the usefulness of regular updates to monitor progress.

Mr McNaught added that the Board's draft governance statement makes reference to internal audit reports and their outcomes. He noted that it would be advisable to make reference to a partial assurance outcome in this instance to give assurance that the issues were being addressed, and support the disclosure.

Action: R McNaught

Mr McConnell thanked everyone for their contributions to the discussion.

The Committee:

1. Noted the Internal Audit Report on Roster Compliance.

6 AUDIT PROGRESS REPORT

The Committee received the Audit Progress Report presented by Mr Hussain. He highlighted there were two outstanding advisory actions in relation to the ESG advisory review which were not due until the 31 March 2025. He added that the Audit Plan was on track and there was one remaining audit relating to the clinical care policy to be completed. Mr Assam noted that they continue to chart themes from the control areas and no major concerns were recorded.

Mr Hardy updated on actions from last months Internal Audit Management Actions Tracking Report in relation to the appointment of Sustainability Champions, as well as the current business Continuity Plan which had been submitted to Scottish Government for consideration. Mr Hardy highlighted that it would be helpful to give consideration as to the long-term nature of this work, and the availability of resourcing, and expressed concern that it may take some time to complete.

Mr McConnell commented that it was appreciated that some actions on the action tracker would take time to complete and were contingent on other factors. Mr Hussain suggested that, as there is quarterly monitoring through Climate Emergency and Sustainability Group and Sub-group, updates could be reported through this internal mechanism going forward.

The Committee:

1. Noted the Audit Progress Report.

7 DRAFT INTERNAL AUDIT PLAN 2025/26

The Committee received the Draft Internal Audit Plan presented by Mr Hussain who provided an overview of the audits planned for 2025/2026. He highlighted the inclusion of the audit area 'Project Management Framework' which had not been examined previously. The framework would be reviewed with an in-depth look taken at how it has been applied in terms of delivery to budget. He highlighted that, in section 2.1 of the report, an audit around Estates and Facilities had not been included on the rolling strategy and noted that this would be updated.

Mr McConnell thanked Mr Hussain for the overview and asked members for preliminary approval of the final draft action plan. Mr McNaught highlighted that the plan was subject to change should the need arise.

The Committee:

1. Noted the Draft Internal Audit Plan 2025/26
2. Approved the Draft Internal Audit Plan 2025/26 with the above amendment

INTERNAL CONTROL

8 CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register update presented by Mr Hardy who provided an overview of the report and highlighted the inclusion of the charts illustrating the longitudinal data mapping risk progress. He noted that ongoing work was in progress to revise corporate risk within each directorate with a view to improving the risk review process ensuring that the approach to risk was proactive as opposed to reactive.

Mr Hardy informed the Committee that high and very high risks remain the same noting that he did not anticipate the four high risks to progress quickly. He added that the removal of the risk ND70 (Failure to utilise our resources to optimise excellent patient care and experience) was still being considered. It was highlighted that 13 risks were at target level and 11 were not, which led to reflection on what changes could be actioned to address these.

Ms Radage commented that the longitudinal data charts were useful. She asked, further to the discussion at the previous meeting of the Committee, whether there was an update on whether sickness absence should be added to the Corporate Risk Register. Mr Hardy responded that there was ongoing discussions with the Director of Workforce with regard to how to formulate a risk to encompass absence issues and that an update would be forthcoming at the next meeting.

Mr Hussain thanked Mr Hardy for the inclusion of the longitudinal data commenting on the u of viewing the movement of risks. McConnell thanked Mr Hardy for the report and members for their contribution to the discussion.

The Committee:

1. Approved the Corporate Risk Register.

9 FINANCIAL POSITION UPDATE

The Committee received the Financial Position update presented by Mr McNaught who provided an overview of the report noting the continuation of a slight adverse variance approaching year-end; a break-even position was forecast, and the savings target was expected to be met. He added that at a recent meeting with the Scottish Government a budget for 2025/26 was submitted. This was accepted and they indicated that they were happy with the current position and forecast. Discussions are ongoing with directorates with regard to individual savings plans with steady progress. In relation to capital, the allocation for the year has been fully utilised with additional funding. He added that another pressurised year ahead is expected with one or two specific projects potentially requiring additional funding.

Mr Currie commented that it was a positive result to achieve a break-even position in the current year given the challenges faced and reflected on how this would be possible to achieve in the new financial year. He noted that a multi-year forecast would be beneficial, looking at the efficiencies with a view to obtaining confidence that savings targets would be met. He queried whether the break-even position would enable Scottish Government to be consider the availability of further funding. Mr McNaught responded that Scottish Government may be more likely to give due consideration under these circumstances.

Mc McConnell asked, in relation to the ‘Agenda for Change’ reform, whether delays in implementing the reduced working week were anticipated. Mr Jenkins updated that there were ongoing discussions around the timeframe for this piece of work.

Mr McConnell thanked Mr McNaught for the report and members for their contribution to discussions.

The Committee:

1. Noted the Financial Position Update.

10 SCOTTISH PUBLIC FINANCE MANUAL UPDATES

The Committee received the Scottish Public Finance Manual Updates presented by Mr McNaught who noted that the key points. He added that compliance with all updates to manuals and the responsibilities of the Accountable Officer were followed appropriately.

The Committee:

1. Noted the Scottish Public Finance Manual Updates.

11 SERIOUS ADVERSE EVENT REVIEW (SAER) ACTION TRACKER

The Committee received the CAT 1 and 2 Annual Update on Outstanding Actions presented by Mr Hardy who provided an overview of the report and noted that consideration was being given as to how to present the report to future meetings. Mr Jenkins informed the Committee that a detailed review was being undertaken within Risk about the presentation of the report and assured members that positive changes would be made.

Mr McConnell thanked Mr Hardy for the report and noted the updates.

The Committee:

1. Noted the CAT 1 and 2 Annual Update on Outstanding Actions.

12 CLIMATE EMERGENCY AND SUSTAINABILITY UPDATE

The Committee received the Climate Emergency and Sustainability Update presented by Mr Hardy who highlighted, in relation to the actions from the Climate and Emergency audit, there were several workstreams being undertaken and planned in the future through the new Business Continuity Plan (BCP) strategy being taken forward by NHS Scotland. He added that this was a protracted piece of work as it required the creation of short term, 5 and 10 year plans.

Mr Hardy asked for the Committee's view on whether it did require this update directly. Mr Jenkins suggested it would be useful to broach this topic with Ms Fallon, who was the Non-Executive Director Champion for this area. Ms Smith commented that the Climate Emergency and Sustainability Update was brought to this Committee to facilitate increased updates and actively monitor progress throughout the year. She agreed that it would be helpful to have a discussion with Ms Fallon to establish whether these updates should continue.

Action – Ms Smith

Mr McConnell thanked Mr Hardy for the updates.

The Committee:

1. Noted the Climate Emergency and Sustainability Update.
2. Agreed to discuss with Ms Fallon re reporting to the Committee.

13 FRAUD UPDATE AND FRAUD ACTION PLAN

a) Fraud Update
b) Fraud Action Plan

The Committee received the Fraud Update and Fraud Action Plan from Mr McNaught who outlined the key aspects noting that the virtual sessions continue to be circulated and alerts issued. He added that these would be reviewed and circulated appropriately through the hospital highlighting newly reported approaches. He commented that no matters had arisen in the last quarter requiring local review and regular contact was maintained with Counter Fraud Service (CFS) who had given positive feedback in relation to actions taken. He confirmed that the Fraud Action Plan was up-to-date and agreed with CFS Chair.

Mr McConnell thanked Mr McNaught for both reports.

The Committee:

1. Noted the Fraud Update.
2. Noted the Fraud Action Plan.

14 CYBER CRIME UPDATE

The Committee received the Cyber Crime Update presented by Mr McNaught who highlighted that there were no major national or local specific risks raised in the last quarter. He added that there was a continued awareness of the current risks and that the systems were successful in detecting and quarantining threats.

Mr McNaught updated that continued staff awareness of risks remains a priority ensuring they remain vigilant and undertake refresher training in this area. He added that compliance for this mandatory training was at a good level.

Mr Moore commented that it was good to see that staff were contacting eHealth which indicated an understanding of the threat. He enquired whether there was software on laptops which would identify risks in advance of staff receiving them to mitigate the chance the threat would be opened. Mr McNaught responded that clear advice was given to staff about the notification procedure and not opening attachments from unfamiliar sources. He added that incidences of staff opening attachments and needing support from eHealth should be minimal though it was important that staff were aware of the importance to notify eHealth if a breach occurred.

Mr Currie agreed and highlighted the importance of creating a ‘safe space’ to enable staff to be supported when reporting if they have accidentally opened an unsafe attachment. Mr McNaught reiterated that the key message to staff was to report a suspicious message however, efforts have been made to reassure staff that they would be supported through this process. He added that was was important to be notified quickly to minimise the damage of an incident.

Mr McConnell thanked Mr Mc Naught for the report and everyone for their contribution to discussions.

The Committee:

1. Noted the Cyber Crime Update.

15 POLICY UPDATE

The Committee received the Policy Update from Mr McNaught who mentioned that there was an upturn in the last few months which was attributed to the timing of some detailed policy reviews; this has now reduced to previous levels. Members were updated that three outstanding policies were approved at the last Policy Approval Group meeting.

McNaught noted that the Policy Approval Group provide effective leadership, maintaining policy updates at manageable levels and addressing activity upturns. He added that there was a number of 'Once for Scotland' policies due, mainly related to HR, which will impact the scheduled policy updates. Mr McNaught highlighted that there was good progress overall with work maintained at a manageable level and policyholder engagement was sought to facilitate this.

Mr Currie asked whether there was a process in place to gauge if a policy would exceed its due date, whether it could wait and the overall impact this delay may have. He also asked how 17 outstanding reviews compared with previous years and what timeframe is expected to bring these policies up to date. Mr McNaught responded that it was expected that these policies would be completed in the next three months. He added that extensions were required for various reasons, such as to await associated legislation updates and opportunities to fast-track policies requiring minor changes as well as consolidating policies and these were taken forward where possible. He clarified that the outstanding policies would not lapse and would still be enforced whilst awaiting review.

Mr Jenkins noted that the paper highlights that there were policies set to be archived and the utility of policies was actively considered, in the context of considering if a protocol or Standard Operating Procedure could be more useful. He added that the launch of the women's service at TSH would likely see an increase in suggested policies.

Mr McConnell thanked Mr McNaught for the report.

The Committee:

1. Noted the Policy Update.

16 ANCHOR STRATEGY UPDATE

The Committee received the Anchor Strategy Update from Ms Merson who highlighted that the paper provided an update on the 2023/2024 metrics to be submitted to the Scottish Government at the end of the month. She added that the table in the report illustrated an overview of the changes observed between 2022/2023 and 2023/2024 broken down into themes.

Ms Merson mentioned that, in relation to procurement and contracts with supported businesses, a dip in local spend was observed in comparison with the previous year which was attributed to the low budget TSH has to spend in these areas. She highlighted that there was increased activity in terms of outreach to specific groups. She asked the Committee to review and decide if the report illustrating the metrics for 2023/2024 should now be submitted to the Scottish Government

Mr Moore thanked Ms Merson for the update and acknowledged the progress made over the last few years. He asked whether there were plans to do work in the areas of 'Equally Safe at Home' and 'Menopause Friendly'. Ms Merson responded that work is being done within the workforce directorate in these areas and progress would be evidenced within the next financial year report.

Ms Radage thanks Ms Merson for the helpful update. Mr McConnell thanked Ms Merson and the Committee approved the report for submission to Scottish Government.

The Committee:

1. Noted and approved the Anchor Strategy Update for submission to Scottish Government.

EXTERNAL AUDIT

17 INTERIM AUDIT UPDATE

The Committee received the Interim Audit Update from Mr Wilkie who highlighted that the risk assessment, planning and preliminary testing phase was completed. He added that progress was in line with the plan and timetable which would enable progression to the substantive testing phase once financial statements were drafted. Mr McConnell thanked Mr Wilkie for the update.

The Committee:

1. Noted the Interim Audit Update.

18 AUDIT RISK ANALYSIS AND PLAN

The Committee received the Audit Risk and Analysis Plan from Mr Wilkie who highlighted there were no significant changes to the draft version of the document. In relation to additions made to the strategy, he noted that considering aspects of the security upgrade works completed in the year which were moving from assets under construction into operational land and buildings with a particular focus on the decisions made around the life of the assets, how they are categorised within the asset register and accounted for on an ongoing basis. He added that the potential significant fraud risk around completeness of expenditure was also included.

Mr Wilkie confirmed that, given the nature of board income streams, and the broad risk around manipulation of when income could be recognised and the appropriate audit standards. He also highlighted that the materiality level, which continued to be based on 2% of expenditure, would be updated once the draft financial statements had been provided.

Mr McConnell asked if the section in relation to wider scope had been added to this version. Mr Wilkie responded that the topics considered were the same though a few areas had been updated to reflect additional understanding. He added no specific risks were identified.

Mr McConnell thanked Mr Wilke for the report.

The Committee:

1. Noted the Audit Risk and Analysis Plan.

19 DRAFT GOVERNANCE STATEMENT

The Committee received the Draft Governance Statement from Mr McNaught, who summarised the content.

In relation to the wording on internal audit and national audit references on page 7 of the report, members were informed that Mr Hussain would be consulted to confirm approval around the way this was referenced, particularly with regard to the the partial assurances noted and the high-level point raised as an action during the year. He clarified that these areas would be be referenced as ‘cleared’ in future governance statements. He mentioned that the figures detailing the attendance of Non-Executive Directors at governance meetings would be updated to reflect this meeting.

Mr McConnell noted that it was helpful to see this report in advance of the year end and would consider this best practice.

Mr Moore noted that whistleblowing had been mentioned in the narrative but had not been referenced as being a report which was brought to the Board, which was required on an annual basis. He noted that consideration should be given with regard to the Clinical Forum reference as this group had not submitted reports. Mr McNaught agreed to check these points raised. Ms Smith clarified that following a pause, the Clinical Forum had restarted.

Mr McConnell asked, in relation to the disclosure on page 7 on the review of effectiveness and matters raised, if a comment was usually added to clarify whether there was an action plan in place. Mr McNaught would add this to the report. Mr McConnell thanked Mr McNaught for the overview.

The Committee:

1. Noted the Draft Governance Statement and the proposed updates for the final version.

20 ANNUAL REVIEW OF STANDING DOCUMENTATION

a) Scheme of Delegation
b) Standing Financial Instructions

The Committee received the Scheme of Delegation and the Standing Financial Instructions from Mr McNaught who noted there has been no significant changes in the year. He added that he would be reviewing the standard documentation with Mr Jenkins prior to the Board meeting. He highlighted that there would be changes made to the secondary delegation from a Committee to a stated individual which would be completed prior to being submitted to the Board in April 2025.

Mr McConnell thanked Mr McNaught for the overview. The Committee approved the Scheme of Delegation and the Standing Financial Instructions and that these should be submitted to the Board, subject to the amendments outlined.

The Committee:

1. Approved the Scheme of Delegation and the Standing Financial Instructions, for onward submission to the Board.

21 REVIEW OF ACCOUNTING POLICIES

The Committee received the Review of Accounting Policies from Mr McNaught who highlighted that there were no significant changes to 2024 accounts and disclosures however, these would be further reviewed in conjunction with external audits before the finalisation of accounts.

The Committee:

1. Approved the Review of Accounting Policies.

22 REVIEW OF BOARD STANDING ORDERS AND CODE OF CONDUCT

The Committee received the Review of Board Standing Orders and Code of Conduct from Ms Smith who highlighted that there were no proposed amendments to the Standing Orders.

In relation to the Code of Conduct, Ms Smith explained that some slight adjustments had been made in terms of wording and layout to be in keeping with the model from the Standards Commission. Members were updated that the section on Training and Development had been removed based on the commission's advice in relation to a delineation between performance issues and the code of conduct.

Mr Currie thanked Ms Smith for the worked completed, and the clarity in this respect.

Mr McConnell thanked Ms Smith for the report and members approved this for submission to the next Board meeting.

The Committee:

1. Approved the Review of Board Standing Orders and Code of Conduct, for onward submission to the Board.

23 REVIEW OF COMMITTEE TERMS OF REFERENCE

The Committee received the Review of Committee Terms of Reference from Ms Smith who highlighted that there were no recommended changes. Mr McConnell thanks Ms Smith and members approved the Committee Terms of Reference.

The Committee:

1. Noted the Review of Committee Terms of Reference.

24 SECURITY, RESILIENCE, H&S OVERSIGHT GROUP UPDATE

The Committee received the Security, Resilience, H&S Oversight Group Update from Mr Hardy who noted that there were no issues from the group that required escalation to the Committee.

The Committee:

1. Noted the Security, Resilience, H&S Oversight Group Update.

25 FINANCE, eHEALTH AND AUDIT GROUP UPDATE

The Committee received the Finance, eHealth and Audit Group Update from Mr McNaught who noted that the group continue to conduct business in line with terms of reference and there were no issues raised by the group or subgroups that required escalation to the Committee.

The Committee:

1. Noted the Finance, eHealth and Audit Group Update.

26 RELEVANT ISSUES ARISING TO BE SHARED WITH GOVERNANCE COMMITTEES

Mr McConnell highlighted that the Clinical Governance Committee should be sighted on the Physical Health Audit and Staff Governance on Roster Compliance. He added that the reporting route for Climate Sustainability should be discussed with Ms Fallon.

Mr Currie suggested that issues around fraud in relation to staff absence, as well as the impact of this, should be brought to the Staff Governance Committee.

27 ANY OTHER BUSINESS

There was no other business raised by members.

28 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 19 June 2025 at 9am** via MS Teams.

The meeting ended at 3:36pm.