The State Hospital

Performance Report 2024/25 and Annual Comparative Figures

CONTENTS

1 INTRODUCTION

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

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.

2 KEY PERFORMANCE INDICATORS (KPIS)

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	Comment	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**

Item	Performance Indicator	Target	RAG	24/25	23/24	22/23	21/22	20/21	19/20	Comment	LEAD
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**

Item	Performance Indicator	Target	RAG	24/25	23/24	22/23	21/22	20/21	19/20	Comment	LEAD
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 SIX MONTHLY INTERVALS

Target: 100%

Data for 2024/25: 91.01%

Performance Zone: Amber

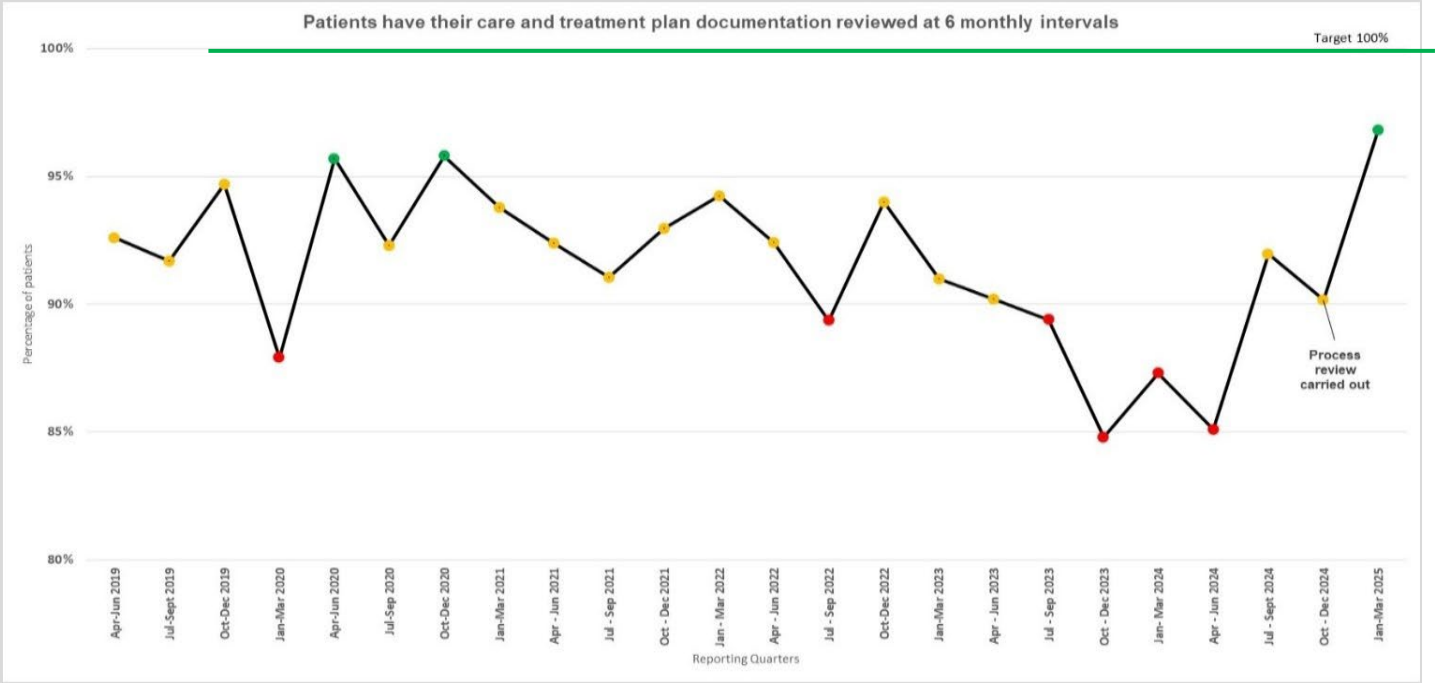
The Mental Health Act 2003 requires the preparation of documented care plans for people who are subject to compulsion. The Scottish Government CEL 13 (2007) identifies that the CPA is the appropriate tool for all restricted patients. The Code of Practice for the 2003 Act gives guidance on the RMO's responsibilities 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 Six Monthly Intervals


Patients have their care and treatment plan documentation reviewed at 6 monthly intervals
Target 100%
100%
95%
90%
85%
80%
Percentage of patients
Process review carried out
Apr-Jun 2019
Jul-Sept 2019
Oct-Dec 2019
Jan-Mar 2020
Apr-Jun 2020
Jul-Sep 2020
Oct-Dec 2020
Jan-Mar 2021
Apr - Jun 2021
Jul - Sep 2021
Oct - Dec 2021
Jan - Mar 2022
Apr - Jun 2022
Jul - Sep 2022
Oct-Dec 2022
Jan-Mar 2023
Apr - Jun 2023
Jul - Sep 2023
Oct - Dec 2023
Jan- Mar 2024
Apr - Jun 2024
Jul - Sept 2024
Oct - Dec 2024
Jan-Mar 2025
Reporting Quarters

NO 2: PATIENTS WILL BE ENGAGED IN PSYCHOLOGICAL TREATMENT

Target: 85%

Data for 2024/25: 94.11%

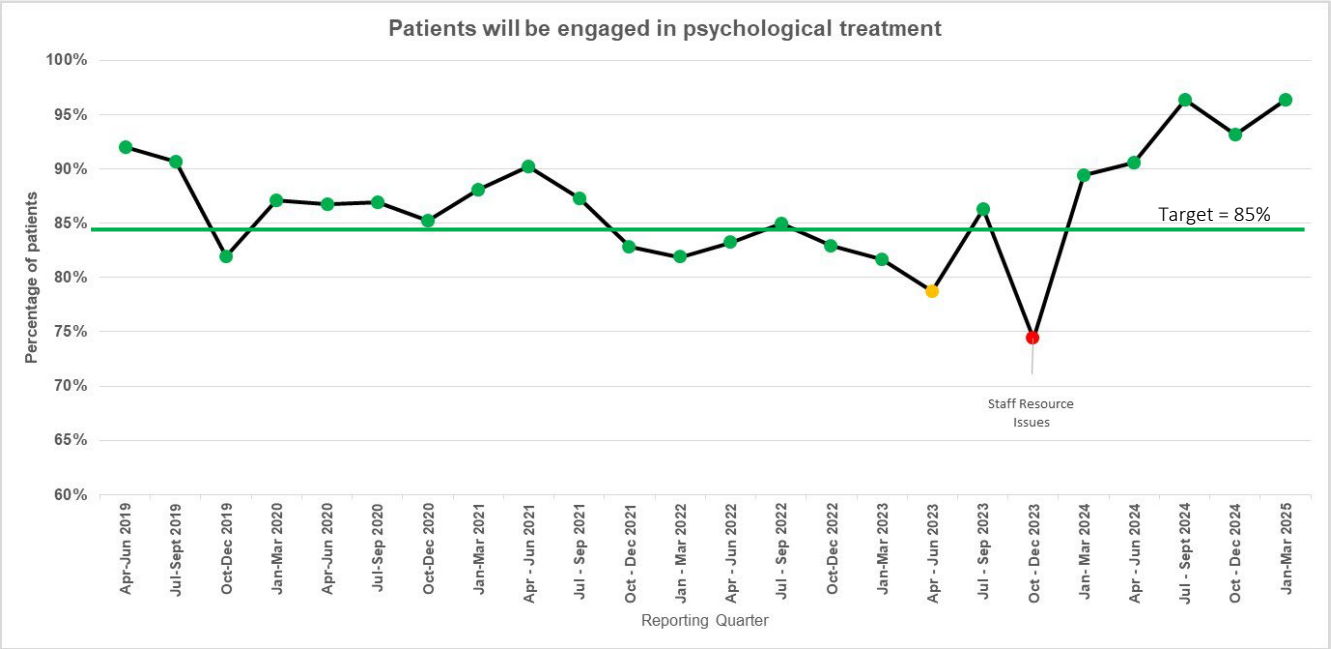
Performance Zone: Green

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%

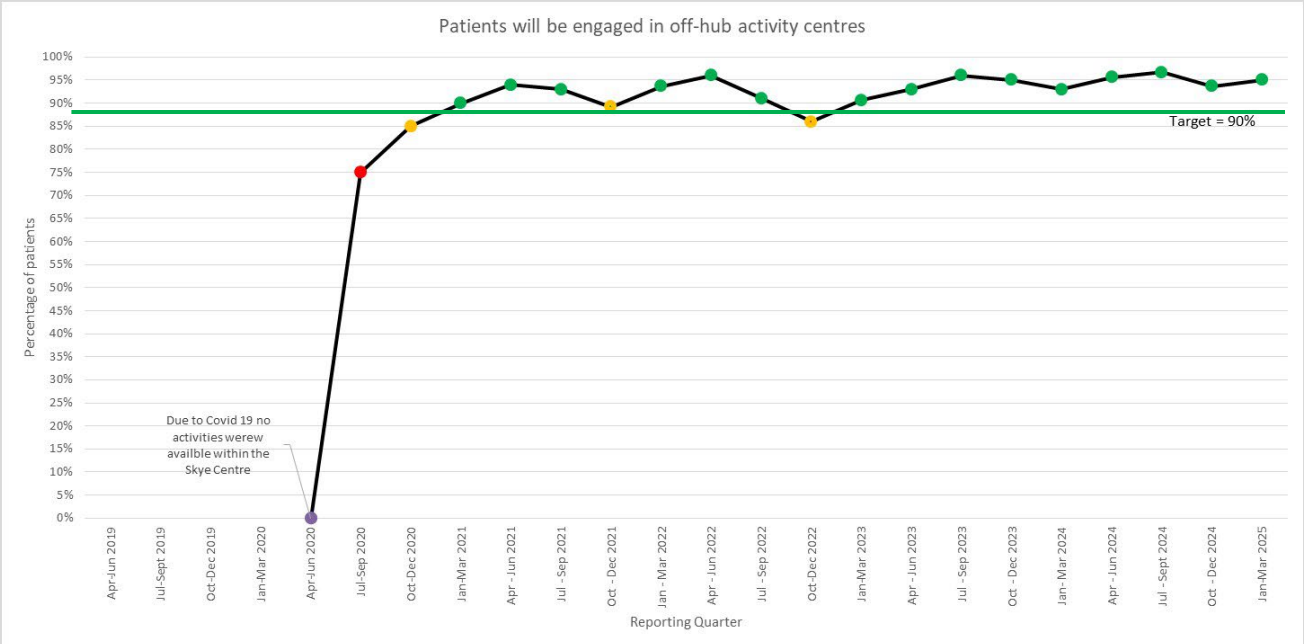
Performance Zone: Green

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%

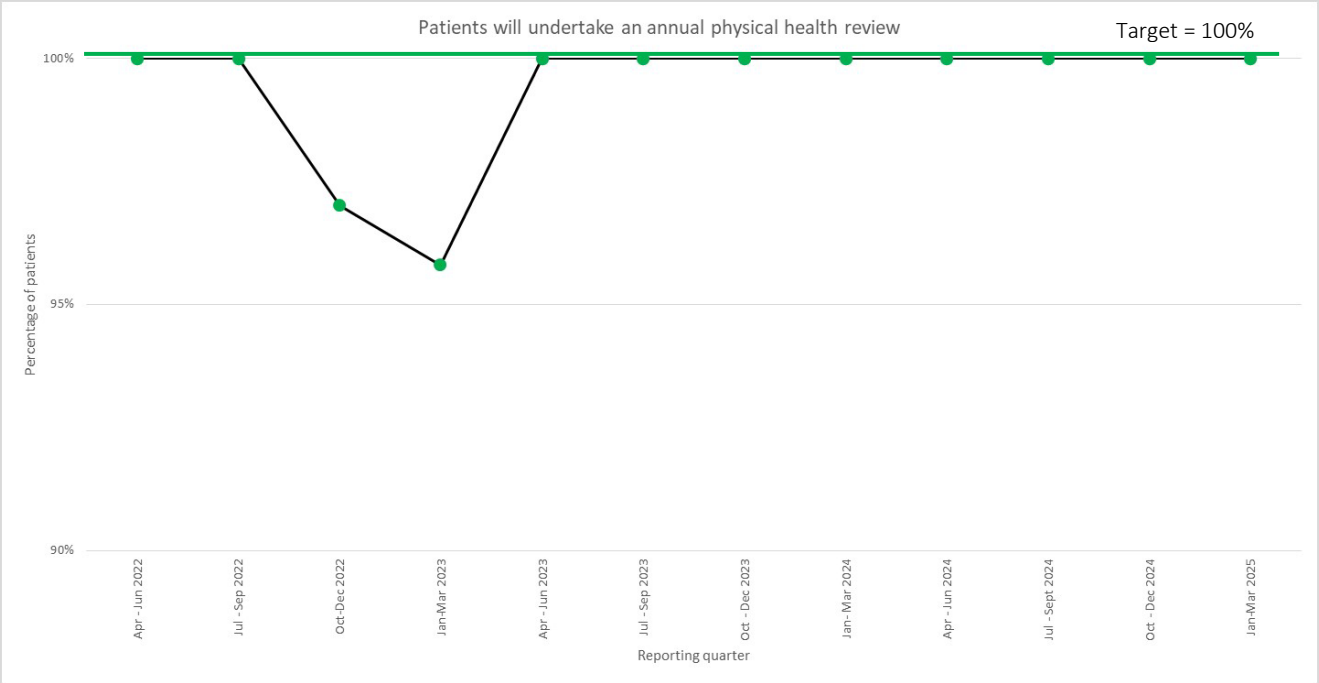
Performance Zone: Green

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

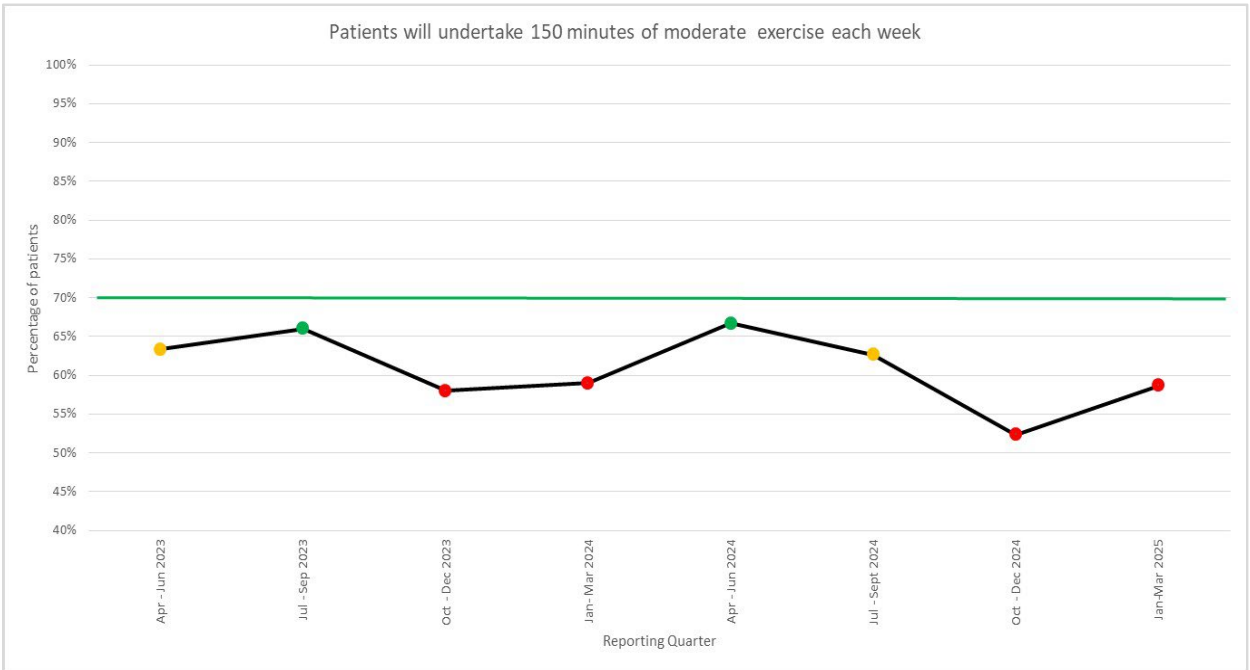
This links with national activity standards for Scotland. This measures the number of patients who undertake 150 minutes of moderate exercise each week.

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 the State Hospital. 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%

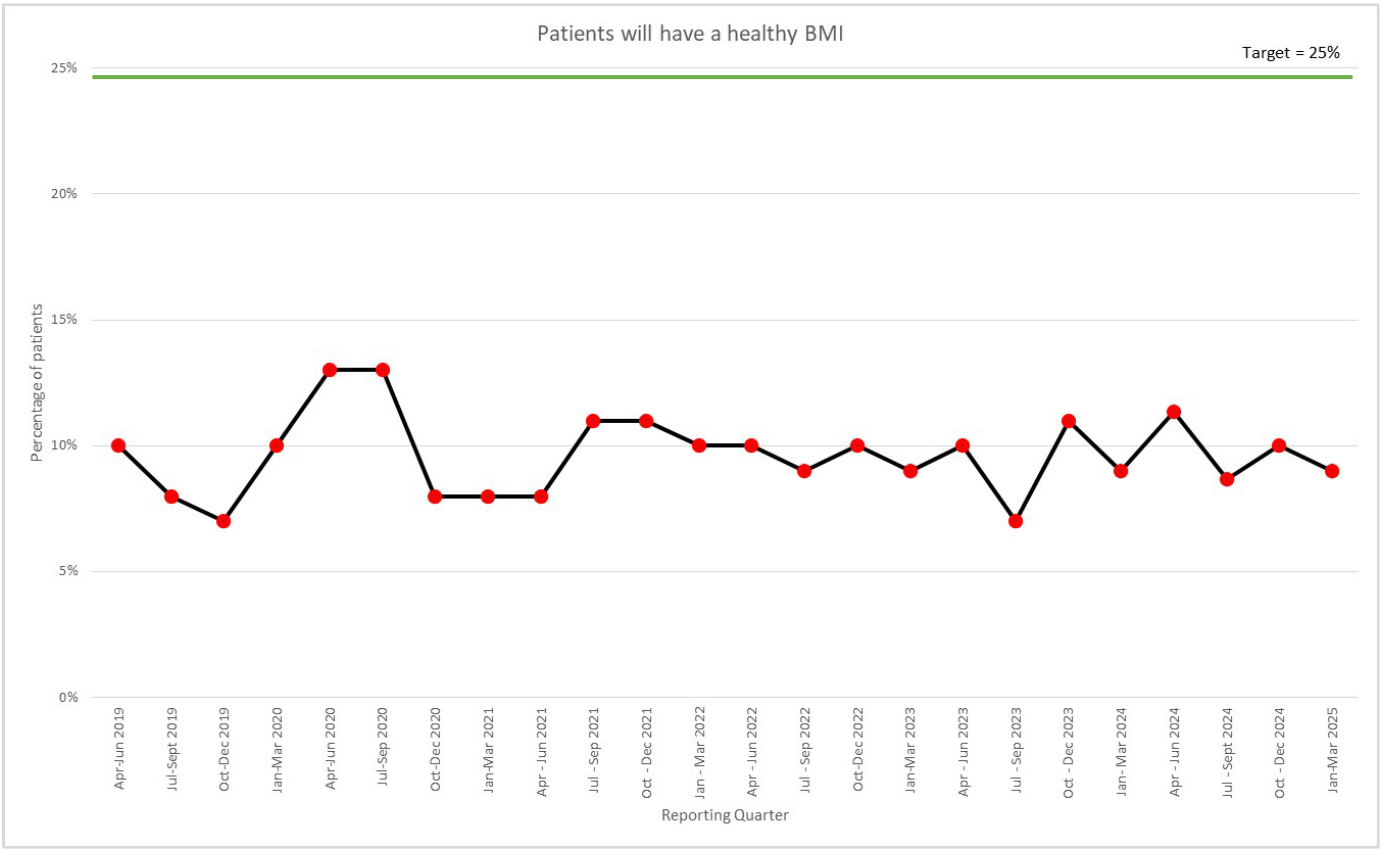
The average percentage of patients who have a healthier BMI increased to 9.75% from 8.92% in the previous reporting year.

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 two 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%

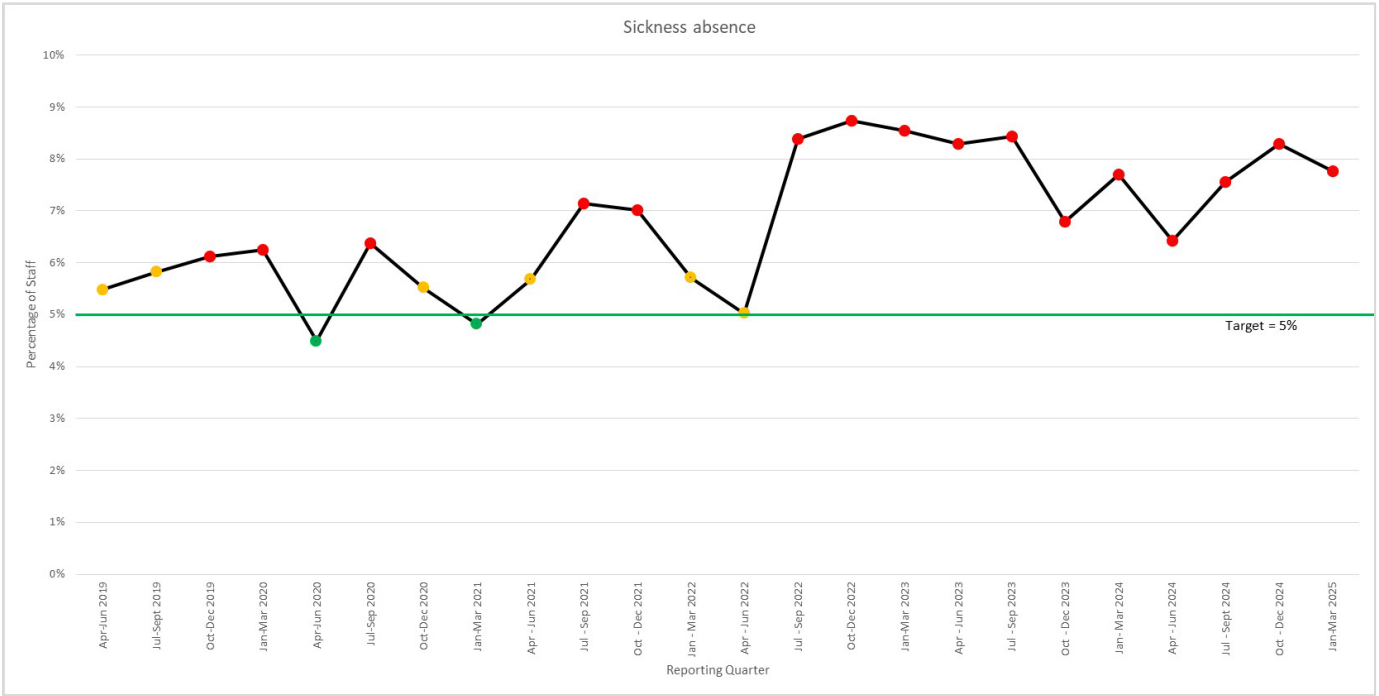
Data for 2024/25: 7.51%

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. The State Hospital remains in the red performance zone for this reporting year.

Chart 7: Sickness Absence



Levels of absence across NHSScotland 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%

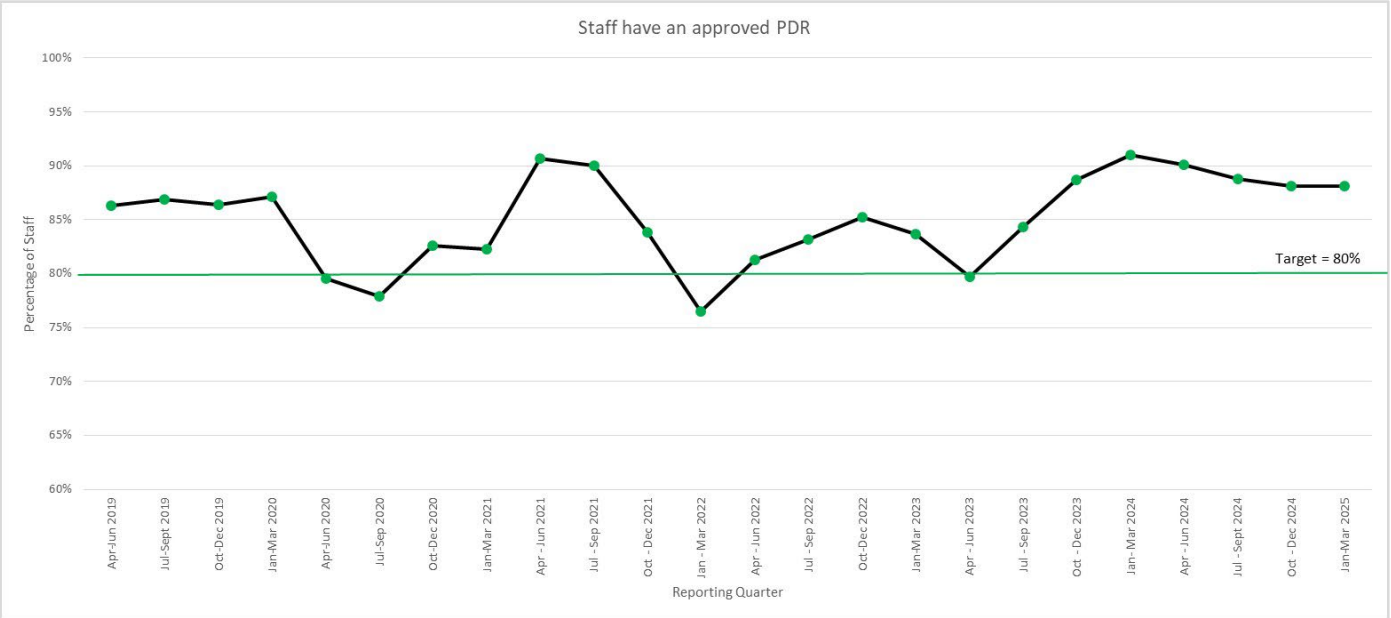
Performance Zone: Green

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%

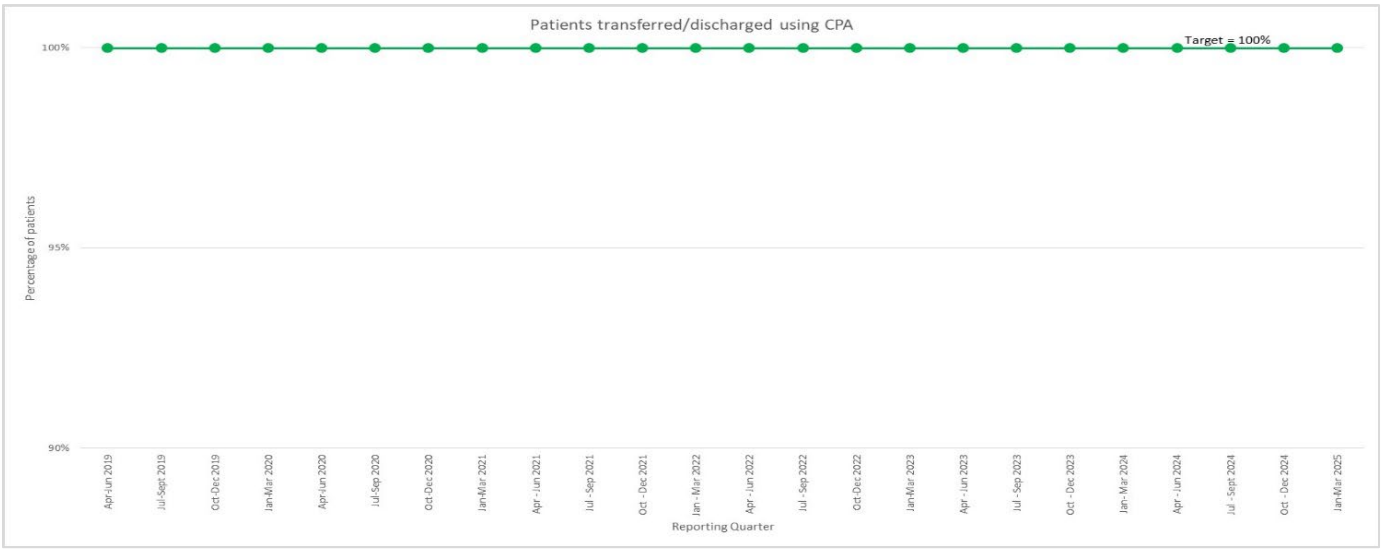
Data for 2024/25: 100%

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%

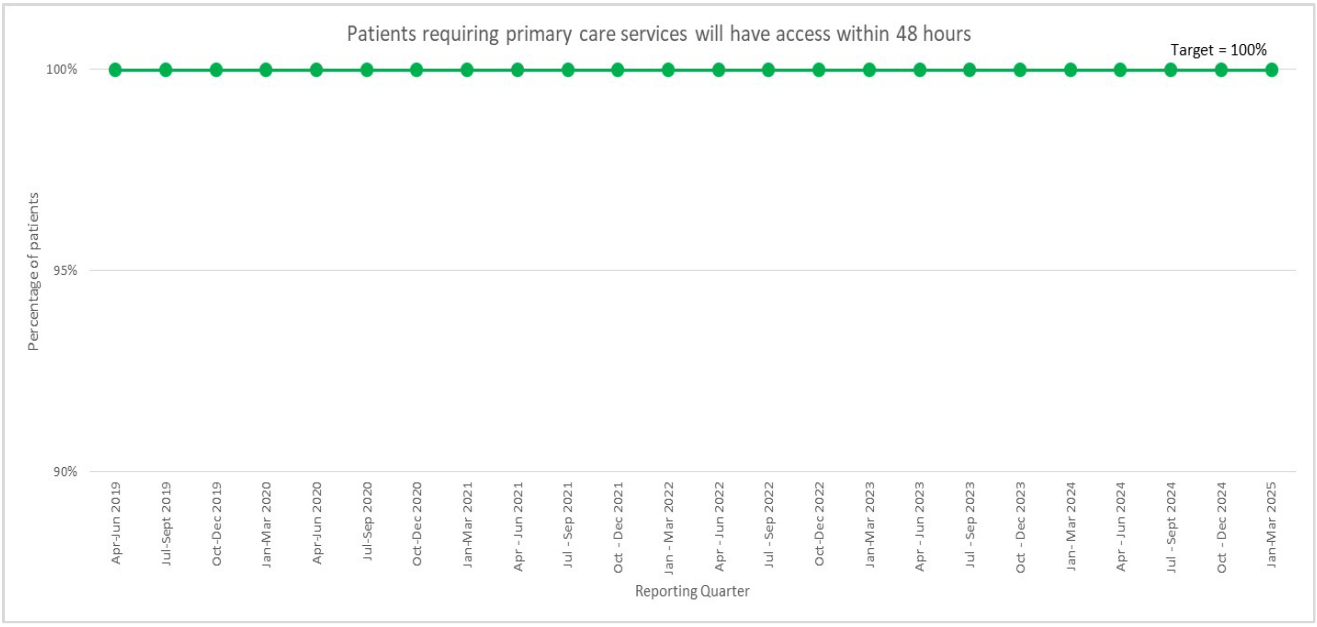
Performance Zone: Green

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%

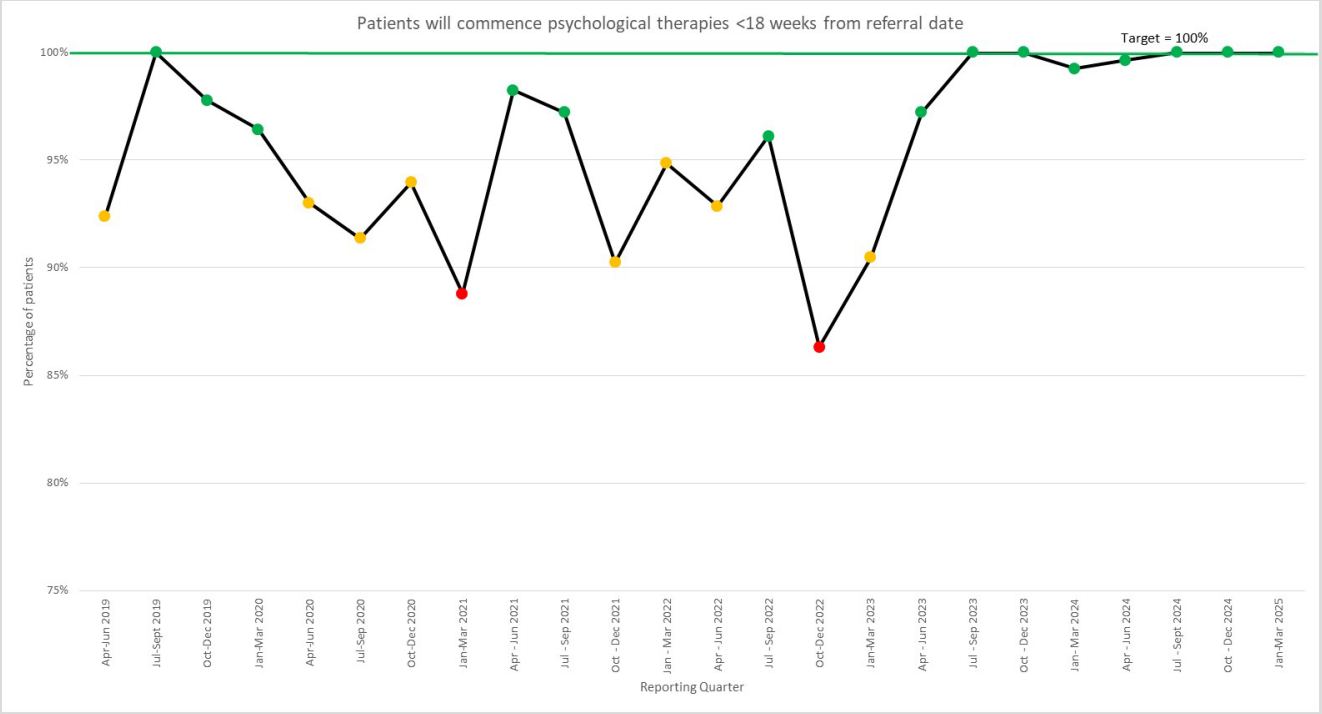
Data for 2024/25: 99.90%

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



The State Hospital has 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%

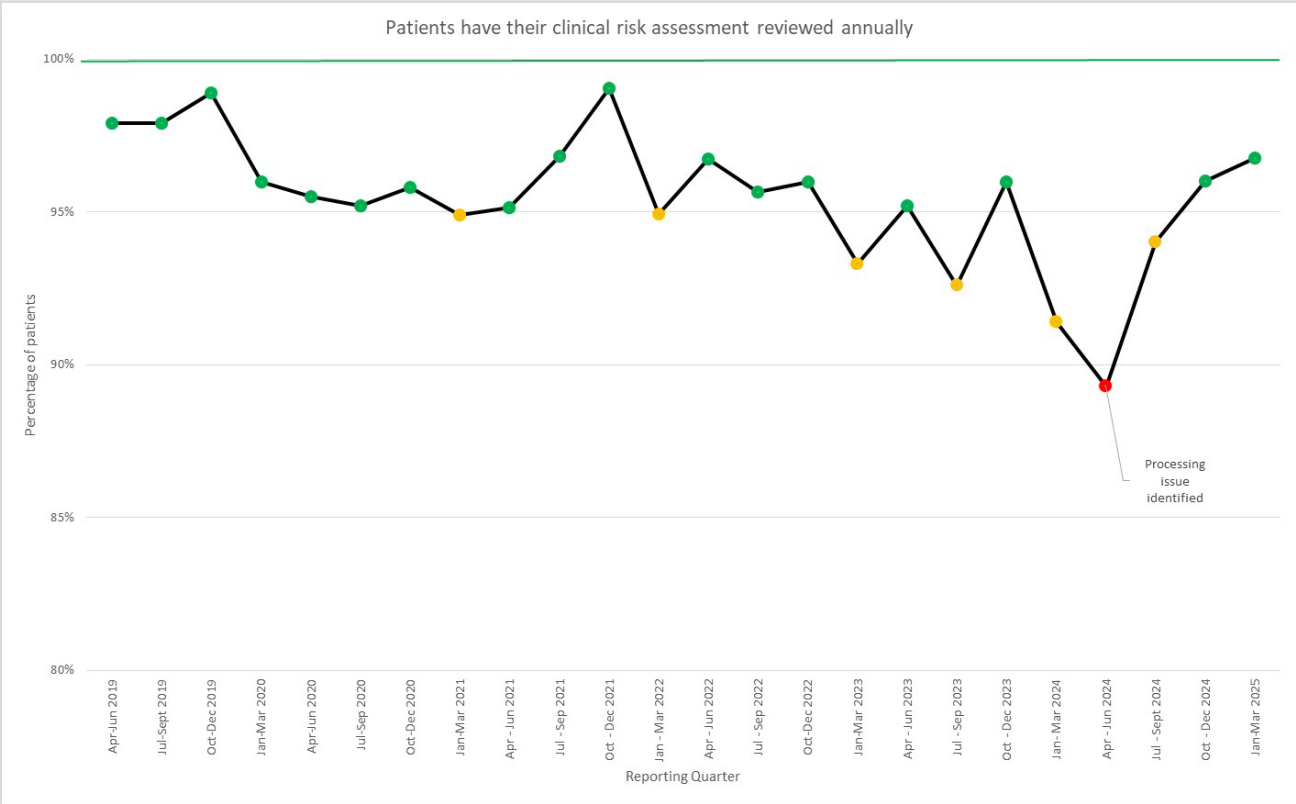
Data for 2024/25: 94.03%

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.

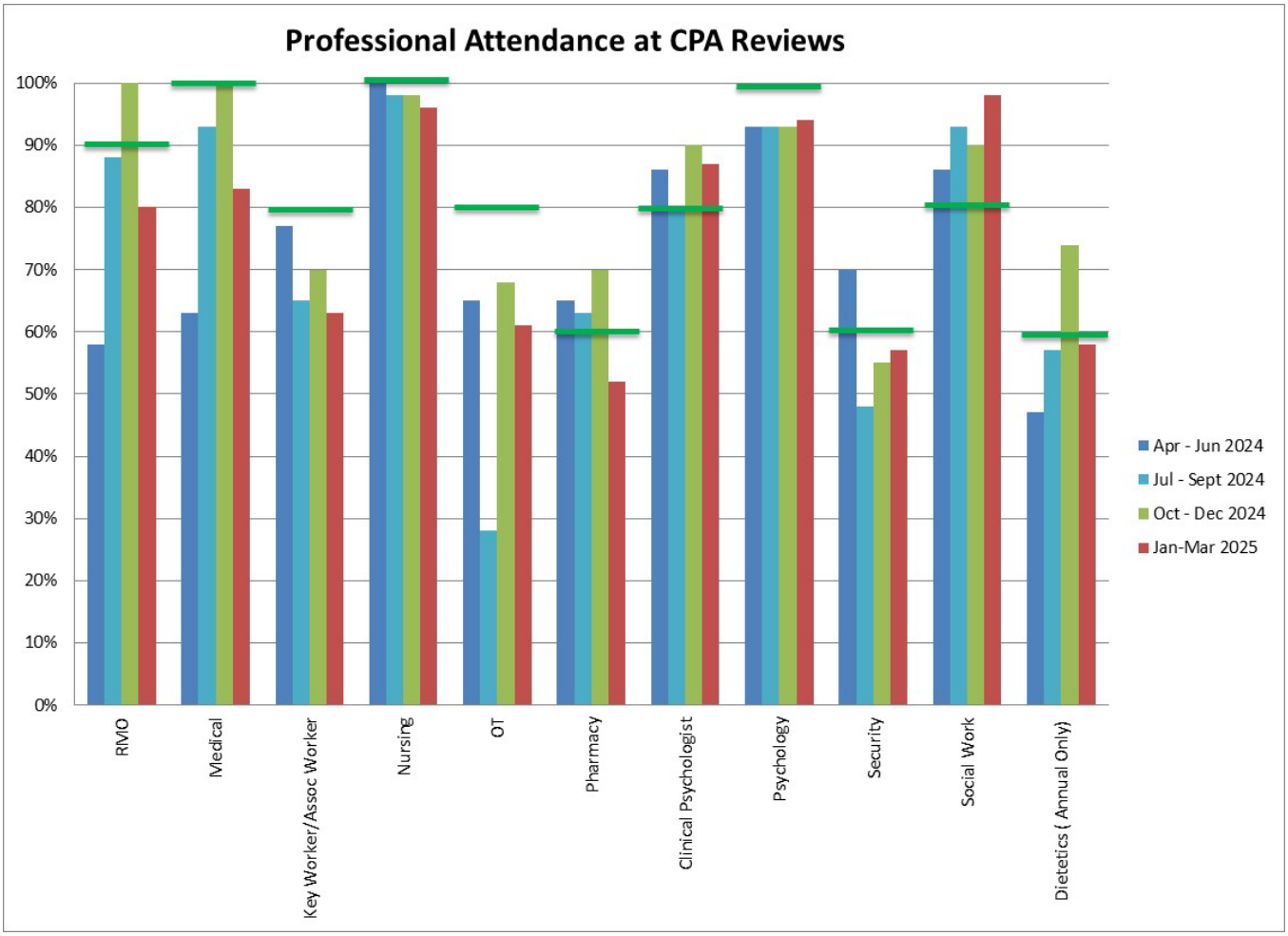
NO 15: ATTENDANCE BY CLINICAL STAFF AT CASE REVIEWS

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 five years.

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
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

Attendance by clinical staff at case reviews

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 whereby 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

Head of Corporate Planning & Business Support
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