THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 28 AUGUST 2025
at 9.30am
Hybrid Meeting: in Boardroom and on MS Teams

A G E N D A

9.30am			
1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 19 June 2025	For Approval	TSH(M)25/05
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 25/67
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**Patient/Carer Story - TSH3030: Patient Partnership Group "Project Pass It On"** Introduced by the Director of Nursing and Operations	For Noting	Presentation
8.	**Project Update for the National High Secure Forensic Healthcare Services for Women in Scotland** Report(s) by the Programme Director	For Decision	Paper No. 25/68
10.10am	**RISK AND RESILIENCE**		
9.	**Corporate Risk Register** Report by the Acting Director of Security, Resilience and Estates	For Decision	Paper No. 25/69
10.	**Finance Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 25/70
10.30am	**CLINICAL GOVERNANCE**		
11.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/71
12.	**Clinical Governance Committee:** (a) Approved Minutes 8 May 2025 (b) Report of Meeting 14 August 2025	For Noting	CGC(M)25/02 Paper No. 25/72

13.	**Clinical Forum:** Draft Minutes of Meeting held on 11 June 2025	For Noting	CF(M)25/02
10.50am	**BREAK**		
11am	**STAFF GOVERNANCE**		
14.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 25/73
15.	**Protecting Vulnerable Groups (PVG) Update** Report by the Director of Workforce	For Noting	Paper No. 25/74
16.	**Equalities Update** Report by the Director of Workforce	For Noting	Paper No. 25/75
17.	**Whistleblowing Update – Quarter 1** Report by the Director of Workforce	For Noting	Paper No. 25/76
18.	**Staff Governance Committee:** **(a) Approved Minutes 15 May 2025** **(b) Report of Meeting 21 August 2025**	For Noting	SGC(M)25/02 Paper No. 25/77
11.30am	**CORPORATE GOVERNANCE**		
19.	**Feedback and Complaints Annual Report 2024/25** Report by the Head of Corporate Governance	For Decision	Paper No. 25/78
20.	**Information Governance Annual Report 2024/25** Report by the Director of Finance & eHealth	For Noting	Paper No. 25/79
21.	**Performance Report Quarter 1 2025/26** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/80
22.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 25/81
23.	**Annual Schedule of Board and Committee Meetings 2026** Report by the Head of Corporate Governance	For Decision	Paper No. 25/82
24.	**Any Other Business**		Verbal
25.	**Date of next meeting:** 9.30am on 23 October 2025		Verbal
26.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
29.	**Close of Session**		Verbal

Estimated end at 12.10pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 25/05**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 19 June 2025.

This meeting took place by way of MS Teams and commenced at 12.30pm

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

In attendance:

Acting Director of Security, Estates & Resilience	Allan Hardy
Clinical Forum Chair	Joe Judge
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 apologies from Ms Fallon and Ms Radage, Non-Executive Directors.

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 24 April 2025 were noted to be an accurate record of the meeting, with one minor amendment in nomenclature.

The Board:

1. Approved the minute of the meeting held on 24 April 2025.

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. Ms Smith asked the Board to note that further progress had been made in respect of Item 7 in that the Patients' Advocacy Service had been allocated dedicated space routinely within the Skye Centre Atrium, to enable a drop in service for patients, as well as pre-arranged appointments.

The Board:

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

5 CHAIR'S REPORT

Mr Moore drew attention to the publication of the Health and Social Care Renewal Framework, as well as the Population Health Framework. These had been published on 18 June as part of the NHS reform agenda. In particular, he noted the proposal for a new body NHS Delivery, which would amalgamate NHS National Services Scotland and NHS Education for Scotland. The aim was for the new body to be operational by April 2026. There were also general statements within the framework, which had relevance any may impact all national boards in terms of collaborative working. He noted that the Board Development Session which had taken place on 1 May had included consideration of NHS Reform, and that the Board would return to this topic at a future date. The Development session had also included governance arrangements for the standing committees, as well as Security standards and assurance on management of Serious Adverse Event Reviews.

Mr Moore advised that he had taken part in a Walkround on 22 May, along with Mr McConnell. This had been in Mull and had been useful giving insights into care delivery more widely. He offered thanks to all the staff involved in the visit for their helpful engagement on the day.

He had also participated in the Sports Annual Awards on 23 May, along with Mr Jenkins. He thanked staff involved in arranging this event which had been an uplifting and enjoyable experience, celebrating patients' achievements.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins began his update by also referencing the NHS reform agenda, and recent publications, highlighting the need to consider these in detail, and any opportunities or impacts for the State Hospital (TSH). He also noted the appointment of Mr Tom Arthur as Minister for Social Care and Mental Wellbeing, providing assurance he and the senior leadership team would welcome the opportunity to Engage with Mr Arthur going forward.

Mr Jenkins referred to the fast pace of progress on the Women's High Secure Service, and noted that this was on today's agenda. Work was also progressing on Phase 2 of the project in relation to a full service in the longer term, and that a site evaluation study would be considered in private by the Board later today.

He also advised that the Board Chief Executives (BCE) Group had met with focus being on waiting times across outpatient and inpatient waiting lists, with a key aim being eradicating any waits longer than 52 weeks.

Mr Jenkins advised that a cyber resilience mock exercise had taken place, to test hospital systems, and that a report on this would be submitted to the Board in private, given the cyber security considerations involved.

He was pleased to note that both the Annual Delivery Plan 2025/26 and the Medium Term Plan had been accepted by Scottish Government, and that this was also on today's meeting agenda. There was also a positive update on the agenda relating to the work progressed to meet the new guidelines on Protecting Vulnerable Groups at the meeting today.

Mr Jenkins advised that he had attended the cross-portfolio ministerial group relating to Health and Social Care and Healthcare in Custody, where there had been a focus on social work services.

Lastly, he confirmed that the latest cycle of quarterly directorate performance meetings had been concluded.

The Board:

1. Noted the update from the Chief Executive.

7 HIGH SECURE FORENSIC HEALTHCARE SERVICE FOR WOMEN

The Board received a paper (Paper No. 25/45) from the Chief Executive Officer on the new development of national high secure forensic healthcare for women within TSH.

Mr Walker joined the meeting and presented an overview of the paper, highlighting in particular the fast pace of the development of the interim service which was due to open on 21 July 2025. The Referral and Admission Criteria had been agreed, and the draft Clinical Guidance document would be considered at the next Women's Project Oversight Board on 26 June. The ward adaptations required were on track for the projected opening date. He then confirmed that recruitment and on boarding of staff was in a positive position, with training commencing on 23 June as planned.

In reference to the Organisational Development Plan, Mr Walker outlined the multi-phase approach, and related programme to take this forward. Finally, that the project timeline remains on track to ensure that the service would be ready to admit patients on the target date.

In relation to Phase 2, he confirmed that the feasibility study had been completed with a recommendation from the Lead Advisors for the Board's consideration.

Mr Walker confirmed that there were no issues to highlight in relation to the funding aspects, as outlined in the report, He confirmed that the Risk Register for the project would be presented to the WPOB, and that this would enable consideration of inclusion within the Corporate Risk Register. The Stakeholder Engagement Plan was continuing to progress and the work required in relation to the Data Protection Impact Assessment was on track.

Mr Moore welcomed this update, and the excellent progress made to date. In his role as Chair of the WPOB, Mr Currie emphasised the importance of delivery this project on time, and commented that the Project Team were performing at a high level with the key milestones being met. In terms of governance, Mr Currie highlighted the helpful nature of summary reporting, and that the information required for decision-making was being provided in a timely way. He added that successful delivery to date gave confidence in TSH more widely as an organisation, particularly for delivery of large scale projects. This could be important in future given the reform underway within NHS Scotland.

Professor Thomson echoed these comments especially on the speed and thoroughness of delivery. She noted that in terms of training, this would be an ongoing journey and should be recognised as such, but that the model used was trauma informed. She thought that it would be important to recognise that the required speed of delivery to open the service meant that there would be a continued need to deliver training once the service was open.

Mr Jenkins noted his thanks to the WPOB and to Mr Walker and his team for the extensive nature of the

work delivered in this respect. Mr Moore echoed this point and offered the Board's thanks to everyone involved. He summed up the discussion from which the Board took assurance on the work to date,

whilst recognising that this was the early stages of the project with considerable distance to go in terms of the overall aims in the longer term.

The Board:

1. Noted the full update within reporting.

8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 25/46) from the Acting Director of Security, Resilience and Estates to provide assurance on the status of the Corporate Risk Register. Mr Hardy summarised this for the Board, noting that all risk had been reviewed within the required timescale.

He advised that three risks had been reviewed by the Corporate Management Team (CMT) with agreement that these should be added to the register. These related to the impact of the Reduced Working Week, the revised requirements for staff under PVG, as well as the level of sickness absence. There were also a number of risks that had been reviewed and considered capable of moving to local risk registers, as described within reporting. He also confirmed that there were seven risks that were currently rated as 'High' on the register, and that these would continue to be monitored closely.

The recommendations of the report were accepted by agreement around the table, and it was noted that this report has also been endorsed earlier in the day by the Audit and Risk Committee.

The Board:

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

9 RISK AND RESILIENCE ANNUAL REPORT 2024/25

The Board received a paper (Paper No. 25/46) from the Acting Director of Security, Resilience and Estates.

Mr Hardy summarised the content of the paper placing it in the context of the role played by the department across the hospital. He noted the structural changes within the team during the reporting period, and described the range of work undertaken across all of the departmental remits as set out in the report. This included the development and maintenance of the Corporate Risk Register as well as local risk registers, alongside the development and review of Resilience Pans. The team had had responsibility for incident reporting, and reviews as well as delivery of the Health and Safety component. Mr Hardy emphases the progress made across all areas, as well as acknowledging the challenges that had been experienced particularly in respect of the management of Serious Adverse Event Reviews, and in staffing resourcing within the team.

Mr Moore thought that the report demonstrated a good sense of progress, and asked about the adoption of In-Phase as a replacement for the Datix reporting system and what training would be required across the hospital. In terms of incident reporting. Mr Hardy advised that there would be minimal impact in terms of incident reporting, but that the system should lend itself to the provision of richer reporting. The plan was to integrate the system over the course of the next 12 months. TSH would be a later adopter compared to other NHS Boards, and any teething problems in implementation should have been resolved.

Mr Moore thanked Mr Hardy for reporting, and noted that there should be updates over the course of the year in terms of the implementation of In-Phase.

Action – Mr Hardy

The Board:

1. Noted the content of the report.

10 FINANCE REPORT

The Board received a paper (Paper No. 25/47) from the Director of Finance and eHealth, presenting the financial position to 31 May 2025 (Month 2).

Mr McNaught advised a small adverse variance at this date, with a year-end break-even position being anticipated. He confirmed that meetings continued to be held monthly with each directorate to address the actions required to achieve and maintain this position. He said that a small amount of planned savings had still to be identified through discussion with budget holders, with the aim being to have these substantially addressed by the end of the first quarter. He noted that the position regarding nursing spend had improved during May, and acknowledged that this would require continued monitoring to ensure spending remained on track. Mr McNaught confirmed that Scottish Government remained content with the current position and forecast for 2025/26.

With reference to the capital budget, demands for the current year would be prioritised against the available allocation. This included specific additional estate demands in the form of necessary repairs and upgrade works, supported by Scottish Government following a submission of requirements.

Mr Moore commented positively on the allocations of funding for smaller capital demands, as well as the reduction in the costs of nursing overtime.

The Board:

1. Noted the content of the report.

11 BED CAPACITY REPORT

The Board received a paper (Paper No. 25/49) from the Medical Director, which outlined bed capacity within TSH for the two month period to 31 May 2025.

Professor Thomson provided an overview of the content of the report including the flow of patients in terms of admissions and transfers, and the flow between services within the hospital. She advised that currently there were eight patients identified for transfer from TSH, and of these four had been fully accepted to do so. This was a much improved position in terms of flow across the wider forensic estate. However, no patients were due to transfer immediately. She then highlighted the position on bed capacity for Major Mental Illness (MMI) patients within TSH, and the likelihood that the Contingency Plan may have to be utilised in the near future, and this was being carefully monitored. She reminded the Board that this meant that there would be a need to identify MMI patients who would move to an Intellectual Disability (ID) ward; or to be boarded within the ID ward at night but spend the day within their usual service. Three patients had been identified as being suitable. This was not optimal and there would be active consideration as to how best to manage the plan.

Mr Moore thanked Professor Thomson for the report and commented on the complexities of managing patient flow, noting that this was the first time that the Contingency Plan had had to be considered due to pressures. He reflected that the plan in place to manage this scenario and the potential for this to occur had been identified previously.

He also noted that there had been consideration of the routing for this report which was currently submitted to both the Clinical Governance Committee, as well as the Board. In future, the report in full should be submitted to the committee, with a route being in place for any issues identified being escalated to the Board as necessary, and asked Ms Smith to take this forward.

Action – Ms Smith

The Board:

1. Noted the content of report.

12 CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT 2024/25

The Board received the Clinical Governance Committee Annual Report (Paper No. 24/50) to provide the Board with assurance on the wide range of activity overseen by the Committee.

Mr McConnell confirmed that the report had been reviewed along with the suite of annual reporting across each standing committee at the Audit and Risk Committee earlier in the day, to give evidence of the scrutiny undertaken throughout the year.

There was agreement around the table that reporting demonstrated that the Committee had fulfilled its remit throughout this year.

The Board:

1. Noted that the Audit and Risk Committee had recommended that this report be presented to the Board for approval.

2. Approved the Clinical Governance Committee Annual Report 2024/25

13 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 25/51) which outlined quality assurance and improvement activities since the date of the last meeting.

Ms Merson summarised the key points from the report, which covered the range of clinical audit work completed and the data evidence within the Variance Analysis Tool (VAT). In relation to quality improvement, she emphasised the success of TSH3030 this year, in which 75 members of staff and 13 patients had taken part over a number of different initiatives. This was leading up to celebration events due to take place of 24 June 2025, and involving both staff and patients. She also noted that it had been a busy period for the realistic medicine workstream, and that the annual Realistic Medicine Conference took place on the 16 May 2025, with three members of staff from the State Hospital in attendance. She also advised that a case study booklet had been created and published by the Realistic Medicine Team at the Scottish Government, which included a case study from the State Hospital.

Ms Raghavan provided positive feedback on the report, which she found helpful as an overview of activity within this remit. Mr Moore asked about further background around the clinical audit on compliance with the Mental Welfare Commission (MWC) Guide on Compliance to Treatment. Professor Thomson clarified the meaning around T2 and T3 paperwork relating to the consent process for medication, and the legal context. There is an essential requirement for the paperwork to be available, as this would inform whether treatment could be enforced. With the change to electronic prescribing through HEPMA, there had been a move away from physical forms being used, and the paperwork should now be available on the electronic patient record on RiO.

Mr Moore commented on this further saying that it would be helpful for the Board to reflect on changes from paper to electronic systems, and how this all came together particularly around the RiO system. He suggested that this should be added to a Board Development Session. Mr Jenkins noted that TSH and the MWC both used this system, but it was not commonly used across NHSScotland. It had been upgraded last year, and he agreed it was essential for it to be kept under review.

Action – Ms Smith

The Board:

1. Noted the content of the report.
2. Arrange Board Development Session on EPR, RiO use and T2/T3 interface.

14 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 13 February 2025, as well as a summary report (Paper No 25/53) of the meeting which had taken place on 8 May 2025.

The Board:

1. Noted the content of the approved minutes dated 13 February 2025.
2. Noted the update from the meeting held on 8 May 2025.

15 STAFF GOVERNANCE COMMITTEE ANNUAL REPORT 2024/25

The Board received the Staff Governance Committee Annual Report 2024/25 (Paper No. 22/4) which demonstrated that the Committee had met its remit and terms of reference. Mr McConnell noted the scope of activity, and advised that this report had also been reviewed and endorsed by the by the Audit and Risk Committee.

The Board:

1. Noted that the Audit and Risk Committee had recommended that this report be presented to the Board for approval.
2. Approved the Staff Governance Committee Annual Report 2024/25

16 REMUNERATION COMMITTEE ANNUAL REPORT 2024/25

The Board received the Remuneration Committee Annual Report 2024/25 (Paper No. 22/54) which outlined the work overseen by the Committee focused in particular on oversight of Executive and Senior Manager performance and as well as consultant discretionary points (CDP).

As Chair of the Committee, Mr McConnell asked the Board to note that during this year, there was improved practice in respect of CDP. He confirmed that report had been reviewed at the Audit and Risk Committee, and provided a sufficient level of assurance for the Board.

The Board:

1. Noted that the Audit and Risk Committee had recommended that this report be presented to the Board for approval.
2. Approved the Remuneration Committee Annual Report 2024/25.

17 ORGANISATIONAL DEVELOPMENT AND WELLBEING STRATEGY

The Board received a report from the Director of Workforce (Paper No. 25/55) presenting the three year Organisational Development and Wellbeing Strategy, aligned to the Medium Term Plan 2025/28.

Mr Wallace provided a high level summary of the strategy, noting that it had had been reviewed in detail by the Staff Governance Committee, with endorsement for the strategy to be submitted to the Board for final approval. Mr Wallace underlined the scope of the engagement work which had supported the development of the strategy which was intended to map the direction of travel for the organisation especially around the cultural landscape.

Mr Moore commented on the importance of this strategy for the hospital, especially the link described between organisational health and performance. He thought that this would be a key pillar that the

Board would return to in the future. On this point, it was agreed that the Staff Governance Committee

would continue to take detailed oversight of the implementation and subsequent impact of the strategy, with regular updates being presented to the Board. On this basis, this should be added to the Board's workplan.

Action – Ms Smith

The Board:

1. Noted that the Staff Governance Committee had endorsed the strategy.
2. Approved the strategy, and agreed the governance framework for its future implementation.

18 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 25/56) which provided updates on workforce performance to 31 May 2025.

Mr Wallace presented a summary overview of the detail within the report, focusing on attendance management as key area of current focus. He confirmed that levels of sickness absence were continuing to improve with a decrease from 8.6% to 6.85% in the period from March to May 2025. He advised that this was principally in long term absences, although it was acknowledged that there was still a big challenge ahead to reach the target level of 5%. He asked the Board to note that reporting identified the departments and wards currently experiencing high levels of absence, and that the future actions required within the context of a person-centred and supportive approach for improvement. The Staff Governance Committee had received assurance in respect of the 'Maximising Attendance' approach to give assurance in this respect.

He also summarised the position across recruitment, employee relation cases and job evaluation, as well as performance on PDPR compliance.

Mr Moore welcomed the report which provided a number of positive updates. Mr Currie echoed this and commented positively on PDPR compliance a being a positive arena in which line manager could engage with staff, including on their health and wellbeing. In this way it could be an early warning system for any issues on the horizon. In respect of sickness absence, he thought that it would be essential to continue to monitor the trend over time to ensure that it continued to move in the right direction, and that the potential for seasonal variation should be recognised. He thanked Mr Wallce for a succinct and accessible report which highlighted the key issues that required the Board's focus.

Ms Raghavan asked about the potential impact of the proposed Reduced Working Week of 36 hours for Agenda for Change staff, noting that this was a good policy for staff wellbeing. However, it would present complexity in terms of working patterns especially for staff working shifts. Mr Wallace described the progress made to date, with working groups established based on the different staff cohorts, and working patterns in place currently. The aim was to make this change most beneficial for individual staff, as well as effective for organisational performance. It would be essential to think innovatively, and recognise that there may be challenges throughout implementation.

Professor Thomson noted the encouraging nature of the report around sickness absence levels, and also that there had been a reduction in the level daytime confinement experience during the reporting period, with a reduction in sickness levels being a contributory factor. She also noted the need to review trends over a longer period and to compare to previous years, particularly around seasonal factors. Mr Wallace agreed with this, and said that previous trends would indicate the potential for an upward spike during summer months, as well as for short term absence during winter months due to coughs, colds, and respiratory virus. The objective was to be able to continue with an overall downward trend over

time, getting as close as possible to the target rate of 5%, even taking into account seasonal variation at particular points in time. He would incorporate this into reporting going forward.

Action – Mr Wallace

Mr Jenkins supported this approach, and added that there was significant and focused work being progressed across directorates with this key objective in sight.

Mr Moore welcomed the decrease in long-term absence, and asked for further clarification on the main reasons for this. Mr Wallace said that this was due to a range of factors, including staff being supported to return to work successfully, as well as conclusion of long term cases through the Attendance Management Policy.

Mr Moore acknowledged the improved position and said that whilst the revised approach may be in its initial stages, it was indicative of positive change, and the Board appreciated the work being progressed in this regard.

The Board:

1. Noted the content of the report.
2. Agreed that seasonal trends should be incorporated into next report

19 PROTECTING VULNERABLE GROUPS (PVG) REPORT

The Board received a paper (Paper No. 25/57) 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, and the actions taken to ensure compliance within the hospital.

He confirmed the updated position as of the first week in June, with 37% of staff having now completed the process in full, and a further 56% now awaiting the outcome of their application from Disclosure Scotland. This left 7%, and that only 1% remained who had not commenced the process to date. Every effort was being made to remedy this. He also noted that when employees received their outcome, there was an option to share this with TSH, and this had to be done within a two week period. If not, the individual would then have to retain a copy themselves and share that instead. He was pleased to note that there had been no negative return from Disclosure Scotland to date. Overall, this represented a positive position for the State Hospital.

Mr Moore thanked Mr Wallace for this report which provided an excellent level of assurance, and Mr Jenkins added his thanks to Mr Wallace and his team for the good work taken forward here, at short notice.

The Board:

1. Noted the content of reporting.

20 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 13 February 2025; as well as a summary report (Paper No 25/58) of the key areas of reporting and discussion at the meeting which had taken place on 15 May 2026.

The Board:

1. Noted the content of the approved minutes of the meeting on 13 February 2025.
2. Noted the update in relation to the meeting held on 15 May 2025.

21 AUDIT AND RISK COMMITTEE ANNUAL REPORT 2024/25

The Board received the Audit and Risk Committee Annual Report 2024/25 (Paper No. 22/59) which outlined the work overseen by the Committee during this period.

As Chair of the Committee, Mr McConnell confirmed that the Committee had approved this report as demonstrating that it had fulfilled its remit throughout the year. He was pleased to note full attendance by members across the year, and advised that the reported provided a good outlined of the work conducted throughout this period. It had been approved by the Committee at its meeting earlier in the day.

He went on to say that that each of the Committee Annual reports submitted to the Board today demonstrated the role of the members, and their commitment. Further the assurance taken from reporting across each remit was clearly demonstrated. He also recognised the work of the support team which was much appreciated.

The Board:

1. Approved the Audit and Risk Committee Annual Report 2024/25.

22 REPORT ON THE ANNUAL ACCOUNTS

The Board received a paper from the Chair of the Audit and Risk Committee (Paper No. 22/60) which detailed the Annual Accounts for the year-end as of 31 March 2024. This paper outlined the requirement to have the Annual Accounts formally adopted by the Board, certified by external audit, and submitted to the Scottish Government Health and Social Care Directorate (SGHSCD) by 30 June 2025.

Mr McNaught then led the Board through a detailed overview of the content, noting that the report was to assist members to navigate through the annual accounts, much of which was statutory disclosures. He confirmed that the format had only minor changes from the previous year, and the report and accounts are reviewed by KPMG, from whom a draft unqualified audit opinion which was stated.

Mr McNaught summarised the key aspects of the Performance Report and Accountability report including the Governance Statement and the Statement of Health Board Members' Responsibilities. And the statutory compliance statement with regard to Chief Executive responsibilities. Reporting included a summary of Board activities throughout the year, as well as detailing senior staff remuneration. He also outlined the Parliamentary Report, giving disclosure on losses and special payments.

He also highlighted the principal financial statements as outlined, and noted the responsibility of the Audit and Risk Committee to report to the Board on the adoption of the accounts, and to give authority as required to the Chief Executive Officer and the Director of Finance and eHealth to sign the accounts.

Finally, Mr McNaught noted this thanks to the finance team and NSS staff with work was conducted collaboratively. This had been a considerable effort by the finance team in particular this year, given that a senior member of the finance team had been absent throughout the process.

Mr McConnell confirmed that the Audit and Risk Committee had considered the Annual Accounts and the associated recommendations in detail at its meeting earlier this morning. He then confirmed that it was the decision of the Audit and Risk Committee to recommend to the Board that it should adopt the Annual Accounts as attached to this paper and submit them to the SGHSCD by the due date.

Mr Currie reflected on the positive position this placed the State Hospital in, in a pressured national landscape. It showed that the required savings had been made, whilst fulfilling the Board's role as a public authority. He agreed that assurance could be taken from the governance processes in place, and the unqualified opinion from external auditors. He also paid tribute to Mr McNaught and his team for their work in this regard.

Mr Jenkins echoed this, especially given the position on staffing within the finance team this year.

On this basis, Mr Moore summarised that the Board was content to adopt the Annual Accounts for the year ended 31 March 2025, and approved the submission to the SGHSCD. He offered thanks Mr

McNaught and to the finance team for this work, which represented a very positive position for the Board. He also offered formal thanks to Mr McNaught for his financial leadership of the organisation, with the break-even position for the Board being a major achievement.

The Board:

1. Adopted the Annual Accounts for the year ended 31 March 2025 and approved submission to the Scottish Government Health and Social Care Directorate.

2. Authorised:

a) the Chief Executive to sign the Performance Report
b) the Chief Executive to sign the Accountability Report
c) the Chief Executive and Finance and e-Health Director to sign the Statement of Financial Position

23 PATIENTS FUNDS ACCOUNTS 2024/25

The Board received a paper (Paper No. 23/61) from the Director of Finance and eHealth, and Mr McNaught provided a summary of its content.

Mr McNaught advised that these funds were the balances of money held by TSH on behalf of patients and that an independent audit had been obtained, with an unqualified opinion from Wylie & Bisset. He advised that the accounts for March 2025 were a summary of the collective patients' income and spending as managed through the TSH patient account – this was a simple statement of income and expenditure

He confirmed that the Audit and Risk Committee had reviewed the accounts at its meeting this morning and recommended to the Board that the Chief Executive Officer, and the Finance and eHealth Director, be given approval to sign the summary income and expenditure statement.

Mr Moore noted that this external audit was not a statutory requirement, but was conducted on the basis of good practice, and welcomed this approach given the substantial sums held.

Professor Thomson asked Mr McNaught for his views on whether any additional support could be provided for patients in financial management, whilst recognising that TSH could not provide financial advice. Mr McNaught confirmed that TSH was not a registered financial advisor, and could not give advice directly. However, finance staff did routinely ask patients if they wished to obtain external advice and would support them to do so.

The Board:

1. Approved the signing of the summary patient funds accounts by the Chief Executive and Finance and eHealth Director.

24 ANNUAL DELIVERY PLAN (ADP) AND MEDIUM TERM PLAN (MTP)

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 25/62) which confirmed that Scottish Government had formally approved each plan. Ms Merson highlighted that the MTP provided the direction of travel for the hospital over the coming three years, aligned to national guidance and within the wider landscape of forensic mental health. The ADP represented the first year of delivery of the MTP, with each critical success factor aligned to the standing committees.

Mr Moore welcomed the report and the way in which the deliverables for the current year were defined and presented. Mr Jenkins added that he was pleased to receive Scottish Government approval of the plans, and offered thanks to Ms Merson and her team for the considerable work that had been completed in this regard.

Mr Currie noted that approval was not necessarily a given, and that this was a positive place for TSH to be in. He offered thanks to Ms Merson for leading on this, and added that it would be a continual process to measure performance against the critical success factors over time.

Ther was discussion on how the Board would receive future assurance, and agreement that reporting should be provided on a six monthly basis, and this would be added to the workplan.

Action – Ms Smith

The Board:

1. Noted the content of the report, and Scottish Government approval in this respect,
2. Agreed that six monthly reporting on progress should be submitted to the Board in future.

25 PERFORMANCE ANNUAL REPORT 2024/25

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 25/62) which provided a high level summary of organisational performance for 2024/25. Ms Merson summarised the position, highlighting the five areas in which performance had not met the target level, as outlined.

Mr Moore asked about Item 5.2 relating to patients completing 150 minutes of exercise each week. It was clarified that the target had been raised from 60% to 70% as a stretch target, and also that this was impacted by seasonal factors. It also varied between different service, with patients within Transitions achieving a rate in excess of 80%, whilst this was more challenging within Admissions and Assessment given clinical acuity. It was agreed that it would be helpful to see this data broken down across services both retrospectively for this report, and in future reporting.

Action – Ms Merson

The Board:

1. Noted the content of the report
2. Requested a breakdown of patient activity levels across each clinical service.

26 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report (Paper No. 25/64) to confirm the updated position on this project. Mr Jenkins asked the Board to note the key points within reporting, in terms of the general project update, confirming that there were areas of commercial and security sensitivity meaning which could not be discussed in a meeting held in public, and would be referred to the Board privately.

Board Members noted this position.

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.

26 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting, which had taken place on 27 March 2025. Mr McConnell provided a verbal update in respect of the meeting which had taken place this morning, on the wider business undertaken as well as annual reporting. He noted in particular the internal audit on the Clinical Care Policy which had substantial assurance. He then noted the suite of assurances related to the annual accounts that had first been considered and endorsed by the Committee, prior to being submitted to the Board, with key input form auditors. He reflected on the importance of the conclusion of this at year-end.

The Board:

1. Noted the content of the approved minutes 27 March 2025
2. Noted the update from the meeting held earlier today.

27 ANY OTHER BUSINESS

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

28 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 28 August 2025.

29 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.

30 CLOSE OF MEETING

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

The meeting ended at 2.45pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	April 24	A.O.B	Reporting template review around the monitoring report, and how to re-frame report template	M Smith	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 Corporate Management Team (CMT) and then take forward for Board and Committees, pending learning taken. **August 2025:** This is linked to pilot work taken through the CMT as well as website accessibility work around reporting. Further work is in progress and will be finalised in the final quarter of the year to ensure all aspects are addressed.
2	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. **CLOSED**
3(a)	October 24	Corporate Risk Register	-Consider Risk SD51 relating to physical security in context of security project finalisation – and post completion period and how to re-frame this risk	A Hardy	August 2025	**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.
3(b)			-Review Workforce Risks and potential to add to CRR – e.g. absence			**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:** Considered and agreed with revisions made. **CLOSED**

			- Update on progress of improvement work on management of SAERs			**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, and reporting through Clinical Governance Committee on learning. **CLOSED**
4	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 - verbal update at meeting that this has now been established and will be assessed on ongoing basis for effectiveness. **CLOSED**

5	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.
6	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 within reporting. **CLOSED**
7	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 **August:** Update included within reporting on agenda (Item 17).

8	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 going forward. **CLOSED**
9	April 2025	High Secure Female Service	Risk to be added to the Corporate Risk Register	A Hardy/ D Walker	August 2025	**June Update:** Update provided on development of this through project Oversight Board. To be reported through CMT and then to Board at next meeting. **August Update**: On agenda as part of reporting (Item 8).
10	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	August 2025	**June Update:** Good progress noted by the Board, and a further update to be provided at the next meeting. **August Update:** On Agenda (Item 15).
11	April 2025	Communications Annual report	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.

12	June 25	Risk and Resilience Annual Report	Regular updates to Board on implementation of InPhase	A Hardy	August 2025	**August Update:** The Project Initiation Document for InPhase has been signed off, and project team set up. Between August and November the system administrators will complete the required training modules for the system until the development of the system begins in November.
13	June 25	Bed Capacity Report	Reporting remitted to CGC on basis escalation route to the Board. CGC to Board for bed capacity	M Smith	August 2025	**August Update:** Agreement that this report would be remitted to Clinical Governance Committee, and any key issues escalated from the committee to the Board as appropriate. **CLOSED**
14	June 25	QI and QA Report	Discussion on T2/3 clinical audit, and link to RiO. Further consideration of this through board development sessions.	M Smith		**August Update:** T2/T3 and link to RiO discussed as part of board development session in August, and wider implications of linkages to RiO added to list of possible future topics to be considered. **CLOSED**
15	June 25	OD and Wellbeing strategy	OD and wellbeing strategy – Board workplan	M Smith	Immediate	**August Update:** Added to board workplan to ensure future assurance reporting, and link to Staff Governance Committee. **CLOSED**
16	June 25	Staff Gov Report	Attendance – consideration of seasonal impacts / data as part of reporting is possible.	S Wallace	August 2025	**August Update:** on agenda as part of reporting (Item 14).

17	June 25	ADP and MTP	ADP /MTP – 6 monthly reporting to return to the Board	M Smith	Immediate	**August Update:** Added to workplan to ensure future assurance reporting **CLOSED**
18	June 25	Annual Performance Report	Performance on 150m of exercise a week – service breakdown	M Merson	August 25	**August Update:** included as part of reporting on agenda (Item 21).

Last updated – 21.08.25 M Smith

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 8
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 Decision

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 was 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 Interim Womens Service attained 'patient ready 'status on 21 July 2025.

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

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

It is the intention that Phase 1 will integrate and co-locate with Phase 2 on its completion, therefore co-locating the three aspects of the patient's treatment journey into a central 'treatment hub' at 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 Womens 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 24 July 2025.

The CPT meets on a fortnightly 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 WOMENS SERVICE

Interim Womens Service

All outstanding elements of work required in advance of the patient ready date of 21 July 2025 have been completed. There has been a slight delay to the delivery of the equipment for the Sensory room which is expected to arrive towards the end of July, this does not impact on the patient ready status of the service.

The Programme Director met with the Chief Executive Officer, WPOB Chair and the Board Chair on 17 July 2025 and provided assurance across all aspects of the service in advance of the patient ready date. The 'patient ready' status was approved and agreement that the reporting and monitoring arrangements will be incorporated within the overall TSH Clinical Model and accountability to the 'Clinical Model Oversight Group'.

Outreach Service

At the WPOB meeting in May members agreed to support the development of a six month pilot for the outreach service. The CPT would undertake engagement across the forensic network and SPS to outline the requirements of the service. A workshop is planned for 19 August 2025 with stakeholders. A paper on the proposed pilot will be submitted to the WPOB on 4 September 2025.

3.3 PHASE 2 UPDATE

At TSH Board meeting on 19 June 2025 support was provided for 'Option 3' (new build within the grounds) and a request made that the CPT should define the next stages of the capital process and provide an updated report to the TSH Board meeting in August.

A subsequent meeting has been held with NHS Assure to explore options available to TSH that are outlined in **DL 2025 (14) – Whole System Infrastructure Planning – Strategic Planning Phase (including updated governance arrangements for Capital Spending).**

As 'Option 3' has indicative costs of £18m, the guidance for 'Project Specific Allocations' above £10m must follow the approval stages set out in the 'Scottish Capital Investment Manual'. The first stage being the submission of a 'Strategic Assessment' (SA) with approval subject to a recommendation from the Chair of the Capital Investment Group to the Chief Executive of NHS Scotland.

The 'Scottish Capital Investment Manual' sets out guidance for completion in the first instance of a SA. Timescales for submission and approval of a SA and the next stages are as follows:

- SA submitted for consideration during 2026/7
- Investment priorities confirmed during 2027/8
- New Outline Business Cases submitted in 2029
- New Full Business Cases submitted in 2031
- New projects ready to start in 2032.

In the interim, NHS Assure have advised TSH to refresh Option 3 and confirm the design and required bed numbers for the service in advance of preparing the SA. A proposal has been developed with Thomson Gray to utilise £32k of the Feasibility Study underspend to refresh Option 3 based upon the remodeling of bed numbers currently being carried out by the clinical service lead.

To support the revised capital process, each NHS Board has been offered a 1:1 support meeting with NHS Assure which will take place on 2 September 2025.

If TSH Board support is approved, the CPT will undertake to refresh Option 3 and commence the SA process with a target date for submission in November 2026.

3.4 FINANCIAL UPDATE

Phase 1
Funding for Phase 1 has been committed by the Mental Health Directorate in year 2025/26 (letter ref MH-MH-FMH-003 // IMHS024) Discussion on recurring revenue will be required for future financial years. This enabled the recruitment of a permanent staff group for the Women's service.

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:	£67k	(spend £67k)
Capital Allocation:	£150k	(spend £97k)
Travel/Expenses Allocation	£6k	(spend £0)

The remaining allocation for Phase 2 is £59k.

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 the WPOB to escalate any risk to the Corporate Risk Register if required.

At the WPOB meeting in July 2025, all risks relating to Phase 1 were approved as 'eliminated' and agreement that the CPT should further develop the risk profile for Phase 2 based upon the

update guidance in DL (2025)14.

There are currently no Very High or High risks on the WPOB Risk Register.

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
Scottish Human Rights Commission
Health Improvement Scotland – Engagement team

4 RECOMMENDATION

The Board is invited to **note** the status of Phase 1 and **agree** to the further development of Phase 2 as outlined in section 3.3.

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 (TSH). 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. 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.	Womens Project Oversight Board (WPOB) 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 WPOB, and to TSH Board.
Assessment of Impact on Stakeholder Experience	Reporting confirmed that a Stakeholder engagement plan has been developed by the Core Project Team and endorsed by the WPOB who 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 particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	The development of the service will reduce current inequalities and gaps in service provision.

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. 25/69

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 9
Sponsoring Director:	Acting Director of Security, Estates and Resilience
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

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 and recent updates

This document summarises directorate risks, tracks changes over time, and provides updates on risk management.

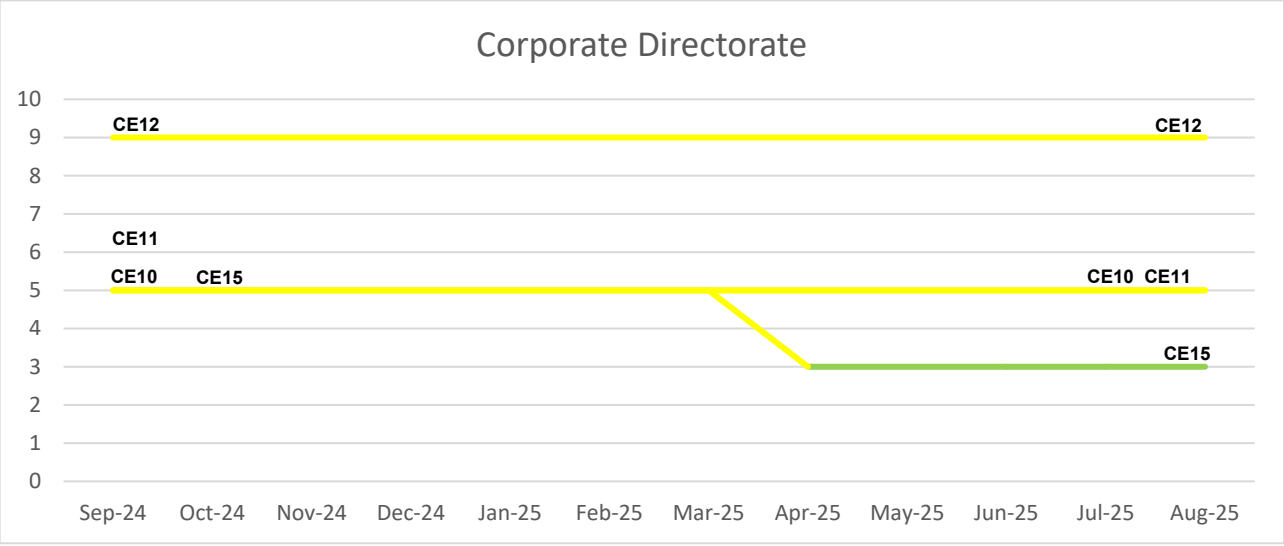
Likelihood	Impact/Consequences				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	Medium (5)	High (10)	High (15)	V High (20)	V High (25)
Likely (4)	Medium (4)	Medium (8)	High (12)	High (16)	V High (20)
Possible (3)	Low (3)	Medium (6)	Medium (9)	High (12)	High (15)
Unlikely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

Corporate

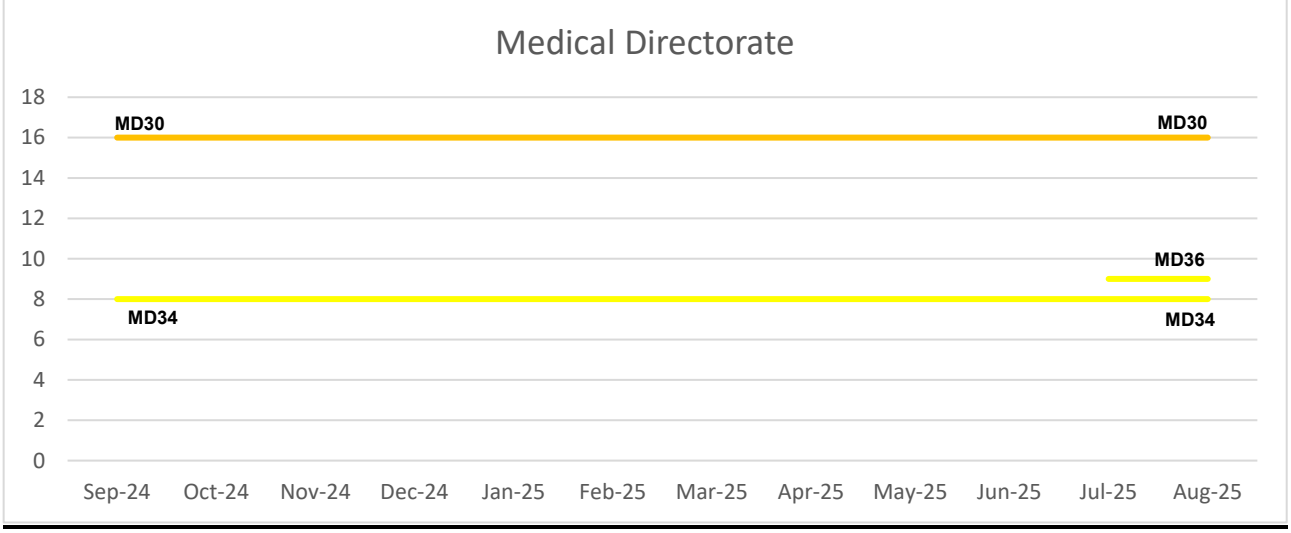
CE12, "Failure to utilise appropriate systems to learn from prior events internally and externally," and SD57, "Failure to complete actions from Cat 1/2 reviews within appropriate timescale," have been consolidated due to the overlapping nature of their risk assessments.

Both elements are overseen by the Director of Security, Estates and Resilience via the Risk and Resilience Department. Moving forward, this risk will be managed solely within the Security Directorate under the designation SD57, retaining the title "Failure to utilise appropriate systems to learn from prior events internally and externally." The merged risk assessment will systematically monitor quality, identification, and timely completion of actions through established learning channels.



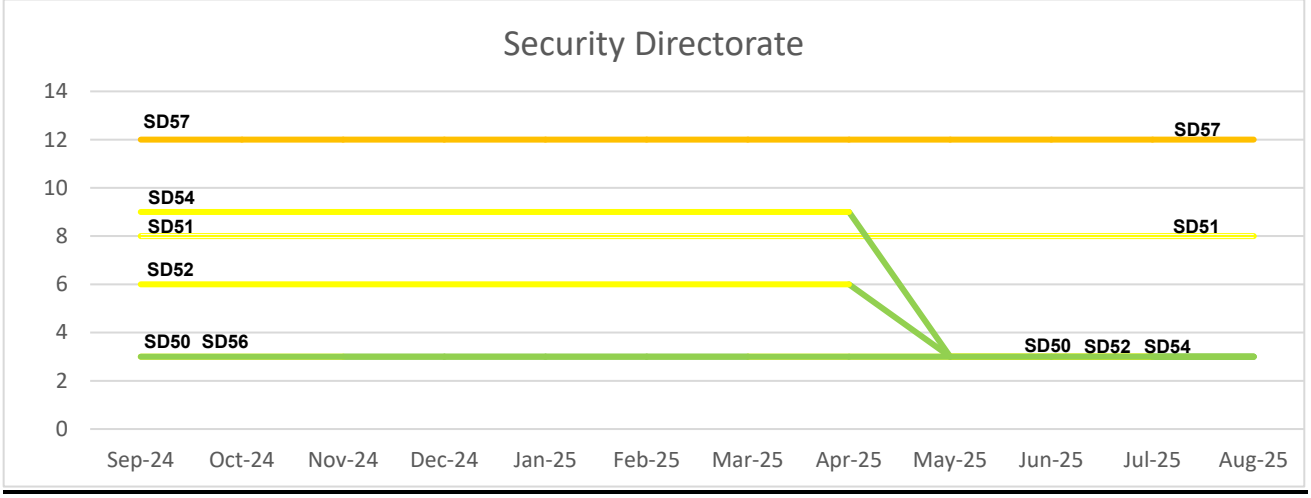
Medical

MD36: Impact on the Female Service patients if the long-term model is not implemented has been added to the Corporate Risk Register; see Appendix 2 for details.



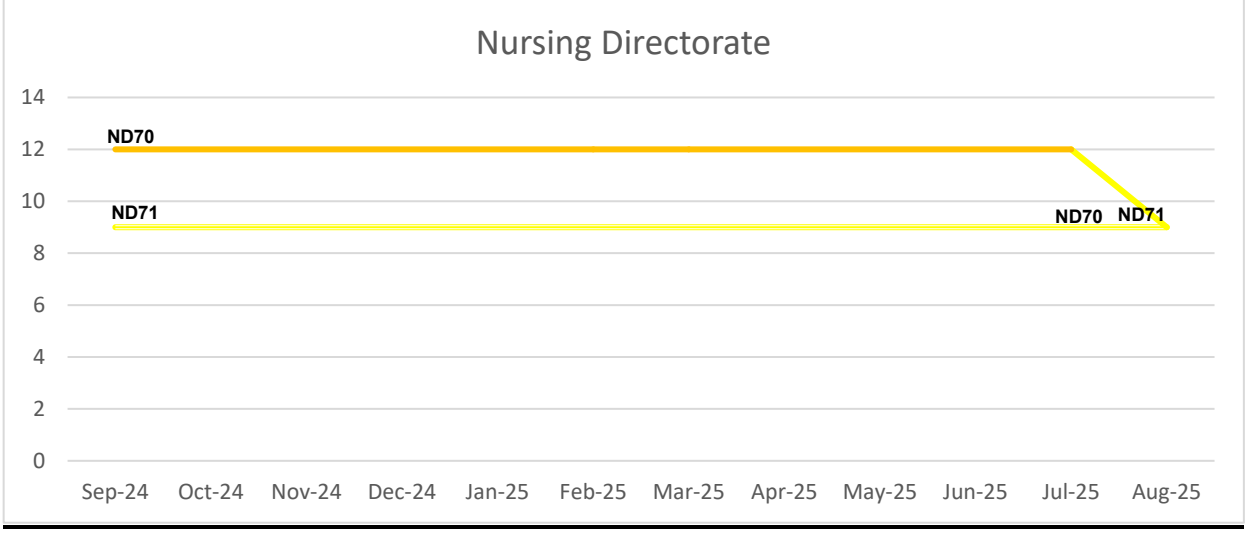
Security

No changes or updates for this directorate.



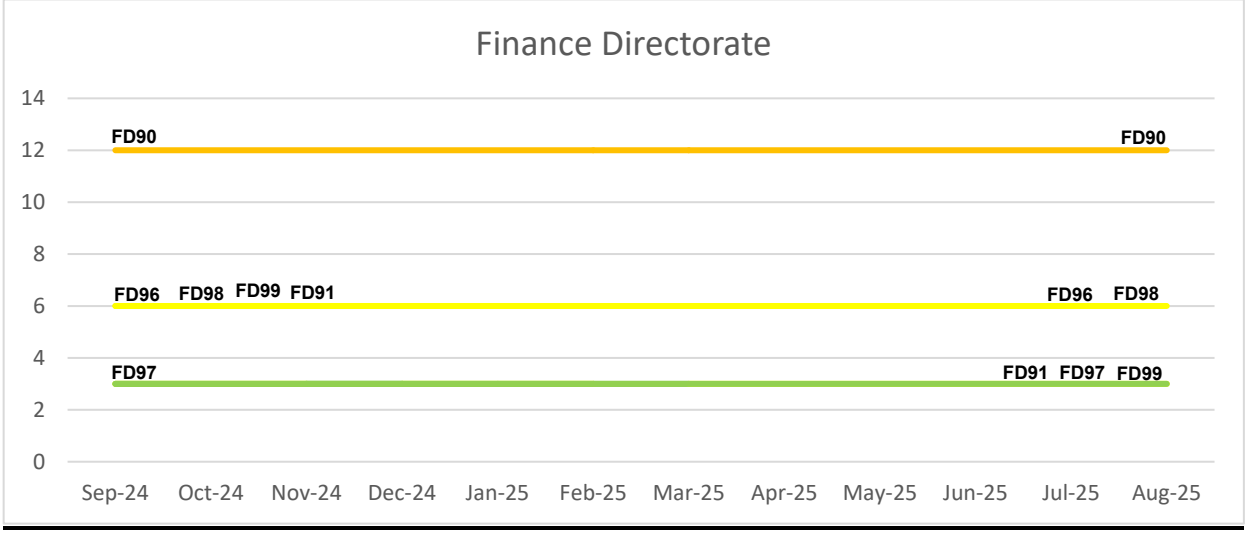
Nursing

ND70: Failure to effectively utilise available resources to optimise patient care and experience. The risk assessment has been reviewed, and the rating is now classified as Moderate x Possible (Medium), lowered from the previous High grading. Additional KPIs have been incorporated, demonstrating enhancements in the utilisation of patient resources and positive impacts on outcomes.



Finance

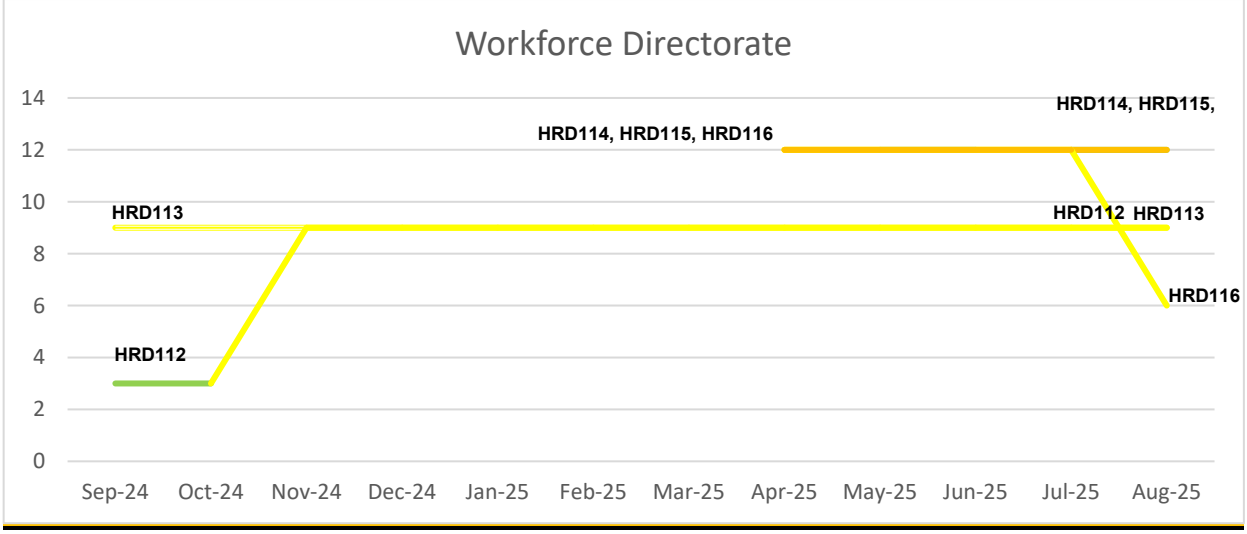
No changes or updates for this directorate.



Workforce

HR113 Job Evaluation is now on the local risk register. There are no current delays at TSH; jobs are reviewed promptly with sufficient staff for matching and quality checks. If circumstances change, the risk will be reconsidered for the Corporate Risk Register.

HRD116 PVG Checks has been reduced from 'High' to 'Medium' and is now at target level of Moderate x Unlikely. This will be monitored for 3 months following the successful rollout of the PVG scheme within TSH.



3.4 Update on Proposed Risks for inclusion on Corporate Risk Register

Since the June Board, MD36: Impact on the Female Service patients if the long-term model is not implemented has been added to the CRR, full details of risk assessment available in Appendix 2.

No additional risks have been proposed for addition to the CRR since the last report.

3.5 High and Very High Updates

The State Hospital currently has 5 'High' graded risks, updates on the progress to reduce from High and Very High below:

Medical Director: MD30- Failure to prevent/mitigate obesity.
The risk has been reviewed with the Lead Dietitian, Clinical Quality Facilitator, Medical Director, and SHC group. Meetings on 10 June 2025 and 29 July 2025 discussed future monitoring methods, including SHC's new two-factor approach. Progress and challenges were presented at CMT, but further discussion is needed to finalise the proposed KPI. The Medical Director has requested another meeting for a resolution.

Security Director SD57- Failure to complete Category 1 and 2 Reviews on Time

Risk SD57 was raised to **'High'** in October 2024 due to concerns that adverse event reviews and actions may not be completed on time amid team pressures. To address this, the Corporate Management Team established the Serious Adverse Event Review (SAER) Group. The group met in July 2025 and will meet on a monthly basis for oversight and management of process. Baseline data on investigation timelines has been set to assess improvement. No reviews have been commissioned yet, but data will be monitored as it becomes available.

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

Risk FD90 has been updated to acknowledge ongoing national financial pressures and projected budget constraints communicated by the Scottish Government for 2024/2025. The risk rating stays at **'High'**.

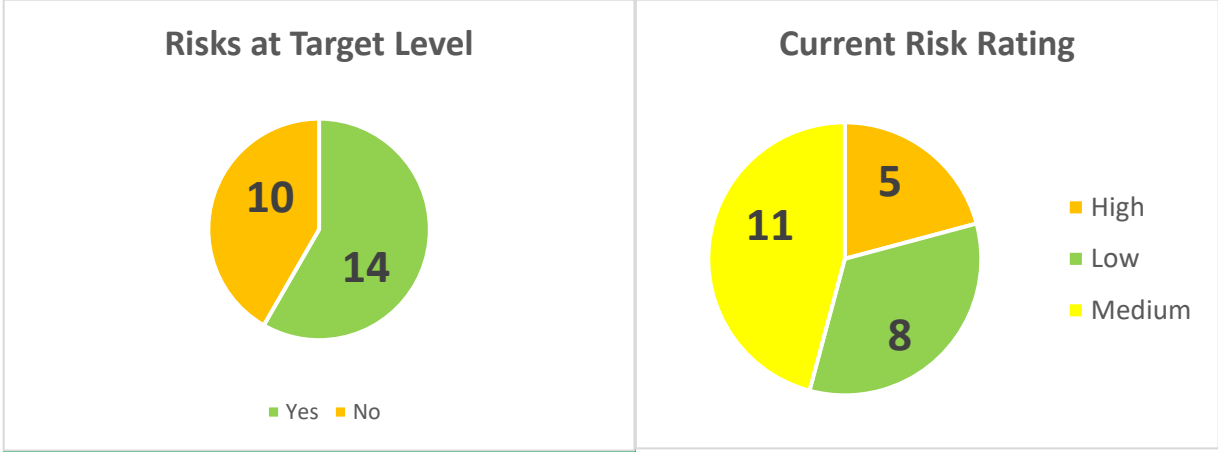
Workforce Director: HRD114 – Reduction in Hours

HRD114 remains graded at High. Work is ongoing with each department to implement the reduced working week from April 1st, 2026. Reduced Working Week (RWW) Subgroup has been set up to ensure progress is made. NHS Boards should have full and final implementation in place by 1st October 2025.

Workforce Director: HRD115 – Sickness Absence

HRD115 remains at High. Progress on absence is positive and showing significant improvement since December 24. Absence figures still remain above the 5% target.

3.7 Risk Distribution



Currently 14 Corporate Risks have achieved their target grading, with 10 currently not at target level.

As stated in the TSH Risk Management Strategy, **low and medium risks are deemed tolerable** within the organisation's established risk appetite. Although certain corporate risks have yet to meet their target thresholds, they continue to fall within the approved risk parameters. The Risk Manager is actively pursuing further reduction of these risks through ongoing assessments and timely updates to maintain effective risk management practices.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			SD57	MD30, HRD114, HRD115,	
Possible	FD91		ND71, HRD112, ND70, MD36	FD90, HRD116	
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)

3.8 CRR Development

The Risk Management Team is actively refining the risk management process and regularly updating the Corporate Risk Register with input from all service directors.

InPhase has been purchased to replace the Datix Incident Management System and will be gradually implemented, with full rollout expected by March 2026. InPhase will manage all risks moving forward. The project was approved in June 2025, the Project Initiation Document (PID) was completed in August 2025, and system training has begun under the oversight of the Project Oversight Board.

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 / ADP /	Monitoring of all Corporate Risks aligned to the organisation
Corporate Objectives Please note which objective is linked to this paper	**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 is no workforce implications related to the publication of this report.
Financial Implications	There are no financial implications related to the publication of this report.
Route to Board Which groups were involved in contributing to the paper and recommendations.	CMT
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).	N/A
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	**1** There are no privacy implications.

High Risks – Reviewed Monthly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	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	Sept 25	Clinical Governance Committee	Not at Target	-
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	Sept 25	Finance and Performance Group	Not at Target	-
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	Sept 25	Security, Risk and Resilience Oversight Group	Not at Target	-
Workforce HRD114	Workforce	Impact of reduced working week	Major X Possible	Major x Possble	Moderate x Unlikely	Director of Workforce	Head of HR	Sept 25	Workforce Governance Group	Not at Target	-
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	Sept 25	Workforce Governance Group	Not at Target	-

Medium Risks – Review Quarterly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	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	At Target	-
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	At Target	-
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	At Target	-
Corporate MD36	Medical	Impact on patients within Female Service if long term model is not fully implemented	Major x Likely	Moderate x Possible	Minor x Rare	Medical Director	Lead RMO – Female Service	Nov 25	Clinical Governance Committee	Not at Target	NEW

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	Not at Target	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Major x Likely	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Nov 25	Clinical Governance Committee	Not at Target	↓
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	Not at Target	-
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	At Target	-
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	At Target	-
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	Not at Target	-
Workforc eHRD116	Workforce	Delay in completion of PVG checks from Disclosure Scotland	Major X Possible	Moderate Unlikely	Moderate x Unlikely	Director of Workforce	Head of HR	Sept 25	Workforce Governance Group	At Target	-

Low Risks – Reviewed 6 Monthly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	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	At Target	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident or Breach	Extreme x Likely	Moderate x Rare	Moderate x Rare	Security Director	Security Director	Feb 25	Security, Risk and Resilience Oversight Group	At Target	-
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	At Target	-

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	At Target	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Feb 25	Security, Risk and Resilience Oversight Group	At Target	-
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	At Target	-
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	Feb 25	Information Governance Committee	At Target	-
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	At Target	-

Appendix 2

Impact on patients within Female Service if long term model is not fully implemented. Ref: MD36

Corporate Objective	Better Care	**Risk Owner**	Medical Director	**Action Officer**	Sheila Howitt

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
There is a risk that TSH will be unable to deliver the full spectrum of care required to achieve the organisation's corporate objectives if the long-term female service plan is not fully implemented.	

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
- There is a risk of sub-optimal care within the female service, as the interim model provides a temporary solution to accommodate female patients until a long-term model is implemented. The current interim service lacks the full range of necessary facilities that would be provided to support the clinical model for Women. The long-term model will incorporate all necessary therapeutic interventions and will be designed as a bespoke service tailored to the specific needs of the patient cohort.. - The Scottish Government may withdraw funding, potentially leaving TSH with an interim service that would need to be financed internally. - There is a risk of reputational damage if the service fails to meet corporate objectives and deliver optimal patient care. - Impact on male service, specifically changes in access to the Skye Centre - Risk that submission for project to Scottish Government is not completed within timescales.		
Individuals or group exposed	Patients, Carers, Staff	Highlight those who would be affected by risk

Benefits	

Effectively managing this risk will support TSH in progressing toward a comprehensive service for the Female Patient Cohort that aligns with user needs and expectations.	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)

Existing Control Measures	List any existing measures in place to mitigate this risk.
• Womens Project Oversight board established to oversee Phase 2 development • Regular reporting to TSH Board • Ongoing stakeholder engagement via established communications Plan • Formal engagement with the Forensic Network and detailed updates to the women's forensic Network Planning group • Established Plan in conjunction with NHS Assure and SG Capital Investment group.	

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	Minor	Rare	Low
Current Risk Rating	Moderate	Possible	Medium

Further Control Measures Required	Include any additional controls identified to
Risk will continue to be monitored and updated as data becomes available alongside any relevant control measures that are identified.	

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
Datix, activity data, financial data etc will be used to monitor the risk as data becomes available.	

Date Added	01/07/2025
Completed by	David Walker, Lindsay Thomson and Stewart Dick
Date Reviewed	01/07/2025
Next Review	01/10/2025

Risk Register	Corporate Risk Register
Directorate	Medical
Group/Committee Monitoring Risk	Clinical Governance Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	28 August 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 July 2025
Purpose of Report:	For Noting

1 SITUATION

This report provides information on the financial performance to 31 July 2025 (month 4), 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 has been submitted to SG, approved and signed off, with a projected breakeven forecast. Regular meetings between TSH and SG monitor progress against targets – the latest being 15 August 2025 from which no significant issues nor concerns were raised.

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 – now being anticipated to complete in the second quarter of 2025.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The current budget comprises of The Scottish Government Revenue Resource Limit core and non-core allocation of £54.293m, in addition £1,246m has been assumed in the budget for capital charges re the enhanced security project.

The State Hospital Annual Budget	£'000
Total Budget	55,539

The year-to-date position is £329k underspent, driven principally by the high level of vacancies across the hospital. Previously the overspend in nursing resulting from the cost of overtime would have offset this underspend and masked the vacancy underspend – however due to the significant decrease in nursing overtime currently being used, we are starting to see this underspend emerge.

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. Additionally, a further £220k has now been indicated for allocation specifically to address LED lighting upgrades – subject to tendering and timeframes being able to be agreed.

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	1,492	1,490	2	0.00		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	1,892	0	0	0	0.00	0.00	RRL phased to period 12 and released as required, additional RRL will be added as further allocations are agreed.
Chief Exec	2,788	940	898	41	27.07	24.98	Vacancies within departments are resulting in a small underspend. Social work budget has been uplifted to reflect the current SLA.
Finance	2,817	978	965	13	33.18	32.13	E-Health strategic RRL funding has not be uplifted in line with pay awards over the last few years, which is creating an underlying pressure. Costs for M365 are currently remaining as a pressure, the annual cost is anticipated to be £180k, it is anticipated that reserves funding will be available to fund in 2025/26. These pressures are offset with staffing vacancies.
Human Resources Directorate	1,240	414	403	12	16.03	15.24	Underspend in training and vacancies across the directorate
Medical	3,830	1,346	1,283	63	20.66	20.95	Pharmacy budget has been uplifted to reflect the current SLA prices. The consultant vacancy has been recruited to and will start in post soon. Additional EPAs have started to cover long term sick leave.
Misc Income	(120)	(54)	(85)	32	0.00		Income benefit from current ECP patient. The final invoice has now been raised with no further benefit anticipated.
Nursing And Ahp's	29,308	9,460	9,472	(12)	435.69	430.20	see below for detailed narrative from nursing directorate
Security And Facilities	9,308	3,104	2,925	179	124.29	114.99	Vacancies across the directorate are contributing to underspend, utilities pressures have been funded from reserves
	55,539	**17,681**	**17,351**	**329**	**656.92**	**638.49**	

Nursing & AHPs (as provided from Nursing Directorate)

As with previous reports, the main contributors to nursing overtime at The State Hospital continue to be increases to the daily operating model because of clinical acuity (including outboarding patients at partnering territorial Boards), vacancies and sickness absence.

As noted in last month's update, pro-active recruiting campaigns to manage the Band 5 vacancy gap continue with the most recent round of interviews taking place in June 2025. These interviews resulted in seventeen individuals being offered Band 5 posts on completion of their nurse training in September, or earlier if individuals circumstance permit (subject to all necessary checks being completed). Work is now underway to start our next round of recruitment campaigns.

As also detailed in previous reports a recruitment event was held in March 2025 with a particular focus on recruitment to the interim women's service at the hospital. Whilst this event did prove successful for the recruitment of Healthcare Support Workers, we did not achieve our desired compliment of Band 5 nurses, meaning we will utilise staff from already existing services to support the opening of the female ward, which is now scheduled for the second week in August 2025.

The State Hospital's Board have been cited on the expected nursing deficits between August and September when our next round of onboarding will take place, and work remains ongoing to balance deficits across the site with daily reporting to Board Directors.

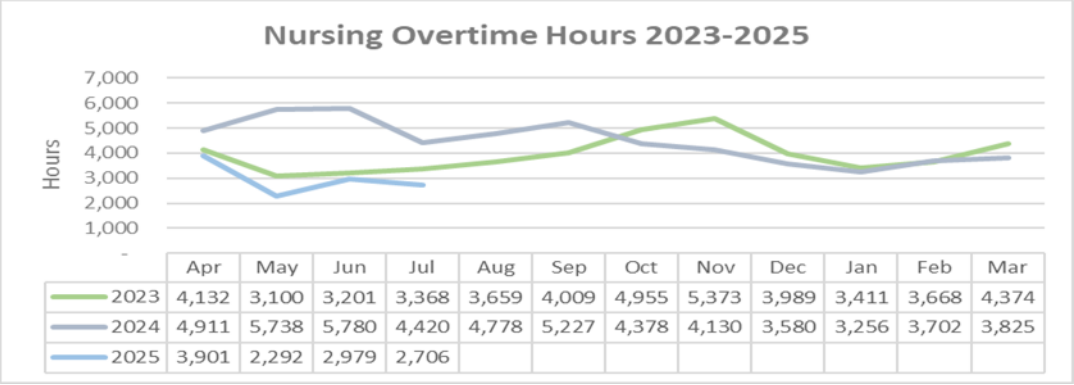
Robust attendance management processes and regular reviews of employee relation cases remain in place as do the monthly finance meetings with Senior Charge Nurse (SCN). These meetings enable supportive discussions with around effective roster management, effective use of allocated funding, and robust oversight of non-pay related spending. This co-ordinated approach to staff and finance management is demonstrating positive effects.

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023	4,132	3,100	3,201	3,368	3,659	4,009	4,955	5,373	3,989	3,411	3,668	4,374
2024	4,911	5,738	5,780	4,420	4,778	5,227	4,378	4,130	3,580	3,256	3,702	3,825
2025	3,901	2,292	2,979	2,706								

- Nursing overtime has reduced significantly during the last three months in comparison to previous years. This is resulting from reduced overtime being utilised following the closure of the additional ward and the recruitment into additional unregistered nurses to reduce the level of overtime required. The year-to-date pressure is mainly a result of the high level of overspend in M1.

M365

- M365 is unfunded and remains as a current pressure.

Energy and Inflation Increases

- A reduction in utilities spend is anticipated compared to last year's, despite the reduction the anticipated spend will remain approximately £200k above the budget allocated for utilities. This gap has been funded from non-recurring reserves in 2025-26

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.

Women's Services

- An allocation of £3.1m has been received from The Scottish Government to fund the costs anticipated for this service. The costs are recorded, and will require to be closely monitored and reported to the oversight board, and to SG.

Benefits:

ECP Patient Income

- There is a year-to-date benefit of £63k as a result of the income achieved from the exceptional circumstances patient from NHS Fife. The patient has now been discharged, and no further income benefit is anticipated at this point from this source.

Travel & Training

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

Vacancies

- The current underspend in the position is driven by the high level of vacancies across the hospital. Although the level of vacancies has not significantly changed the reduced cost in overtime has resulted in this benefit emerging.

4 ASSESSMENT – SAVINGS

Savings targets of £1,780k have been identified, with further work to be done to meet the current gap in savings. Savings are 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	23	17	(6)
Finance	78	26	30	4
Human Resources Directorate	37	12	11	(1)
Medical	113	38	34	(4)
Nursing And Ahp's	822	274	249	(25)
Security And Facilities	660	220	252	32
	1,780	**593**	**593**	**0**

It should be noted that of the Hospital's budget only 86% of costs are pay related this makes it difficult to achieve recurring savings whilst ensuring a safe environment for staff and patients.

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.

As noted in 3.2, 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 added allocation of £220k re LED lighting upgrading will be confirmed once the timing and tendering of this work has been addressed, now being underway.

The Enhanced Security Project has been capitalised it is anticipated to be fully completed in Q2 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 continue to be the highest risk factors this financial year.

Capital
Capital projects and plans are agreed and monitored through the Capital Group, and the budget is expected to 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 Board
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:	28 August 2025
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Head of Clinical Quality Corporate Planning, Performance and Quality 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 to embed quality assurance and improvement as part of how care and services are planned and delivered

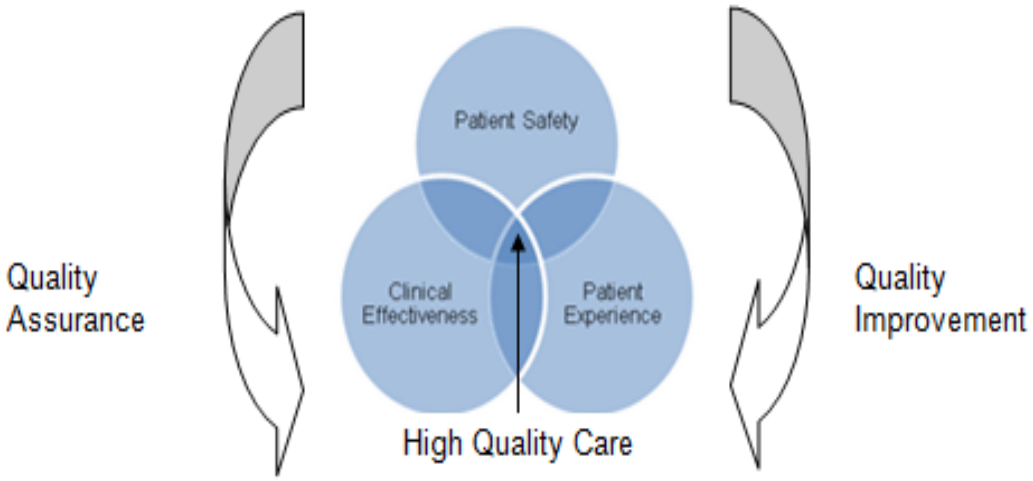
2 BACKGROUND

Quality assurance and improvement in the State Hospital links to the Clinical Quality Strategy 2024 – 2029. This strategy was presented to the State Hospital Board in August 2024 and adopted as the State Hospital 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.

The State Hospital 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 eight clinical audits:
  - ❖ Epilepsy Audit
  - ❖ Lithium Audit
  - ❖ Medication Trolley Audit
  - ❖ Medicine Fridge Audit
  - ❖ Oxygen cylinder Audit
  - ❖ RMO Contact with Patients
  - ❖ Nursing Progress Notes
  - ❖ Unvalidated Progress Notes

- An update on the work of the Quality Improvement Forum including current training and progress of the QI initiative 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 the State Hospital .

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

1. ASSURANCE OF QUALITY

1.1 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 eight audits completed and actioned through the Commissioning Group:

- Epilepsy Audit
- Lithium Audit
- Medication Trolley Audit
- Medicine Fridge Audit
- Oxygen cylinder Audit
- RMO Contact with Patients
- Nursing Progress Notes
- Unvalidated Progress Notes

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 (at least once per month)										
Controlled Drugs Audit to ensure practice meets legal requirements		n/a			n/a	n/a				
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		
Oxygen Cylinder Checklist to ensure oxygen cylinders are fit for purpose to use and checked weekly										

Epilepsy Audit

The aim of this audit was to provide assurance to the PHSG that The State Hospital practice for patients with a diagnosis of epilepsy is compliant with national SIGN guidelines. This is the first time this audit has been completed within the State Hospital. Although the audit showed very good compliance for a first cycle audit, there were areas for improvement including the completion of

sudden unexpected death in epilepsy (SUDEP) risk assessments, ensuring escalation plans are held within the emergency care plan section of RiO and the completion of individualised epilepsy care plans. These actions are being taken forward by the Physical Health Steering Group who commissioned the audit.

Lithium Audit
This audit measures adherence with the Lithium Monitoring Standards. While there was very good adherence to these standards overall, there had been delays with some of the monitoring due to a member of staff being absent from the Health Centre. An action will be taken forward by the Medicines Committee who commissioned this audit to build some additional resilience into this process. There was excellent compliance for patients at the initiation stage with all baseline monitoring meeting the standards.

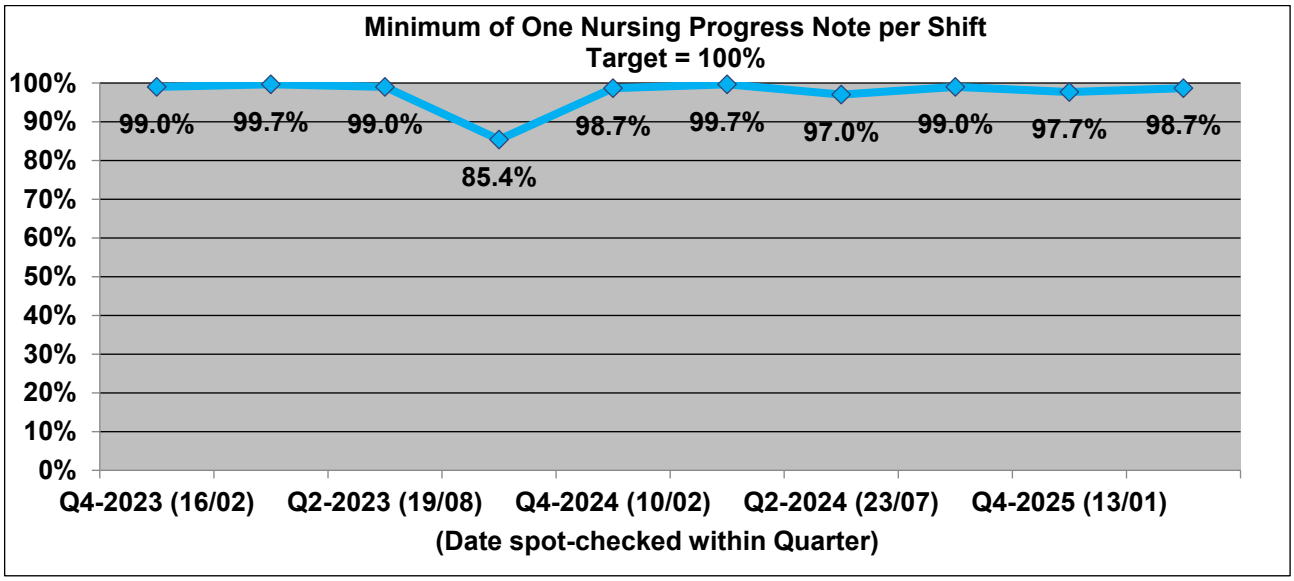
Medication Trolley Audit
This audit measures adhered with the Patient Safety standards for medication trolleys. Very good compliance was found across the hospital, but there was an issue with some wards not using the HEPMA checklists and concerns raised that staff were signing the medication trolley check form to say they had checked the trolley before they had done the medication round. The trolley check is to ensure that the trolley adheres to the standards at the end of the medication round before it is handed over to the next medication nurse. Practice Development have agreed to take forward this action through the Medicines Committee.

Medicine Fridge Audit
Due to the importance of some medications being kept at the correct temperature within fridges, a Refrigerator Temperature Monitoring Log was introduced to all wards. This audit ensure that staff are completing these checks and raising any issue to Estates in a timely manner. Although the audit showed slightly less compliance that last year, there was still very good compliance across the hospital.

Oxygen Cylinder Audit
A State Hospital Oxygen Cylinder ward check form was implemented in 2024 to ensure that the correct checks were being carried out regularly on the oxygen cylinders within the wards so they would be fit for purpose when required by any patients. Excellent compliance was noted with this audit, with only one ward within the hospital not using the form. This has been fed back to the relevant ward.

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 very good assurance that this standard is being met. There were only 2 patients where it was 7 weeks between seeing their RMO. There were a further 4 patients that had not been seen in July, but this was due to a medical member of staff unexpectedly going off on long term sick leave and their caseload being transferred to another RMO. All these patients were seen at the start of August.

Minimum of One Nursing Progress Note per Shift
The audit gives assurance that we are meeting the above standard. This audit showed excellent compliance against the standard.



Unvalidated Progress Notes

Although there was a slight increase from 52 to 80 unvalidated notes across the month of May. This remains below 1% of the overall notes that have been entered during May.

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

The quarterly variance analysis data (covering April – June 2025) showed that MDT attendance had decreased within the Admission & Assessment, Lewis Treatment & Recovery and ID Services, whilst it increased within Arran Treatment & Recovery and Transition Services. Although some services had experienced decreases in overall MDT attendance, Medical, Psychology, Social Work, Dietetics and Pharmacy met their attendance targets.

NHS SCOTLAND

HOSPITAL WIDE VARIANCE ANALYSIS FLASH REPORT

Date: Apr-June 25

Overview and areas of good practice

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

The quarterly VAT report is split as follows:

Apr-June	Annual	Intermediate	Total	VAT completion	MDT attendance
Admission	0	4	4	100%	64% - decreased from 77% in previous quarter
Arran T & R	5	3	8	99.5%	74% - increased from 72% in previous quarter
Lewis T & R	6	6	12	98.8%	69% - decreased from 71% in previous quarter
ID	3	3	6	99.2%	71% - decreased from 74% in previous quarter
Transition	6	5	11	97.6%	65% - increased from 59% in previous quarter
Total	20	21	41	98.8%	69% - decreased from 70% in previous quarter

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

All interventions continue to show random variation

- Overall MDT attendance: 68.5%
- Overall completion rate: 98.8%
- All disciplines (except Medical at 94%) achieved or exceeded 95% completion.
- Highest attendance: RMO (85%), Psychology (88%), Social Work (93%)
- Lowest attendance: Security (39%), Dietetics (60%)
- Patient attendance: 78%
- Carer attendance: 42%
- LDP targets – Medical, Psychology, Social Work, Dietetics and Pharmacy met their LDP attendance targets

Areas of concern

- **LDP Targets**: Security, Occupational Therapy and Nursing did not meet their LDP attendance targets

Any challenges with the systems that are being addressed

Work continues with e-health to pull to data direct from RiO – testing will continue in July and August. In the meantime, it is important that professions continue to complete the VAT data as normal

2. QUALITY IMPROVEMENT

2.1 QI Forum

The QI Forum continues to meet on a six week basis focusing on its purpose to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches.

2.2 TSH3030

The QI Forum supported the QI initiative TSH3030 offering teams the opportunity to take forward a QI project for 30 minutes a day for 30 days. This ran from 1 to 30 May 2025. Twenty one teams from across TSH registered to take forward projects, with 16 submitted final posters. A total of 75 staff and 13 patients completed their TSH3030 QI projects 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)

Awards ceremonies took place on the 24 June 2025 to celebrate and recognise the improvements that teams achieved. These events were well attended by staff and patients. The final posters have been made available on the State Hospital intranet site and have been displayed in the staff canteen, Wellbeing centre and in the QI & RM noticeboard at reception. The QI Forum and support from Clinical Quality Officer are developing a case study book of all the posters with statements from each team on what 'worked well' and 'even better if' reflections.

The QI Forum are exploring the continuation of some of the projects and supporting teams on their QI journey to sustain and spread the projects following the success of TSH3030. Nine of the final 16 teams have expressed an intention to continue with their projects following the completion of the initial TSH3030 period.

The PPG are exploring how QI tools can be utilised to support the continuation of Project Pass It On. A member of the QI Forum attended the PPG on the 31 July 2025 to discussion this further, with a PPG creative session being arranged for the end of August to explore ways of developing a structured process for sharing key updates and feedback from the weekly Patient Partnership Group.

QI Forum will seek opportunities to share the learning from the 2025 cycle of TSH3030 more widely, including opportunities to present the initiative in poster format at appropriate conferences.

2.3 QI Capacity Building

2.3.1 - ScIL

Training is ongoing with four staff participating in total; two members of staff concluded the programme in June 2026 with their final assessments currently being reviewed. Two members of staff are currently undertaking the project stage of the programme with a project on demonstrating patient involvement by the use of BRAN questions, evidenced within the care plan review section and the other project is still being scoped for commencing in October 2025.

Recruitment for the next cohort of ScIL 53 has commenced and will close in August 2025. This has been advertised through the staff intranet site and members of the QI Forum.

2.3.2 -QI Essential Training

Cohort 4 has been scheduled between August and September 2025 with nine staff expressing an interest.

Cohort 5 has been scheduled between December 2025 and January 2026, and this will be advertised throughout the months of October and November 2025.

2.4 Realistic Medicine

There has been a slight delay in the introduction of Team Based Quality Review (TBQR) due to sickness, leave and demanding priorities. A mock TBQR Panel has been arranged through the admissions service in August 2025 to review the process requirements. The recommendations from this will be submitted to the Learning into Practice Group in October 2025 with the intention of scaling up and embedding into the other service leadership groups.

3. EVIDENCE FOR QUALITY

3.1 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 June to 31 July 2025, 31 guidance documents have been reviewed. There were 26 documents which were considered either not relevant to TSH or were overridden by Scottish guidance and 4 documents which were circulated for information and awareness. The final guidance from HIS regarding clinical governance standards requires further work done which the Head of Clinical Quality is taking forward.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required
HIS	3	2	1
MWC	1	1	0
National Institute for Health & Care Excellence (NICE)	27	1	0

There are currently seven 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 was 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 to the Chair separately to progress. The Physiotherapist on SLA to TSH has also received the documentation to review. Both Asthma guidelines have been reviewed with their evaluation matrices completed and undergoing final review before presentation to PSHG for sign off. The 3 remaining guidelines all have evaluation matrix reviews underway with varying degrees of progress.

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 in draft and currently under review.	September 2024	December 2025

Body	Title	Allocated Steering Group	Current Situation	Publication Date	Projected Completion Date
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 CQ Facilitator to meet with Chair to progress action points. Documents sent to Physiotherapist for contribution.	November 2024	December 2025
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. Draft version completed and currently awaiting checking by GP. Anticipated to be table at PHSG in September for final sign off.	November 2024	September 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. Draft version now completed and currently awaiting checking by GP. Anticipated to be tabled at PHSG in September for final sign off.	November 2024	September 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 experiencing difficulty re identifying possible dates for attendance. Relevant disciplines contacted for written feedback re content of evaluation matrix initially. Chair of PHSG advised to be taken forward by SHC. Date to be agreed for SHC group to review.	January 2025	December 2025
NICE	Gambling-related harms: Identification, assessment and management	MHPSG	Evaluation matrix with Psychology for completion. Progress delayed due to reviewer's involvement with creation of female service.	January 2025	October 2025
SIGN	Prevention and remission of type 2 diabetes	PHSG	Evaluation matrix with Psychology for completion. Anticipated to be tabled at PHSG in August for final sign off.	March 2025	August 2025

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE **CGC(M)25/02**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 08 May 2025.

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

Chair:	
Non-Executive Director	David McConnell
Present:	
Board Chair	Brian Moore
Non-Executive Director	Shalinay Raghavan
In Attendance:	
Health Psychologist	Alison Eadie [for 5a]
Head of Psychology	Dr Liz Flynn
Acting Director of Estates and Resilience	Allan Hardy
Consultant Forensic Psychiatrist	Dr Khuram Khan
Senior Nurse for Infection Control	Jonathan Lee [Item 12]
Director of Nursing and Operations	Karen McCaffrey
Clinical Pharmacist	Lewis McKeown [for Item 9]
Director of Finance & eHealth	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Consultant Forensic Psychiatrist	Dr Stuart Semple [for Item 7]
Head of Corporate Governance	Margaret Smith
Medical Director	Professor Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting and noted apologies from Ms Fallon and Mr Currie, Non-Executive Directors. It was noted that Ms Raghavan, would join the meeting shortly. To ensure that the meeting was quorate, Mr Moore was co-opted as a member on this occasion.

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 13 February 2025.

Mr Moore noted that there had been discussion on refreshing the Psychological Therapies 12 Month Report and the Activity Oversight Group Report in terms of content, and that this should also be noted so that the action could be taken forward.

Action: Secretariat

The Committee:

1. Approved the minute of the meeting held on 13 February 2025.
2. Amendment noted on refresh on reporting as discussed.

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 1 – University of Edinburgh – Research Funding:
Professor Thomson noted that two invoices had been received but had been mislabelled so could not be accepted. Attempts were being made to resolve this.

Action 7 - Incidents and Patient Restrictions Reporting:
Professor Thomson noted recent discussion at the Board Development Day, and that this would continue to be progressed.

Action 9 – Areas of Good Practice/Concern:
Professor Thomson noted that the action point should be amended to reflect that the review was looking into the spike in use of the soft restraint kit and should not include the use of as-required medication. This review was underway, and an update would return in this respect.

Action 10 - Areas of Good Practice/Concern, Learning from Incidents and the use of CCTV.
Professor Thomson advised that this work was progressing in terms of how CCTV could be used for review of practice, as well as being discussed with partnership colleagues. Professor Thomson noted that the use of CCTV for learning and sharing of good practice was a positive development, highlighting the need for staff to have a clear understanding of what this is being used for. Mr Jenkins concurred with the points raised by Professor Thomson reiterating the need to take this forward in partnership. Ms McCaffrey highlighted that the other High Secure Hospitals in England utilised CCTV to learn from any incidents. Ms McCaffrey thought that once agreement on usage is reached and communicated effectively that staff will be able to see benefits in this practice.

It was highlighted that all other actions are either complete or on today's meeting agenda for discussion.

The Committee:

1. Noted the updates from the Rolling Action List.

5 SUPPORTING HEALTHY CHOICES 6 MONTH REPORT

a) 6 MONTH REPORT
b) APPENDIX 1 SUPPORTING HEALTHY CHOICES ACTIONS

The Committee received the Supporting Healthy Choices 6 Month Report presented by Ms Eadie, who summarised the four aims that the Supporting Healthy Choices Group have been focusing on over the last six months.

Ms Eadie set out the group's aims for the next six months, noting that the group had already made good progress on their 12-month aims with 21 completed action points and 12 still in progress out of the agreed 33 action points.

Mr Jenkins expressed support for the Supporting Healthy Choices Group and thanked them for work undertaken so far and highlighted that the approach of looking at targeted and focused areas would give longer terms outcomes and benefits.

Mr Moore thanked Ms Eadie for the report and overview provided and asked for further update on the ongoing work with Aston University. Mr Moore also asked if the work and learning of the group so far would influence the review of the Key Performance Indicator in relation to patient BMI.

Ms Eadie replied that the group had looked at various options and was currently exploring the alternative options to solely using BMI as a measurement, however she noted that some more discussions and learning around this would be required. Ms Merson added that any findings would be brought back to the Committee. Mr Jenkins added that any changes would not be identified or put in place immediately, but that an update should be available within the 6 monthly report.

In relation to the work with Aston University, Ms Eadie informed members that an in-person development day had taken place in March 2025 with learning and proposals already underway from this. A key learning point from this day was a proposal that had been submitted to the Medicines Committee in respect to the use of Metformin. Ms Eadie also highlighted that the collaboration with Aston University could provide support in terms of literature reviews and method support as the programme developed, as well as help on how to evaluate any new pathway.

Professor Thomson commended the work undertaken by the Supporting Healthy Choices Group and noted the progress of the 33 action points that had been identified. She highlighted that two upcoming TSH3030 projects had direct links to the action points, one being hospital shop pricing and the other related to anti-obesity drugs. Professor Thomson also noted that at the next meeting there would be a review on reporting requirements.

Mr McConnell thanked Ms Eadie for the report, overview and updates provided and also noted thanks to the wider Supporting Healthy Choices Group.

The Committee:

1. Noted the Supporting Healthy Choices 6 Month Report.
2. Noted Appendix 1 Supporting Healthy Choices Actions.

6 PHYSICAL HEALTH: SUPPORTING HEALTHY CHOICES AUDIT

Professor Thomson provided an overview of the Physical Health: Supporting Healthy Choices Audit and highlighted that a rating of reasonable assurance had been achieved. She noted that the auditors had suggested minor changes, which had been progressed and the action in relation to the Physical Health Strategy was being taken forward.

Mr McConnell thanked Professor Thomson for the overview.

The Committee:

1. Noted the Physical Health: Supporting Healthy Choices Audit

7 DISCUSSION ITEM: UNSCHEDULED CARE

Dr Stuart Semple joined the meeting for this item. He noted that this report had been requested following an audit conducted in 2023 on unscheduled care whereby some areas of improvement had been noted. Dr Semple provided an overview of the members who contributed this report and highlighted the areas on which the report focused, providing background and context for each area.

Mr McConnell thanked Dr Semple and the group for the report and commented that this was an important piece of work for patient healthcare and operationally for the State Hospital (TSH).

Ms Raghavan noted the importance of the report and asked how the monitoring and evaluation of suggestions and changes noted in the report would take place. Dr Semple replied that there was a summary table of all recommendations which was currently being worked through, and that an update would be provided in due course.

Mr Moore welcomed the report and recommendations and highlighted that during a recent visit to the NHS Lanarkshire Flow Navigation Centre it was apparent that there was a major initiative underway to redesign procedures for unscheduled care. Mr Moore also noted the high cost of a patient boarding out and the benefit to the organisation if this was available to be spent elsewhere. He highlighted that as the initiative around unscheduled care developed and evolved, there would be a need for TSH to continue to explore all possibilities in this respect. Dr Semple agreed with the points raised by Mr Moore and noted a recent case where a patient boarding out waiting on treatment could have potentially been treated at TSH if the virtual bed system had been in place. He also noted that this system could potentially be piloted.

Mr Jenkins thanked Dr Semple and the group for the work undertaken and for the informative report. Mr Jenkins noted his support for the recommendations and the need for continuous development to ensure that TSH was at the forefront in using the latest approaches to provide the most appropriate service in the most appropriate place.

Professor Thomson highlighted the governance pathway of this report, which had been presented to the Corporate Management Team with an update due in August. She asked members if they would be happy for this body of work to be incorporated into the Physical Health Steering Group Annual Report or was the preference for a separate report in this regard. Mr Jenkins noted his preference to keep this disaggregated from the Physical Health Steering Group for at least the next 6 to 12 months, to ensure it was being afforded the due diligence it deserved, given the wider range of work that the Physical Health Steering Group was working on. Mr Moore concurred with Mr Jenkins and expressed his preference for this to be presented as a progress report.

Mr McConnell agreed that this should be a specific update report going forward, with the view to receiving a six-monthly report at the November meeting. Professor Thomson agreed and noted that an update report would be presented at the November Clinical Governance Committee meeting, at which point it could be ascertained whether to incorporate it into the Physical Health Steering Group report or to keep as a stand-alone report.

Action – Professor Thomson/ Secretariat

The Committee:

1. Discussed and noted the content of the presentation.
2. Requested an update Report to return in the November meeting.

8 CLINICAL GOVERNANCE COMMITTEE

a) ANNUAL REPORT 2024/25
b) TERMS OF REFERENCE

The Committee received the Clinical Governance Committee Annual Report 2024/25 presented by Ms Sheila Smith, who indicated that the content of the report had been streamlined to provide a more focused overview of the recommendations of the Committee. This also included the terms of reference of the Committee.

Professor Thomson thanked the Clinical Quality Department for the work carried out which was demonstrated within the report and noted the volume of work progressed in the background.

Mr McConnell noted members agreement to approve the Annual Report and Terms of Reference.

The Committee:

1. Endorsed the Clinical Governance Annual Report 2024/25.
2. Endorsed the Committee Terms of Reference.

9 MEDICINES COMMITTEE ANNUAL REPORT 2024/25

The Committee received the Medicines Committee Annual Report for 2024/25, and Mr McKeown joined the meeting. He provided a detailed summary overview of the report, highlighting the key points and work undertaken by the Medicines Committee.

Mr Moore thanked Mr McKeown for the report and highlighted the medication incidents and enquired into whether any patterns or issues had emerged from these. Mr McKeown noted that there had been a significant amount of work undertaken by the Nursing Practice Development team through improvement of the safer use of medicines policy to ensure that incidents were reported via the Datix system, which would likely produce an increase in the reporting of these incidents. He advised that no pattern had emerged from the incidents recorded but assured the Committee that all incidents were reviewed, to gain a better understanding of why they had occurred and to identify any themes.

Professor Thomson confirmed that the Medicines Committee received a quarterly report on any medication incidents. However, she noted that that a summary report would be incorporated within Patient Safety report as this was where overall responsibility lay for actions which arose in this regard.

Professor Thomson highlighted the detail of work that the Medicine Committee and Pharmacy team were progressing in relation to policy and guideline updates and that it was positive that HEPMA (electronic prescribing) could now be used to its full extent. She also highlighted that a decision had been taken to move away from the Prescribing Observatory for Mental Health, which was a national audit system, as the program was not necessarily the best fit for TSH. She assured members that the programme of work and the governance that had been put in place to replace this national system was robust and that the Medicines Committee were committed to the continual oversight of this.

Mr McConnell thanked Mr McKeown and the Pharmacy Team for the report and noted the helpfulness of the information provide around incidents, prescribing and the HEPMA system.

The Committee:

1. Noted the Medicines Committee Annual Report 2024/25

10 NURSING RESOURCE REPORT Q4

The Committee received the Nursing Resource Report for Quarter 4 presented by Ms McCaffrey who provided an overview and highlighted the key areas for the benefit of members. In particular, she advised that the risk rating in relation to resourcing remained at high, but that work was focused on improvement in this area given the recent changes agreed through the Board. She also highlighted the work underway through the Workforce Governance Group to look at potential ways to develop the Supplementary Staffing Register.

Ms McCaffrey also noted that following discussion at the most recent Board Development Session, there would be a refresh of reporting for the Committee, linked to how reporting was framed for the Staff Governance Committee.

Mr Moore welcomed the review into the report to try to mitigate duplications in reports and asked if there were any reasons for the current plateau in relation to supplementary staffing and what could be put in place to develop this area in the future. He also asked for further clarification on the cultural aspects mentioned in relation to the staff resourcing incidents reported.

Ms McCaffrey replied that in relation to Supplementary Staffing they were limitations on the staff eligibility to join this cohort of staff, and agreement made in partnership that staff who were retiring

and students who were at Year 3 stage of training were eligible to join. Ms McCaffrey noted that there were measures that could be looked at to increase this body of staff with potential consideration being given to offering staff who were leaving the hospital the chance to join the register.

In relation to cultural aspects, Ms McCaffrey noted variability in the reporting of incidents across the hospital with duplicate reporting being made through Datix (incident reporting system). She added that responsibility lay with the daily resource meetings and discussions between multidisciplinary leaders to agree processes to address staffing issues. Mr Jenkins also referenced this point and added that this was being picked up through a review of incident reporting by the Risk Team.

Mr McConnell thanked Ms McCaffrey for the report and overview provided.

The Committee:

1. Noted the Nursing Resource Report Q4.

11 DAYTIME CONFINEMENT REPORT

The Committee received the Daytime Confinement (DTC) Report presented by Ms McCaffrey who provided an overview and highlighted the key points within the report.

Ms McCaffrey's overview highlighted that this was the first report from the Daytime Confinement Oversight Group which had been stood up to streamline this workstream, and which would report into the Organisational Management Team. She added that the report contained a detailed summary of the position at this stage to ensure that the Committee had a full view of this.

Ms McCaffrey summarised the remit of the Daytime Confinement Oversight Group which was to ensure that they had oversight into how DTC was being addressed, with the aim to return DTC to a never event. In future, if triggered, this would then be addressed as part of the business continuity policy. It was also noted that the Clinical Quality Department had been instrumental in supporting the group's understanding of the levels of DTC through data reporting.

She noted that there had been substantial improvement in the levels of DTC with the recent introduction of additional staff within the nursing team, and that the aim was for this to continue. Ms McCaffery further highlighted that the report showed that there were several occasions where there had been adequate staffing levels, but the gender balance had not been sufficient.

Mr Moore welcomed the coordination of this and noted the involvement of the Service Leadership Teams (SLTs) in taking responsibility in this regard. He noted variability across each service area in this regard and queried how joined up this was rather than being locally focused. Mr Moore also welcomed the addition of weekend activity information contained within the report. Ms McCaffrey added that it was important for the SLTs to recognise their responsibility within their own areas, and was also mindful of the way in which DTC may have different impacts within different clinical services. She also noted the role of the Clinical Model Oversight Group in this regard in terms of pulling services together.

Mr Jenkins added assurance that focus was on eliminating DTC across the site, especially in the context of additional nursing resourcing being put in place. He added that the Nursing and Operations Directorate Performance meeting had recently taken place, which had allowed greater consideration of this and emphasised the need to reduce sickness absence within nursing.

Mr McConnell noted the usefulness of the level of detail in the report given that this was the first report of its kind. He asked if there was a DTC plan in place or if the work schedule of the group would determine the work to be carried out. Ms McCaffrey replied that a draft plan was in place at

the present with some refinement required, which would be brought back in future reporting.

The Committee:

1. Noted the Day Time Confinement Report.

12 INFECTION PREVENTION AND CONTROL REPORT Q4

The Committee received the Infection Prevention and Control Report for quarter 4, and Mr Lee joined the meeting. He presented an overview of the report and highlighted the key areas for the benefit of the Committee.

Ms Raghavan asked for clarity in terms of the audit results and asked if this was undertaken on all staff or if it was stratified into different categories of staff. Mr Lee referred to the graphs contained within the report and noted that the first page showed the different staff groups that were observed performing hand hygiene. He noted that every member of staff who entered each area was observed and audited on hand hygiene practices. He added that the second page contained the results from the knowledge questions, carried out with Nursing and Healthcare Support workers.

Ms Raghavan asked if, now that the baseline had been established in terms of staff knowledge, there would be re-testing in future following re-training. Mr Lee highlighted that each month every ward carried out hand hygiene observations along with one of the other nine Standard Infection Control Precautions, which ensured the continual collection of data alongside assurance audits.

Mr Moore welcomed the detailed report on hand hygiene and the approach taken to attempt to understand the issues that affect this and the overall staff awareness of this issue. Mr Jenkins concurred with Mr Moore's remarks and thanked Mr Lee for the approach taken to ensure staff knowledge and awareness increased and improved. Mr Jenkins also noted the results from ward-based staff and queried if the focus on the COVID pandemic had impacted general day to day practices. Mr Lee agreed with the point raised by Mr Jenkins and highlighted the need to support staff to increase knowledge levels.

Professor Thomson asked if the standards set for inspections conducted by Healthcare Improvement Scotland were the same for all health settings or if there were variations depending on the nature of the environment. Mr Lee replied that the standards were the same for all NHS environments and all healthcare settings. However, he noted that the difference for TSH was in how the standards were applied and managed.

Ms McCaffrey thanked Mr Lee for the report and noted that it demonstrated the work undertaken by the Infection Control Committee. She referred to the points raised in relation to COVID and added that the work being carried out by Mr Lee would help to support the staff in their practice and in application of correct standards. Ms McCaffrey noted the importance of local leadership in this regard, especially the Senior Charge Nurse cohort, and provided assurance that this would be managed through the Infection Control Group who would look in detail at any actions arising from audit work.

Mr McConnell thanked Mr Lee and welcomed the report.

The Committee:

1. Noted the Infection Prevention and Control Report Q4.

13 BED CAPACITY REPORT AND APPENDIX 1

Members received the Bed Capacity Report presented by Professor Thomson who provided an

overview and highlighted that there continued to be a push to move eligible patients through from Treatment and Recovery to Transitions to continue to free up beds with the Admissions service and added that, although the situation was tight, it was manageable.

Mr McConnell thanked Professor Thomson for the report and overview provided.

The Committee:

1. Noted the Bed Capacity Report and Appendix 1.

14 CORPORATE RISK REGISTER – CLINICAL RISKS

The Committee received the report on Corporate Risk Register – Clinical Risks from Mr Hardy who provided an overview of it for the benefit of the Committee.

Mr McConnell thanked Mr Hardy for the report and noted that the layout being broken down to specific clinical risks was useful to allow focus on each area.

The Committee:

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

15 INCIDENTS AND PATIENT RESTRICTIONS Q4

The Committee received Incidents and Patient Restrictions Report for Quarter 4, presented by Mr Hardy who provided an overview of the report. He highlighted that Personal Attack Alarms activations had decreased during the reporting period from 65 to 55, and that the need for physical restraint had decreased from 87 to 76 and that a third of the restraints occurred within the Intellectual Disabilities service.

Mr Moore noted that to prevent duplication of information being reported to the Clinical Governance Committee, further thought should be given as to what the Committee would like this report to contain. This would allow the report to be more streamlined and important information to be more readily apparent.

Mr Hardy agreed with this point and welcomed work being carried out to tailor the report. Mr Jenkins also concurred with these points and requested discussions with Professor Thomson and Mr Hardy on how this could be achieved.

Professor Thomson agreed and noted the need to establish what information was included in quarterly reporting compared to regular annual reports. Mr McConnell concurred with the points raised in relation to the need to review the content of this report especially in respect of the quantity of data it presented- reflecting on the risk of the underpinning messages becoming diffuse as a result.

Action – G Jenkins/ Professor Thomson/ A Hardy

The Committee:

1. Noted the Incidents and Patient Restrictions Report Q4.
2. Review of the Report content

16 LEARNING FROM ADVERSE EVENTS ACTION TRACKER

Mr Hardy presented the Learning from Adverse Events Action Tracker to members and noted that the Clinical Governance Group had taken oversight of the tracker and highlighted that good progress had been made with only six actions outstanding.

Mr McConnell thanked Mr Hardy for the overview provided.

The Committee:

1. Noted the Learning from Adverse Events Action Tracker.

17 LEARNING FROM COMPLAINTS & FEEDBACK REPORT Q4

The Committee received the Learning from Complaints & Feedback Report for Q4 from Ms M Smith who provided a summary of the report. She noted the improvement in the number of complaints resolved at Stage 1 of the process as being positive. She outlined the main issues that had arisen during the quarter which included a range of issues including the grounds access process and visitor protocol for food and fluids, as well as clinical treatment. She noted the work progressed with the Patient Partnership Group to help to encourage patient feedback about the complaints process itself, and highlighted the positive feedback received from carers about Family Centre visits, and being able to attend a recent ceremony celebrating patient achievements.

Mr Moore thanked Ms Smith for the comprehensive report and the highlighting of the ongoing work in relation to improving staff knowledge and understanding of the complaints process and allowing them to take ownership of any issues raised. Mr Moore further noted that complaints around fluid and nutrition was a recurrent issue and asked for some context around this. Ms Smith advised that this had come through informal feedback as well as a formal complaint. She noted that the Person-Centred Improvement Team and Dietetics had undertaken work around reviewing the protocol and thought that the key issue was the importance of consistency in how this was implemented. Ms McCaffrey echoed this in terms of how the protocol was applied.

Ms Raghavan also noted the comprehensiveness of the report and welcomed the progress shown. She further noted the complaints feedback form had changed as a result of input from the Patient Partnership Group and welcomed this.

Mr McConnell thanked Ms Smith for the report and welcomed the focus on early resolution of complaints.

The Committee:

1. Noted the Learning from Complaints & Feedback Q4 Report.

18 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

Areas of Good Practice:

Professor Thomson highlighted the Unscheduled Care Report and the discussion held by members, and commended the Medicine Committee Report, in particular the pages that outlined all of the guidelines reviewed and the work undertaken.

Mr McConnell highlighted the work being undertaken by the Supporting Healthy Choices Group.

Areas of Concern:

Mr McConnell noted that any areas of concern were already noted through the follow up actions recorded, and that there were no other matters raised.

19 COMMITTEE WORKPLAN 2025

Mr McConnell noted that the Supporting Healthy Choices Report was due at the November meeting, also that an Unscheduled Care 6-month update should also come to the November meeting.

It was also noted that the Committee would consider how reporting for the new female service would be considered, as this came to fruition.

Action- Secretariat

20 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

It was noted that the Clinical Governance Annual Report would be submitted to the Audit and Risk Committee, and then the Board,

The Nursing Resource Report was noted to link to the remit of the Staff Governance Committee.

21 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

Professor Thomson suggested Clinical Care in relation to the female service, and this was agreed by the Committee.

22 ANY OTHER BUSINESS

Professor Thomson noted the recent discussion at the Board Development Day around reviewing the interdependencies of the Board and Standing Committees and reflected on the volume of work that the Clinical Governance Committee took oversight for given its primary purpose for the delivery of healthcare. She welcomed any fresh ideas on the way forward, and for the workplan.

23 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 14 August 2025** at 09:30 hours via Microsoft Teams.

The meeting concluded at 1228 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 12b
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 14 August 2025.

1	Research Committee	Reporting was received on the activities of the Research Committee, and the range of research activities undertaken at the State Hospital during 2024/25. A further report was considered which outlined the Research Strategy for the period 2025/29. These were received positively and welcomed the evidence based approach taken, and the opportunity to raise the profile of research externally. There were clear links to the Forensic Network, and discussion on how research can be linked in a way that benefits clinical care within the hospital, and how to link it to governance structures more explicitly.
2	Annual and 12 Monthly Reports: -Mental Health Practice Steering Group (MHPSG) -Rehabilitation Therapies -Patient Learning -Duty of Candour -Patent Safety Programme	The Committee received several reports as listed and there was detailed discussion around key factors in reporting. For the MHPSG, the committee discussed how to translate this work to further embed into practice, and considered operational aspects, and trauma informed care was considered as an example of this. Positive progress was noted in the delivery of rehabilitation therapies, and also in patient learning activities. Assurance was given in the delivery of Duty of Candour and the Patient Safety Programme.
3	Daytime Confinement	The Committee was pleased to note the significant progress that had been made in this respect, and discussed how this had been achieved, with confidence expressed at meeting the deadline of 1 October to eliminate this as a practice. The committee supported the definition of this as representing potential harm to patients.

4	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). Good steady progress was noted, and the change in approach in the past year welcomed.
5	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.
6	<u>Reporting on:</u> 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. Detailed reporting was received on all aspects of incidents and patient restrictions, and there was agreement that this reporting should be redesigned around the aspects of assurance required by the Committee.
7	Specified Persons Report	The Committee noted that this report was required by Scottish Government in line with mental health legislation. It had previously been submitted directly to the Board and had been remitted to the Clinical Governance Committee this year. The report was approved for submission to Scottish Government.
8	Learning from Adverse Events (Serious Adverse Event Reviews).	Progress on actions were noted, and the Committee considered the reporting to be operationally led and requested assurance reporting on the learning taken from completed SAERs.
9	Learning from Complaints & Feedback Q4 Report	The Committee received quarterly reporting on the key performance indicators in the management of complaints as well as the main issues which had been raised and the learning taken. Reporting also outlined feedback received during the quarter, including positive feedback from both patients and carers.
10	Clinical Care of Women's Service	The Committee received a presentation from the Clinical Lead for the women's service which outlined the significant progress which had been made allowing the interim service to open on the target date of 21 July. There was discussion around the challenges that had been experienced, and well as the associated risks of introducing this new service. The presentation focused on the clinical care aspects, and the guidelines which had been developed to support the service, as well as looking ahead to Phase 2 of this project. The Committee provided positive feedback on the work to date, given the pressures and challenges experienced, and took assurance from the reporting.
11	Areas of good practice/concerns	The methodology outlined within research was commended. The committee also undertook some self-assessment in terms of its own reporting arrangements and considered that a refresh of approach should be taken forward, and this should encompass the number and length of reports. There may be less need for data and operational details, and more focus on

		patient care and the specific assurance sought by the committee as a governance structure, and the duties and responsibilities of the committee in this regard, separate from service delivery.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minutes 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 in 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 to 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

CLINICAL FORUM **CF(M)25/03**

Minutes of the Clinical Forum held at 2.00pm on Wednesday 11 June 2025 via Microsoft Teams,

Chair:
Dr Joe Judge — Consultant Clinical Psychologist

Present:
Consultant Nurse — Hamish Fulford
Pharmacist — Ashleigh Wallace

In Attendance:
Head of Corporate Governance — Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Smith welcomed everyone to the meeting. Apologies were noted from Dr Stuart Doig, Consultant Forensic Psychiatrist representing the Medical Advisory Committee, and Ms Diane Mullen, Dietitian, represents Allied Health Professionals. She noted that the first business of the day would be the election of a Chair, and that if this was successful, she would pass to them to chair the meeting.

2 ELECTION OF CHAIR AND VICE CHAIR

Ms Smith advised members that Dr Judge had submitted an expression of interest in the position of Chair. Ms Wallace formally nominated Dr Judge, with Dr Fulford seconding the nomination. In line with formal procedures, Dr Judge was confirmed as Chair of the Forum, and Ms Smith handed over the meeting to Dr Judge to preside.

It was noted that the position of Vice Chair would be considered at the next meeting.

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 24 March 2025 were approved as an accurate record.

4 REVIEW OF ROLLING ACTIONS LIST

Forum members received the Rolling Actions List and noted progress on actions from the last meeting.

It was agreed that election of a Vice Chair would be added to the agenda for the next meeting.

5 WOMEN'S SERVICE

Members received and noted the project update on the Women's Service. The Chair noted that interviews for a Clinical Psychologist position within the service had taken place, but there had been no update regarding the successful candidate.

The Chair noted that guidance for the Interim Women's Service had recently been circulated to various committees and groups for feedback, and noted that it would be helpful for the Clinical Forum to be included in the distribution. Ms Smith confirmed that she would pick up this action with the Project Team, to advise that the Forum is now active and to request its inclusion in any future communications.

Action – M Smith

6 REVIEW /UPDATES FROM EACH GROUP/PROFESSION

(a) Medical Advisory Committee

There was no representative from the Medical Advisory Committee in attendance at this meeting.

(b) Psychology Professional Practice Group

The Chair provided an update from the Psychology Professional Practice Group. He noted that a longstanding concern was the continued rise in the number of individuals qualifying as Clinical Psychologists in Scotland (around 90 per year) despite limited job opportunities. He further noted the Scottish Government, NHS Education for Scotland and Heads of Clinical Psychology were aware of this issue and were reviewing longer term workforce planning.

The Chair noted there was concern around the title 'Psychologist' not currently being protected, which allowed anyone to use the term and present themselves as an expert. He confirmed that efforts were underway by the two main professional psychology bodies in Scotland to address this.

The group recently reviewed guidance circulated for the Interim Women's Service. Their initial feedback was around the proposed leadership structure, and that roles should be assigned based on individual competencies rather than being determined by professional discipline.

Daytime confinement continued to present challenges as psychology staff were frequently being asked to backfill nursing time in the wards or take the emergency responder.

(c) Nursing

Dr Fulford requested clarification on whether his participation in the Forum was intended to represent the Nursing Directorate, given his dual role in nursing and psychology. Ms Smith confirmed that he was included in the membership of the Clinical Forum in his professional capacity as a nurse, and that she was in discussions with Ms Clark, Associate Director of Nursing, regarding further development of a Nursing Advisory Group. This group would provide nursing representation on the Forum alongside Dr Fulford. Ms Smith confirmed she was reviewing draft Terms of Reference (ToR) for this group at present, and had noted that in other NHS Boards, there could be multiple members of the Area Clinical Forum to represent nursing cohorts. It may be that this could be considered within the State Hospital. This would come back to the Forum for consideration.

Action – M Smith

Dr Fulford informed members that he had recently commenced a Reflective Practice Group (RPG) at the Skye Centre, which was regularly attended by activities and support staff. He queried where the views of these staff groups could be represented within the hospital's governance structures, and Ms Smith proposed looking into practices in the medium secure units to see if there were established models for representing similar staff groups. Dr Fulford advised that staff involved in the RPG feel underrepresented despite working directly with patients and suggested it would be helpful to define more explicitly in the ToR for the Forum what is meant by 'clinical' within the hospital context. The Chair agreed and Ms Smith will source ToR from other Boards to inform this process.

Action – M Smith

(d) Allied Health Professionals

There was no Allied Health Professional representative in attendance at this meeting.

(e) Pharmacy

Ms Wallace provided an update from the Pharmacy Team. She advised that the Clinical Pharmacy Service had received extra resource for the Women's Service, however this resource was reallocated to the Pharmacy Technical Service for recruitment of a Band 6 Pharmacy Technician, who would undertake a Lead Technician role.

Ms Wallace noted that the Development Day at the end March with the Organisational Development Team was successful, and a further Development Day was planned in October.

She advised that a request had been made by the Lead Nurses and Nursing Practice Development Team that the Pharmacy Department report more prescribing errors through Datix. This request was made because Datix reports suggested that nursing staff appear to be responsible for the majority of medication errors, whereas prescribers are associated with significantly fewer. Ms Wallace advised that this is not a completely accurate representation, as the Pharmacy Team frequently identify and correct minor prescribing anomalies, which are not reported on Datix. As a resolution, the Pharmacy Team are considering the definition for what was described as a pharmacy error and reported on Datix.

(f) Health Centre: Dentistry and Optometric

There was no representative from Dentistry or Optometric in attendance at this meeting.

The Chair noted that some groups and disciplines were not represented at this meeting and suggested that, moving forward, it would be helpful to request a written update from those unable to attend. Ms Smith agreed and proposed the development of a standard update template, which could be circulated in advance to facilitate the submission of updates from absent members.

Ms Smith informed the Chair that a new Personal Assistant was joining the Corporate Services Team in the near future and would take on secretariat responsibilities for the Forum.

7 ANY OTHER BUSINESS

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

8 NEXT MEETING DATE

The next meeting will be held on 25 August 2025 at 11.30am via Microsoft Teams.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 14
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 July 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

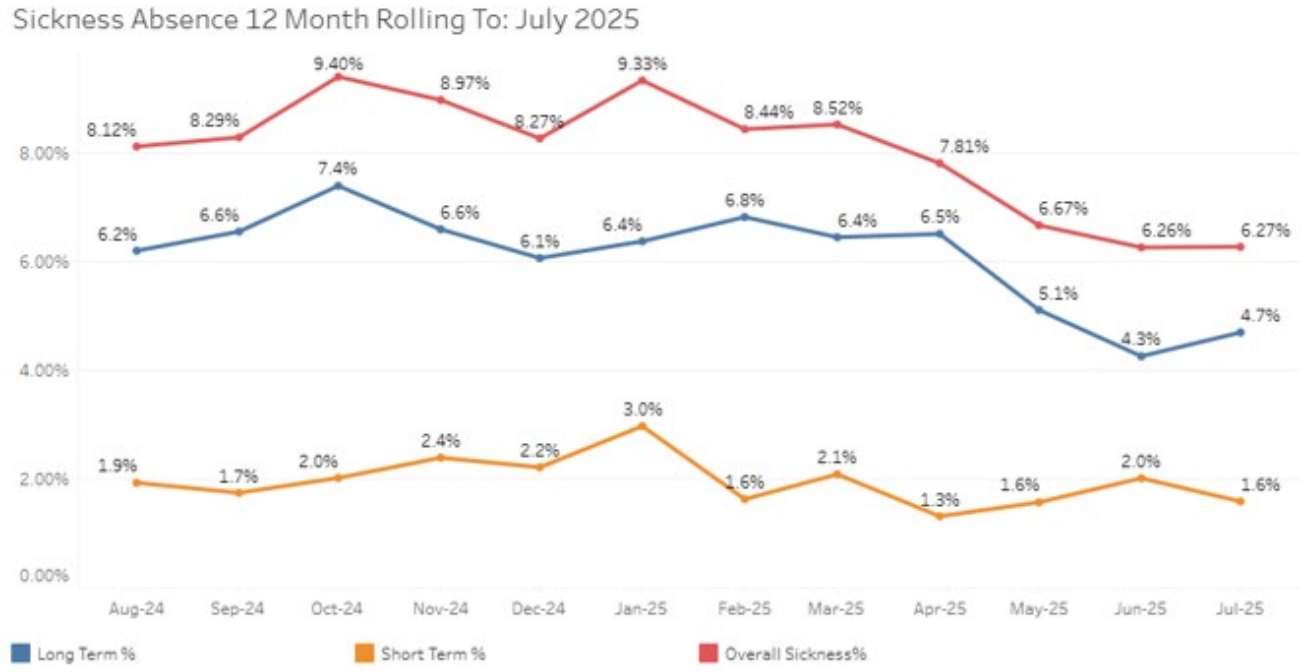
TSH Sickness Absence (Aug 24 – Jul 25)

Sickness Absence remains a significant challenge for TSH in maintaining sustained improvement.

Our June position of 6.12% is the lowest monthly absence figure since May 2022 (remembering COVID special leave was also available at this time) and forms part of a continual improvement since May 2025.

There has been a continued decrease in sickness absence rates since March (8.5%) until end of July for which the predicted absence rate is 6.27%, as outlined in Graph 1 below:

GRAPH 1 – all staff



The main contributing factors to the improved absence figure in July is:

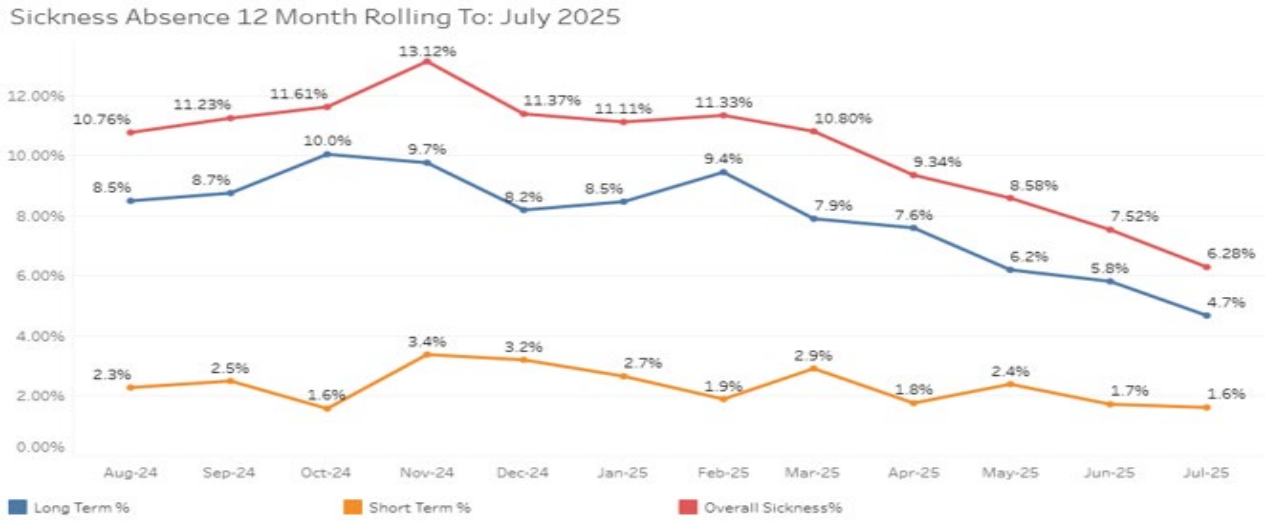
- Continued downward trend across the Nursing cohort (13.12% at peak to 6.28% this month) as described below
- Significantly improved position in relation to long-term absence (although July did see a small increase). Long-term absences under 5% in only the last two months and a peak of 7.4% in October.

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 (August 24 – July 25)

The reduction in absence is reflected in Nursing (from 10.8% in March to 6.28% in July), albeit still higher than the national target. Sickness within Nursing remains the major challenge for TSH

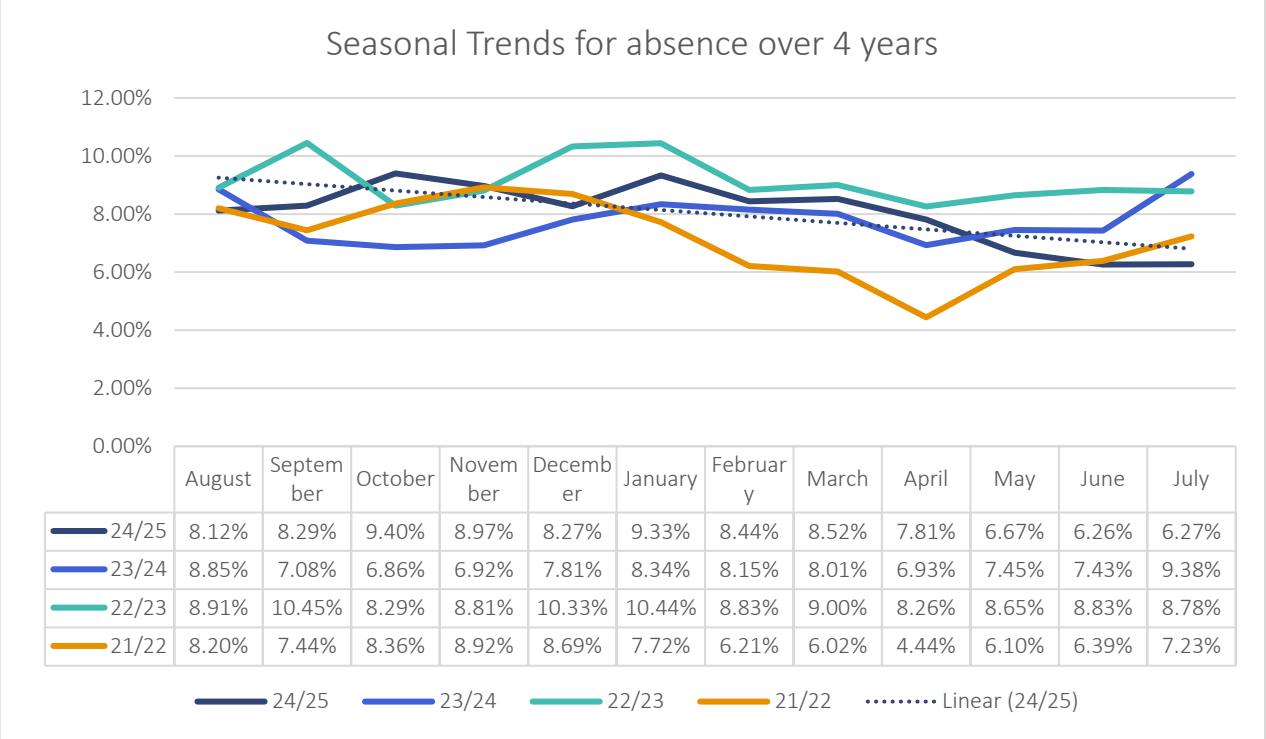
GRAPH 2 – nursing hubs



GRAPH 3 – Seasonal Trends

There are limitations in terms of trend analysis over the last 4 years, in part due to the crossover of the covid years, and in particular the utilisation of special leave to record covid, which in turn masked sickness absence.

However, both the 24/25 line and the average trend for 24/25 highlight the positive nature of the current position, potentially setting a lower baseline prior to an anticipated peak over the winter months.



	August	September	October	November	December	January	February	March	April	May	June	July
24/25	8.12%	8.29%	9.40%	8.97%	8.27%	9.33%	8.44%	8.52%	7.81%	6.67%	6.26%	6.27%
23/24	8.85%	7.08%	6.86%	6.92%	7.81%	8.34%	8.15%	8.01%	6.93%	7.45%	7.43%	9.38%
22/23	8.91%	10.45%	8.29%	8.81%	10.33%	10.44%	8.83%	9.00%	8.26%	8.65%	8.83%	8.78%
21/22	8.20%	7.44%	8.36%	8.92%	8.69%	7.72%	6.21%	6.02%	4.44%	6.10%	6.39%	7.23%

ATTENDANCE MANAGEMENT OBSERVATIONS

Patterns/Trends for TSH:	Positive continued reduction in absence over June and July Not experience usual pattern of increase over the summer. Preparedness for Winter increase is key.	
Identified Departments of Concern:	Estates Lewis 1 Lewis 2	16.29% 11.22% 10.11%
Identified Departments of Improvement since March 2025:	AHPs Iona 2 Lewis 3 Mull 2	From 11.6% to 2.76% From 8.58 % to 4.15% from 14.35% to 3.4% From 16% to 1%
Reasons:	**Key reasons for long-term absence:** Anxiety/Stress/depression/other psychiatric illnesses, injury fracture, other known causes not otherwise classified **Key reasons for short-term absence:** Gastrointestinal, injury fracture, Anxiety/Stress/depression/other psychiatric illnesses	
Activity:	At the time of reporting, for the month of July, 7 members of staff were invited to a Stage 1 meeting, and 1 member of staff invited to a Stage 2 meeting. Engagement at Occupational Health remained 69% of all management referral appointments which is the same as the previous month. A further 20% were rearranged, with 4 DNAs.	

National Position

The challenge of reducing absence in a sustained manner remains a key theme across NHS Scotland. The National figures below are produced centrally and retrospectively by SWISS and tend to have a slight variance to the figures reported in boards through SSTS and at 3a earlier in this paper.

Board	Total (%)
Scottish Ambulance Service	8.8
NHS 24	8
NHS Forth Valley	7.49
NHS Lanarkshire	6.82
NHS Western Isles	6.48
NHS Fife	6.38
NHS Greater Glasgow & Clyde	6.3
NHS Ayrshire & Arran	6.21
NHS Tayside	6.16
NHS SCOTLAND as a whole	6.08
The State Hospital	5.97
NHS Highland	5.97
NHS Lothian	5.78
National Waiting Times Centre	5.70
NHS Dumfries & Galloway	5.65
NHS Orkney	5.48
NHS Borders	5.40
NHS Shetland	4.90
NHS Grampian	4.85
NHS National Services Scotland	4.76
Healthcare Improvement Scotland	3.33
Public Health Scotland	3.02
NHS Education For Scotland	2.32

The State Hospital have consistently been within the top 5 highest sickness absence rates for all Boards, for some time. However, for the month of June 2025, TSH have dropped to 10th and just below the national rate for sickness absence across NHS Scotland.

The sustained improvement of absence over the last 5 months has been encouraging, but there is also recognition that the unpredictability of sickness absence and the predictability of seasonal trends will likely see an increase as we move into winter.

Our key challenge will remain trying to get as close to 5% absence target, but also ensuring that we have the lowest baseline prior to the peaks of winter.

In order to support this, the planned activity as outlined in our last report will continue as we seek to maintain a sustainable approach to maximizing attendance:-

- Regular RAG Reviews
- Continued partnership working with focus on providing a safe working environment
- Encouragement and monitoring of consistent Pathways usage
- Improved communication and awareness of impact of absence
- Manager development
- Accountability and performance management for areas which require additional support

It is also hoped that by aligning with the work focusing on prioritizing organizational health and improving employee experience, this will also begin to reflect positively in terms of Maximizing Attendance.

(b) RECRUITMENT

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

TIME TO HIRE	88 days (KPI of 75 days)	KPI impacted by requirement to extend closing dates, arrangement of an interview and agreement of start date
VACANCIES ADVERTISED	4 posts were progressed during July.	
SUMMARY OF NURSING VACANCIES:	Band 6 was under-establishment by 2.00 WTE, with interviews scheduled for 14 August. Band 5 was under-establishment by 20.27 WTE, which related to the overall increase of establishment to support the opening of the Female Service. Recruitment has been completed, and 15.00 WTE are expected to start between August and October. Band 3 is currently over-establishment by +3.87 WTE.	
EMPLOYABLITY:	The State Hospital will participate in the demonstrator programme for the second time since its initial trial in 2024. This year, the hospital will host three participants across the departments of Housekeeping, Catering, and Clinical Administration. Recruitment process is underway with interviews scheduled for first 2 weeks in August. As part of our Workforce and Anchor Strategy, we aim to increase the number of Modern Apprenticeships in the next 3 years. Consideration of these roles have been incorporated into the vacancy approval process for appropriate roles to encourage uptake.	

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	46.13 WTE (from 52.57 WTE in March 2025)
NURSING	28.91 WTE (from 31.59 WTE in March 2025)
SSR	9.85 WTE (from 11.23 WTE in March 2025)

(c) EMPLOYEE RELATIONS - LIVE CASES

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

- There are 3 current ER cases, one of which commenced in the month of July. One has been ongoing for 4 months has a key date scheduled for September to conclude (*within 6 months*).
- Two ongoing bullying and harassment cases initially raised in May have progressed to the formal investigation stage following unsuccessful attempts at early resolution.

Active ER Casework – timescales

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

7 cases have concluded since the last Board. 5 cases took 8 months to conclude due to the complexity involved and in the 2 further cases, the employees left employment before the process could be concluded.

(d) LEAVERS

Leavers

- There were 4 leavers in July 2025.
- 3 within the Nursing and AHP Directorate and 1 in the Medical Directorate.
- This totals 15 leavers YTD, turnover of 2.04% financial year to date.
- Exit interview compliance within the current financial year is 46.67% with 7 out of 15 leavers completing the interview.

(e) JOB EVALUATION

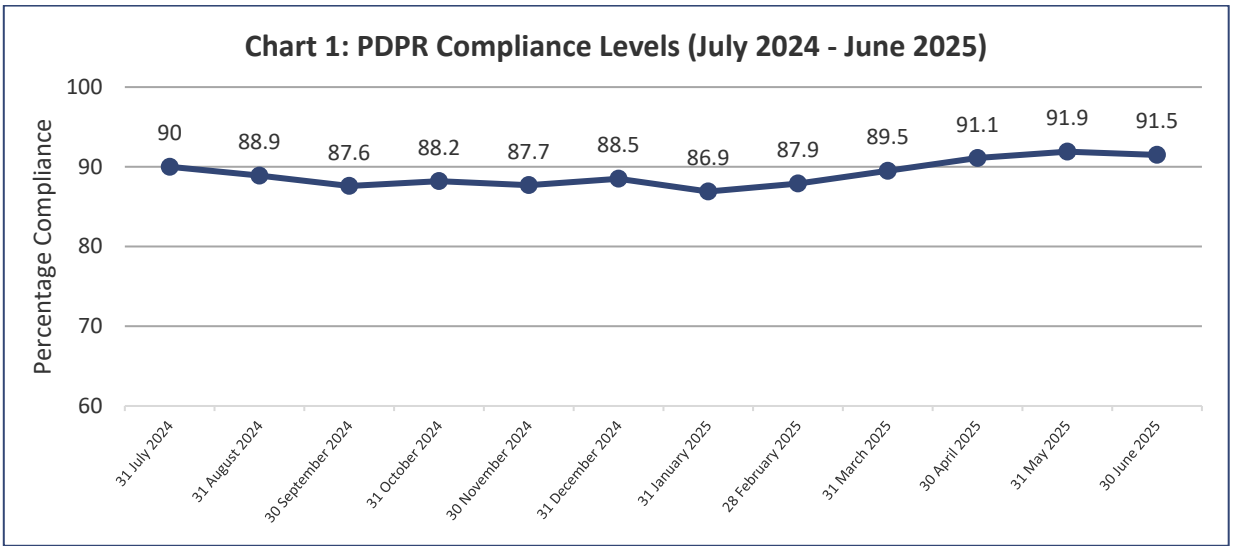
Progress & Status – July 2025

- Two posts received their outcomes during the first week in July (both within the 14 week target).
- One review outcome was given (within the 14 week target).
- No posts are outstanding at the end of July 2025

(f) PDPR COMPLIANCE

A key priority within the State Hospital's Staff Governance Action Plan is to ensure that all staff have an annual Personal Development Planning and Performance Review (PDPR) meeting with their line manager. As at 30 June 2025, 591 staff (91.5%) had a current (i.e. live) review.

Chart 1 provides details of PDPR compliance for the period from July 2024 to June 2025, indicating that a high level of compliance is being effectively maintained.



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:	28 August 2025
Agenda Reference:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
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

As advised previously, under the Disclosure (Scotland) Act 2020, Disclosure Scotland has introduced a number of changes to current processes, which will impact on The State Hospital. Effective from 1 April 2025, PVG membership is mandatory for all regulated roles; 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 and in a healthcare setting.

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 commenced a programme of work to carry out the required checks for these staff.

Staff groups affected received targeted communications advising of the legislation changes and actions required by them, supported by the HR team.

There were 237 employees who were required to obtain PVG membership.

All required applications were submitted to Disclosure Scotland by the deadline. As of the time of reporting, 226 applications have been completed, with 6 applications currently outstanding and being processed by Disclosure Scotland

The table below summarises the organisational position at 15th August 2025:-

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	No. Complete PVG ISSUED
TOTAL	**237**	**237**	**0**	**237**	**237**	**0**	**6**	**231**

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 Compliance with Legislation
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, WGG
Risk Assessment (Outline any significant risks and associated mitigation)	Risk in: - Failing to meet the legislative timeline - Potential delays in recruitment - 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

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Equalties Update
Purpose of Report:	For Noting

1 SITUATION

In March 2024, Fiona Hogg, Chief People Officer at Scottish Government wrote to Chief Executives and Human Resource Directors setting out an additional requirement to 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 Board's own Anti Racism Plans.
Subsequently, it was confirmed in writing on 16 December 2024 that the update in relation to the development and delivery of anti racism plans would not be within ADP reporting, but in a flexible format with the first report provided by 31 January 2025.
On 24 June 2025, a further update was requested by Scottish Government by end of July 2025.

2 BACKGROUND

Since the start of 2025, a Workforce Equalities Group (WEG) has been established, along with a non Executive Director Champion for Equalities.

This review has been instigated by the departure of the Senior member of the Clinical Team who was responsible for equalities, the change in Executive Lead for Equalities and the recognition that greater focus and commitment was required to support this area of work.

It was also agreed that the TSH approach to Anti-Racism would form a key element of our review and would be an integral part of our revised approach to Equalities.

To date, the WEG has met on 3 occasions with a focus on identifying our key priorities and beginning to shape these into a plan.

This included a staff wide survey on equalities to assist in the understanding of lived experience from our staff, which had a 15% response rate and provided valuable insight into our work environment.

3 ASSESSMENT

In line with the Scottish Government guidance on the anti racism update, I have summarised under the key headings below:

(i) GOVERNANCE

The Workforce Equalities Group has now met on 3 occasions and have developed a draft Equalities (Anti Racism) Action Plan for 2024/25 and will be responsible for overseeing the implementation, along with reviewing progress on our Equalities Monitoring Outcomes for 2025/29.

The development of the Board's Anti Racism Plan will form part of the overall Annual Action Plan, and a number of key priorities have been established in this regard.

The Workforce Equalities Group will provide regular updates to the Workforce Governance Group and formally to Staff Governance Committee.

A non executive director has also been appointed as Equalities Champion.

(ii) PRIORITIES

The work of the WEG (Workforce Equalities Group) has identified the following broad equalities priorities, which will incorporate or run parallel with Anti Racisim:-

a) Senior commitment and Visibility from the Executive Team
- Statements from Chair, Champion and Chief Executive to outline the Board position on Equalities (including Anti Racism)
- Quarterly video updates from a member of the Senior Team on Equalites
- Regular Agenda Item on Board Meeting
- Dedicated Board time, through Development Sessions, to discuss and focus on equalities, including Anti Racism.

b) Education & Awareness
- Face to face training on standards and expectations of behaviour.
- Develop Equalities into existing training.
- Review Training Programme to support Equality and Inclusion.
- Develop quarterly masterclass sessions on relevant topics.
- Create a yearly schedule of training to support Equality and Inclusion.

c) Zero Tolerance
- Senior Leadership Team to set clear expectation of behaviours.
- Awareness of Zero Tolerance to be escalated throughout the site.
- Encourage staff to speak up and call out behaviours that are not acceptable.

d) Reporting & Monitoring
- Provide a safe environment for staff to raise concerns confidentially.
- Ensure suitable systems are in place to record incidents appropriately.
- Monitor trends and incidents through Workforce Equalities Group.

e) Cultural Development
- Work to support a culture where staff feel safe to raise their concerns.
- Ensure that all concerns are taken seriously and dealt with appropriately.
- Create a culture of belonging and inclusivity

(iii) KEY MILESTONES

In respect of our priorities, our key milestones are:-

Milestone	Date
Established Workforce Equalities Group in place	Completed
Integrate Anti Racism into our Equalities approach and Equalities Monitoring Outcomes 2025/28	Completed
Workplace Equalities Survey	Completed
Equalities Annual Action Plan in place for 2025/26	Draft Completed
Review of Training Requirements (initial Assessment)	Completed
Board Statements from Chair, Champion and Chief Executive	Q2
Roll out of communication strategy/approach with a focus on awareness	Q2
Roll out of Train the Trainer for Equalities	Q3
Refined monitoring and reporting of equalities related incidents	Q3
Cultural Development, aligned to Organisational Health work undertaken by Organisational Development	Ongoing throughout 2024/25
Review of adverse outcomes for Patients (Seclusion and application of SRKs) by ethnicity/Race	Q4

(iv) PARTNERSHIP WORKING

We continue to work closely with the Employee Director and our staff side colleagues as we review our overall approach to Equalities and Inclusion at TSH.

A member of Joint Staff Side is part of the Workforce Equalities Group.

Broader partnership working and interaction with Minority Community Groups will be reviewed as we progress and develop our approach. Clearly, as a Board, our patient considerations tend not to relate to access, but more support for our patients when they are staying at TSH.

(v) EXECUTIVE LEAD

Stephen Wallace, Director of Workforce, will be Executive Lead for Equalities and the Anti Racism Plan.

The non Executive Lead for Equalities is Shalinay Ragnathan.

4 RECOMMENDATION

The Board are asked to note the continued evolution of our approach to Equalities and Inclusion at TSH and approve the update in terms of key milestones, specifically with reference to Anti Racism.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Equality and Diversity
Workforce Implications	Creating Inclusive Workplace
Financial Implications	N/A
Route To CMT Which groups were involved in contributing to the paper and recommendations.	N/A
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Creating a more inclusive environment
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).	This group is remitted to work under this act, along with other legislation in terms of working towards an inclusive environment.
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:	28 August 2025
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Report, Quarter 1 of 2025-26 - Update
Purpose of Report:	For Noting

1 SITUATION

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

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

2 BACKGROUND

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

3 ASSESSMENT

The Quarter 1 update is from 1 April 2025 to 30 June 2025. No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO.

In the performance year 2025/26, the State Hospitals Board for Scotland had no cases raised under Whistleblowing to date.

In advance of Speak Up Week this year, and in response to a request from the Board, we have been looking at reinforcing routes for staff to speak up and emphasizing how easily they can be accessed. A draft of the communication material is attached at Appendix A.

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 ▪ Support the Independent National Whistleblowing Standards, and support this workstream locally including promoting awareness for staff.
Workforce Implications	Ensuring robust standards for whistleblowing are adhered to. Encouraging the development of a positive proactive 'Listening' Workplace.
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	
Risk Assessment (Outline any significant risks and associated mitigation)	NA
Assessment of Impact on Stakeholder Experience	NA
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

APPENDIX A


SPEAK UP
IN THE WORKPLACE
Your manager should be your first point of contact, but there are multiple avenues available for raising concerns.
1
YOUR LINE MANAGER OR THEIR LINE MANAGER
Raise any issues or concerns directly with your manager(s).
2
HUMAN RESOURCES
Contact HR to discuss your concern and get advice on how to handle it.
3
TRADE UNIONS
Seek advice and support from your trade union.
4
CONFIDENTIAL CONTACTS
Raise issues confidentially with designated contacts.
5
PEER SUPPORT
Talk to trusted colleagues and peers.
6
OCCUPATIONAL HEALTH
Access OH services for guidance and support.
7
WHISTLEBLOWING
Report serious concerns anonymously

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE **SGC(M)25/02**

Minutes of the meeting of the Staff Governance Committee held on Thursday 15 May 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	Stuart Currie
In attendance:	
Associate Nursing Director	Josie Clark
Head of Organisational Learning and Development	Sandra Dunlop
Chief Executive	Gary Jenkins
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Corporate Services Team	Bonnie Murphy (minute)
Head of HR	Laura Nisbet
Head of Corporate Governance	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting, and formal apologies were noted from Ms Cathy Fallon and Ms Shalinay Raghavan, Non-Executive Directors. It was also noted that Mr Stephen Wallace, Director of Workforce and Graeme Anderson, Organisational Development (OD) Manager, 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 20 February 2025. The minute was agreed as an accurate reflection of the meeting.

The Committee:

1. Approved the minute of the meeting held on 20 February 2025.

4 MATTERS ARISING AND ROLLING ACTIONS LIST

There were no matters arising. Ms Radage noted that most of the actions on action list were closed and that Item 2: the Wellbeing Strategy would be discussed later in the meeting under Item 9a.

The Committee:

1. Noted the updates from the Rolling Actions List.

5 STAFF GOVERNANCE COMMITTEE ANNUAL REPORT 2024/25

The Committee received the Staff Governance Annual Report 2024/25 presented by Ms Radage who provided an overview of the report. She noted that there had been a change in how information was presented, and that the agenda had been realigned to match the staff governance pillars. She added that the changes had resulted in a greater focus within reports which in turn facilitated in-depth conversations.

Ms Radage highlighted that, in addition to the usual metrics reported on, progress in other areas had been discussed such as organisational development, wellbeing, learning and whistleblowing. She noted that the best practice section helped to illustrate the positive activities which had taken place and highlighted the reactive and proactive responses to challenging events. Ms Radage concluded that the Staff Governance Committee had been productive and constructive throughout the year.

Mr Currie agreed and added that the report was helpful and provided a clear account of the activities over the year and that the Committee had actively identified and actioned areas of improvement. He highlighted the substantial section on good practice, and the productive way in which the Committee had approached its business.

Mr Moore thanked Ms Radage for the overview and noted the progress. He made a further suggestion around the addition of a section to highlight key areas of concern, noting this within the context of evidence of balanced discussions in relation to the issues the Committees encountered. Ms Smith agreed with the point made by Mr Moore and noted that the inclusion of challenges would increase transparency, and this data was already being collected by the committees throughout the year. She agreed to explore how to formally record this information across each of the governance committees in the future, within annual reporting. Ms Merson commented that this could also be aligned to quality improvement, and there was support for this suggestion. Ms Radage added that this would enable a means to review what has been achieved over the 12-month period.

Action – Ms Smith

Mr Jenkins commented that the report was meaningful and conveyed a sense of continuity and reality, showed continuous improvement, and offered the opportunity to review the activities of the year retrospectively.

Ms Radage noted a minor amendment required within the Terms of Reference at section 3.4. relating to provision of support to the Committee, and Ms Smith agreed to make the necessary amendment. Members approved the Staff Governance Annual Report 2024/25.

Action: M Smith

The Committee:

1. Approved the Staff Governance Annual Report 2024/25, subject to minor amendment as discussed.

6 WORKFORCE PLAN 2025- 2028

The Committee received the draft Workforce Plan 2025-2028 presented by Ms Nisbet who highlighted that the plan would be structured along the five pillars of workforce planning and

outlined the vision, objectives, and key priority of organisational health, which had been discussed as part of the medium-term planning event. She added that Scottish Government had not indicated a submission date for the plan which afforded time to build on initial engagement and present a more detailed plan to Heads of Service to ensure that the plan was relevant and meaningful for their services. She advised that the plan would be shared with the Partnership Forum, prior to going to the Corporate Management Team and would be brought back to the Committee in August. Ms Nisbet welcomed discussion from members on whether the plan captured the key areas discussed as well as areas highlighted through engagement channels.

Mr Jenkins noted that he was comfortable with the themes and that it was beneficial to be in a position to have the time and ability to shape the plan in a way that works for the organisation.

Mr Moore asked about the challenge of single person dependency in some key areas in relation to succession planning and highlighted that, as a smaller organisation, any such vulnerabilities had a greater impact. He also asked for more background on the development of a partnering role and approach by HR and what improvements were expected from that.

Ms Nisbet replied that succession planning was a key area being considered in detail through engagement sessions and reviewing department structures and demographics with a view to prioritising attention in vulnerable areas. In terms of the partnering role, she commented that a key change would be a move to HR working more proactively, and liaising with Heads of Service to understand what the challenges were within each remit, from a workforce perspective. Efforts were being made to explore a range of solutions in this respect.

Mr Jenkins highlighted the need to further develop leadership, across the organisation and noted that it could be beneficial to employ a partnership approach to provide consistency. In respect to succession planning, and the related risks he thought it would be beneficial to consider this more formally within a risk based approach, and including this within local risk registers, or as an addition to the Corporate Risk Register. Ms Radage agreed that this would be a useful approach so that progress could be tracked. She added that the recent proactive recruitment approach in relation to nursing had been a helpful initiative in mitigating the risks associated in this area.

Action: S Wallace

Ms Radage summarised for the Committee in terms of the good progress that was demonstrated hers, as well as the link to other papers also on today's agenda, particularly the OD and Wellbeing Strategy.

The Committee:

1. Noted the Workforce Plan 2025-2028.
2. Consider Succession Planning in terms of Local and/or Corporate Risk Register.

7 FITNESS TO PRACTICE ANNUAL REPORT 2024/25

The Committee received the Fitness to Practice Annual Report 2024/25, presented by Ms Nisbet who highlighted that there had been no lapses or concerns regarding registration during the year.

Ms Radage thanked Ms Nisbet for the report which was very helpful in providing assurance.

The Committee:

1. Noted the Fitness to Practice Annual Report.

8a WORKFORCE REPORT

The Committee received the Workforce Report to 30 April 2025, presented by Ms Nisbet who provided a summary of the key aspects. She highlighted a significant increase in activity and volume in relation to recruitment linked to the introduction of a high secure women's service within the State Hospital in July 2025. This had impacted the KPIs and there were incidences where the recruitment process was taking longer to conclude as a result. She reported that there was a decrease in supplementary staffing and overtime, linked to the recent additional recruitment of healthcare support workers. She noted that there was general information included in the report around employability initiatives, and advised that there was focus on collating data from Exit Interviews. An annual report was being prepared in this respect and would come to the Committee at its next meeting.

Action – Ms Nisbet

In relation to the Workforce Equalities Group, Ms Nisbet noted there had been good engagement to date and that an action plan was being developed for submission to the Board.

Action – Mr Wallace

Ms Radage thanked Ms Nisbet for the helpful report and opened up to members for comments or questions.

Mr Currie thanked Ms Nisbet for the overview and noted that there were positive trends in relation to the use of overtime, and also in terms of employee relations cases. He added that this may be due to good work being done by HR and line managers in the approaches being taken. He noted the importance of keeping incidents low in relation to formal process and asked if the timeframe of 3-6 months was appropriate for these cases. He also commented on the continuing development of the Workforce Equalities Group, as a positive addition to the employment offer available within TSH.

Mr Connor noted that that the use of overtime had reduced, which was a positive development given the number of extra hours and commitment pledged by staff. He added that this change may be due to factors such as reduced sickness absence and additional staff resourcing. He further noted that there was an increase in employment relation cases being resolved through early resolution, but also highlighted the lengthy timelines to conclude formal cases, and the subsequent impacts of this both on the individuals involved as well as the organisation as a whole. He added that the potential of staff being absent from work for over six months as a result was excessive.

Ms Radage thanked Mr Connor for this perspective and noted that this could be hugely disruptive. Ms Nisbet commented that there was a level of detail and complexity within individual cases and that the different circumstances of each case meant that a balanced view had to be taken about the progress made to get to the right outcome. She added that it was a priority for the department to progress cases quickly and professionally and acknowledged that this could at times be a challenge within a small organisation.

Mr Moore commented that he was really pleased to see the work evidenced on employability initiatives included in the report, and noted the importance of having demonstrator participants. He added that the possibility of foundation apprenticeships was welcomed.

Mr Jenkins concurred with points made by Mr Moore, and recognised the positive steps forward within staffing. He acknowledged the complexity that was inherent within employee relations cases, and agreed that a review of the details and timelines of individual cases would help to highlight opportunities for improvement in the processes. He suggested that it would be helpful to meet to discuss this further with Mr Connor and Ms Nisbet to identify areas of improvement, especially around how to manage these within a small organisation.

Action: L Nesbit

Ms Nisbet highlighted that in relation to best practice, the Vision newsletter contained an update on the employability exercise with stories about people who were able to undertake the demonstrator programme and would share this with the Committee, as it was a positive programme.

Ms Radage agreed that this would be useful, and it widened the range of routes through which staff came to the organisation and showed the opportunity to do things differently.

She noted that it was encouraging to see reduced staff turnover, which alongside other key indicators may indicate a change in culture and perception of the organisation. In respect of the Workforce Equalities Group, this was also progressing well. She noted that a formal update was due to return to the Committee on this in November, and it appeared to be considering fresh approaches, and it would be interesting to see how this continued to develop. She noted the action in respect of employee relation cases, and that it would be helpful to understand any improvement work in this regard.

The Committee:

1. Noted the Workforce Report.
2. Noted the action on management of employee relation cases.

8b MAXIMISING ATTENDANCE

The Committee received the Maximising Attendance Report presented by Ms Nisbet who gave an overview. She highlighted that this was a key challenge for the organisation as had been recognised by the Committee. She noted that April saw a reduction in long and short-term absences across the organisation, particularly within nursing. However, she thought there should be a note of caution given the challenge to sustain the reduction and reduce absence levels further. She added that there had been detailed analysis around the extent and depth of the absence profile, and it was observed that a significant portion of the workforce have had at least one absence. This accounted for almost 50% of absences overall, showing the extent of absences across the organisation.

Ms Nisbet noted that the report contained information linking absence rates to the estimated overall costs to the organisation, which were based on some broad assumptions and as a result were likely to be conservative in this respect. She added that the report included the external situation in terms of other Boards as well as benchmarking against Rowanbank and the Orchard Clinic. She also summarised the key barriers and challenges, and the increased focus on escalated meetings which continued the development of the absent pathways to support staff back to work. She linked this to future actions which were continuing to evolve, and be worked though in partnership, to ensure that every opportunity to improve performance in this area was being considered. She also noted the linkage to the OD strategy which would be discussed later in the agenda and explained that it was recognised that leadership, the working environment, and culture were key to being able to make a sustainable improvement in relation to sickness absence. She added that the need to manage staff within the policy framework was essential, and it was important to ensure managers had the capability and confidence to make decisions and have supportive discussions with staff.

Ms Radage thanked Ms Nisbet for the helpful report and commented positively on the content of the report which helped focus the key elements for the Committee.

Mr Jenkins provided some further context in relation to performance in this area within Nursing and Operations in particular and noted that he had recently led the most recent quarterly performance review for this directorate. He said that a sustained target performance improvement approach was being taken, which underlined the need for local ownership of this. The areas experiencing the greatest challenge had been identified within this context. He also noted the partnership approach being taken presently which was essential to this. He provided assurance that further consideration was being given to taking a consistency type approach where a small team managed this across the organisation, and this had to be balanced against ensuring continued local ownership. Ms

Radage reflected on the prominence this issue had within the performance framework, and this gave assurance that it was at the very forefront of importance for senior leaders.

Mr Currie agreed with this point, and that it was good to see the priority being given to this. He thought that there was a potential risk in disempowering line managers who should continue to take responsibility for performance within their own teams. The reality was that this was an integral part of their roles, and they were best placed to do this especially within business as usual processes such as PDR which encouraged wider discussions and the ability to support staff. He thought that whilst it was positive to see a downward trend, it may be difficult to continue this in the longer term. The key priority was to support staff back to work, but there was a positive financial impact for the organisation as well. The savings could be invested in staff wellbeing setting up a virtuous cycle. He also reflected on the comparison of absence rates to the potential of an increase of cases where staff capability was under review, and that this did not appear to be the case presently, which was encouraging. This was more about a pro-active preventative approach being taken which was a more positive approach. Mr Currie also commented on the usefulness of the report in identifying issues so that the Committee could address this from a scrutiny and assurance viewpoint. Ms Radage agreed that there are some important points raised, and that the report helped to highlight the challenges being faced.

Mr Connor thought the absence rates were not sustainable in the long term, and this was very clear. He thought that there may be a risk of a seasonal impact over the summer. He had added this to the agenda for the next Joint Staff Side meeting, so that there could be discussion and the opportunity for staff side colleagues to contribute as well.

Ms Moore commented that he appreciated the provision of the data and welcomed the reduction. He highlighted concern around 44% of staff having had one absence which accounted for 47.8% of absences in the last 12 months, and considered how this could be manged and improved upon. He noted that at the recent Board Development Day, there had been discussion on this issue, and consideration of how this was communicated to staff. He said that it may be beneficial to consider the risks and benefits of considering a more robust approach being taken. It would be helpful to think further about the options available. Ms Nisbet agreed and added that a discussion would have to be approached with consideration and sensitivity. She indicated that, in relation to the delivery communication to line managers, a two pronged approach could be taken forward with board wide communications.

Ms Radage agreed that it was a good idea to consider different approaches, and to do so thoughtfully when communicating to staff as a whole. This could include highlighting the financial costs to the organisation and the opportunities that were potentially lost as a result. At the same time, there would need to be sensitivity and caution in this area, to ensure that staff who were experiencing serious illness continued to feel fully supported.

Mr Jenkins commented on how ownership of this was perceived at different levels of the organisation, including by senior leaders. At team level there needed to be more understanding of their own performance and how this compared to other departments. This would be taken forward at the next Leadership Development Day, and it should fit well with the organisational health and performance approach being led through Organisational Development. He agreed that there were sensitivities around the communications approach and that this would be useful to consider within that development session, linked to structure and leadership accountability.

Ms Radage noted that how communication was received by employees was dependent on the quality of the manager. She also thought that the existing pathways were helpful, especially for new managers. It would also mean consistency across the organisation. She added that the report illustrated a proactive approach which would lead to sustainable improvements and that it would be important to keep a focus on this, acknowledging the challenges in this area. Ms Radage thanked members for their contribution to discussions.

<u>The Committee:</u>

1. Noted the Maximising Attendance Report.

8c e-ROSTERING UPDATE

The Committee received an e-Rostering Update presented by Ms Nisbet who informed members that the report was generated in response to a recent internal audit report, which had resulted in an outcome of partial assurance.

She added that the audit was tasked initially to review the Time of in Lieu and shift swapping practices, however, the scope was extended to look at rostering practices more generally. She added that, although the e-rostering system had been implemented, some manual processes were still being used in conjunction with the new system due to being in a transitional phase at the time of the audit. The audit identified issues proposing immediate and long-term actions which were expected. She noted that the audit outcome provided an opportunity to plan and provide assurance, and that the implementation of the reduced working week would help review the system in greater detail and address issues prior to the April 2026 deadline. The audit helped to highlight weaknesses in the system which had already been identified, and would help to progress the improvement required.

Mr Jenkins informed members that he had been involved directly in the response to this audit, and was leading bi-monthly meetings with Director of Finance and eHealth, the Director of Nursing and Operations and the Director of Workforce. Directors were expected to take accountability for actioning the required actions.

Mr Moore commented that the national issue of compatibility had been highlighted previously and asked if progress was likely to be made in the near future. He also asked what the limitations were in relation to implementing the new system locally. Ms Nisbet replied that the system difficulties in terms of interfacing with payroll remained and that there was no confirmed timescale for this to be resolved. This meant that there was a continuing need to “double key” using two systems. She added that this issue would not prevent the organisation from fully utilising the system more widely.

Mr Connor asked, in relation to the management actions 4, 5 and 7, how the Committee would obtain assurance that the actions were being completed as outlined, particularly in relation to following the relevant protocols. This was around what would change in terms of practice. Mr Jenkins responded that the Director of Nursing and Operations had been asked to obtain evidence from Lead Nurses through monthly audits on compliance. This represented a detailed check process to ensure compliance. He had requested bi-monthly reporting arising from this. Ms Clark echoed this by advising that this work was already being progressed.

Ms Radage noted that it was encouraging how quickly these issues were being responded to following the audit. She thought it was important to identify the milestones on this, and Mr Jenkins noted that formal reporting would come back through the Audit and Risk Committee meeting, and that could provide a mechanism to ensure any issues arising for this Committee would then be shared.

The Committee:

1. Noted the e-Rostering Update.

9a CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

The Committee received the Corporate Risk Register - Staff Governance Risks and Ms Nisbet highlighted the movement and changes made recently.

The risks associated with the workforce plan and deliberate leak of information had been returned to the local risk register, as appropriate control measures are in place. She noted that the risks regarding compliance with PMVA training and job evaluation would remain on the Corporate Risk Register but would be continually reviewed in relation to the compliance levels.

Ms Nisbet reported that a further three risks had been identified: new PVG Disclosure Scotland legislation, failure to adequately reduce and control sickness absence and the impact of the reduced working week across services. These were being reviewed in detail and would be proposed for escalation and agreement to the Corporate Management Team prior to being submitted to the Board for consideration.

Mr Currie reflected on those key risks that could be consequential across the whole organisation, in terms of how these were linked together. Mr Jenkins replied that he thought that this was contained within the detailed risk assessments completed, with the links across these to other risks being contained therein.

Ms Radage asked about the job evaluation risk and noted that it had been escalated due to the challenges that had existed historically on the timescales, with delays being experienced. However, this had since been resolved albeit that there was a potential risk related to the Agenda for Change Band 5 nurse review. She asked whether this risk should be specific to this element rather than the process as a whole. Mr Jenkins agreed with this point, and Ms Nisbet added that it was important to reframe the risk, as the potential risk had shifted to ensure the impact of risks was calculated accurately.

The Committee:

1. Agreed that the Corporate Risk Register: Staff Governance Risks represented an accurate statement of risk.

9b OD & WELLBEING STRATEGY

The Committee received the OD & Wellbeing Strategy, and Ms Dunlop provided an overview of this. She began by describing the development of the strategy which involved detailed diagnostic work and extensive consultation with staff at all levels over the last 12-15 months. She highlighted that direction, leadership and management and work environment were the three key strategic priorities: direction, leadership and management and working environment. It was also essential that wellbeing remained at the centre of each of these priorities.

In relation to the eight core commitments outlined in the strategy, she indicated there was a focus on a programme of culture change, embedding shared values, shared behaviours across the organisation and creating a more inclusive, supportive, and safe working environment as well as building team resilience and promoting collaboration. This would help to improve performance within teams. The strategy also outlined the metrics that would be used to measure progress against these commitments, as well as developing a health dashboard to give data relating to organisational health, and using that to drive change.

Ms Dunlop highlighted that consideration was being given to the staff recognition approach in terms of how to build staff recognition into day-to-day practice and how to strengthen staff support systems and ensure they were responsive, reflective of staff needs and accessible. Members were informed that, in relation to leadership and management, a more structured succession planning process and coherent framework for managers, in terms of competence and behaviours expected would be developed. Ms Dunlop asked for the Committees endorsement of the proposal and planned three-year approach for implementation, given the wide scope and complexity of the strategy.

Ms Radage thanked Ms Dunlop for the overview and invited members comments or questions.

Mr Jenkins noted that the strategy illustrated really good progress in relation to organisational development and effectiveness as well as the importance of adopting an inclusive approach in the introduction phase. He added that the strategy was introduced at a seminar session to the whole organisation, which was well received.

Mr Connor noted that the strategy was positive from a staff perspective and was welcomed for its suggestions around culture initiatives and change. Ms Clark welcomed the inclusion of the 'Excellence in Care' link within the strategy.

Mr Currie thanked Ms Dunlop for the helpful report and thought that it represented a positive way forward, but the difficulty may be implementation which would be really important and should be a shared responsibility. It needed to be integral to the organisation and was an exciting development for TSH. He noted the importance of collating ideas of how to harvest the experience of staff prior to leaving the organisation, especially in relation to succession planning. Ms Dunlop commented that the approach adopted to the development of the strategy should enable smooth implementation as care had been taken to be inclusive and generate enthusiasm for the process.

Mr Moore welcomed the report saying that it was a helpful read, especially the diagnostic and engagement work. He thought that some of the issues discussed at today's meeting formed some of the themes in the strategy, especially leadership and management competence. He asked about how this would be developed and resourced, and if a bespoke approach would be developed or would progress be reliant on existing opportunities with the NHS. He also noted the detail contained within reporting around metrics, and how these would be utilised, commenting on the more qualitative aspect of the strategy. Ms Dunlop responded that, in relation to leadership development, this would be case of a combination of approaches using regional and national resources, as well as a more tailored internal provision specific to TSH. She highlighted that there was a focus on development at all levels for leaders and managers.

Mr Moore asked if there was a shorter version of the strategy which could possibly be used to communicate with staff on an ongoing basis, and at induction sessions. It was a strategy that all staff needed to own and develop over the three year period. He also said that that there had already been progress made over the past few years in terms of organisational culture i.e. this was building on good work that had already been done. Ms Radage agreed that it would be helpful to produce a pared down version for communication purposes and consider how to maintain the level of engagement over the three-year period. Ms Dunlop replied that staff and managers had been provided with a condensed version, and there would be continued engagement throughout the implementation period, to build motivation. Ms Radage thought that maintaining communication and momentum with staff would be key moving forward.

Mr Jenkins agreed with Mr Moore in relation to this being the ongoing continuous development of the organisation and the refreshed impetus achieved with regard to engagement. He thought it would be important to think about the tangible ways through which to anchor this, going forward. He also thought that some of qualitative aspects from the strategy should appear across different metrics in the organisation and it would be helpful to reflect on what this would look like going forward. Mr Jenkins commented that the OD Manager had been invited by the Head of People and Change for NHS Scotland, to present on this due to the comprehensive offer and unique approach. There might be some national interest over what this strategy might deliver organisationally. It was essential to keep focus on the key aspects of the strategy as it was implemented within TSH.

Ms Merson commented that it was a very good strategy and a well-grounded product. She welcomed the cohesion across the medium-term plan, the ADP, the workforce plan, and the OD Strategy in terms of being able to demonstrate the linkage between the strategies to staff.

Ms Radage noted that, although challenges were expected in relation to implementation, the strategy offered a solid foundation to help ease and facilitate significant progress, especially the continued focus on wellbeing. There was discussion on the governance arrangements, with agreement that following agreement at the Board, this would be reviewed twice yearly by the Staff Governance Committee to take detailed oversight of its progress and resultant impacts. It was also suggested that this was added to the next Committee meeting agenda to allow wider discussion.

Action – Secretariat

The Committee:

1. Approved the OD & Wellbeing Strategy for onward submission to the Board.
2. Agreed to add this as a discussion item at the next meeting.

10a OD, LEARNING AND WELLBEING REPORT

The Committee received the OD, Learning and Wellbeing Report presented by Ms Dunlop. She summarised the key aspects including that PDPR compliance was at 91% at the end of April, and that Statutory and Mandatory training and Healthcare Support Worker Induction training maintained good levels of compliance. She further highlighted that a reduction in compliance with refresher training standards was experienced in quarter 4. This was escalated to the Organisational Management Team and since then compliance has improved.

Ms Dunlop noted that a new mandatory training procedure was developed to give clarity around the expectations and requirements for statutory and mandatory training in response to the internal audit carried out at the end of 2024 and was now in place. Members were informed that positive feedback was received with regard to the Excellence Awards and staff did not feel the absence of patients detracted from the event. She also noted that the Wellbeing Centre, Peer Support Network, Staff Care Specialist service and the Time for Talking service had received good engagement.

Ms Radage thanked Ms Dunlop for the helpful overview and invited members comment or questions.

Mr Jenkins noted that it was interesting that family issues and parenting was the second most important thing to staff when using the peer support service, as it helped to highlight the importance of this for staff. Ms Radage agreed with this, and added that it was good to see that the Peer Support Network was well used. It was important to recognise that there are indications that staff have personal pressures which need to be considered and supported.

Ms Radage noted that the Responding to Medical Emergencies training compliance was reported at 60% and asked if this figure had seen improvement since the report was submitted. Ms Dunlop confirmed that the figure was for the refresher training and work was being done to improve the statistic. The figure for the initial training was at 100%.

Mr Moore acknowledged the positive data in relation the Healthcare Support Worker Induction compliance and the importance of this training to prepare staff to work with the patient group.

The Committee:

1. Noted the OD, Learning & Wellbeing Report

11a PARTNERSHIP FORUM APPROVED MINUTES

The Committee received the approved Partnership Forum Meeting minutes from 28 January 2025 and 11 March 2025. Ms Radage noted that it was helpful to have sight of the minutes for openness and transparency.

The Committee:

1. Noted the Partnership Forum Minutes.

11b WORKFORCE GOVERNANCE GROUP MINUTES

The Committee received the draft Workforce Governance Group meeting minute from 18 March

2025. Ms Nisbet noted that the new structure of the agenda was in progress and there was good engagement with the group. Mr Jenkins added that discussions at the meeting demonstrated that the key organisational concerns were being discussed at an operational level.

The Committee:

1. Noted the Workforce Governance Group Minute.

12a COMMITTEE WORKPLAN 2025

Members received the Committee workplan for 2025. Ms Radage noted that the workplan was helpful and appeared to be working well.

The Committee:

1. Noted the Committee Workplan 2025.

12b AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

The following areas were highlighted:

Mr Jenkins noted the e-rostering audit as an area of improvement.

Mr Moore highlighted the employability initiatives, and Ms Nisbet confirmed she would share further information in this respect.

Mr Currie noted the positive format and succinct approach of the Maximising Attendance report.

Ms Nisbet highlighted that the TSH response changes to the PVG Disclosure Scotland legislation was an emerging area of best practice noting that over 200 staff had been checked and 50% of the workforce had engaged with the process already. She added that she would provide updates on progress at the next meeting. Ms Radage agreed that this was a positive start.

12 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Mr Jenkins noted that he would have a discussion with the Audit and Risk Committee Chair to ensure e-rostering was being brought to the right Committees and the points raised by Mr Connor in relation to the governance and assurance aspects.

Action – G Jenkins / Secretariat

13 ANY OTHER BUSINESS

There were no additional items for discussion.

14 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 21 August 2025** at 0930 hours via Microsoft Teams.

The meeting concluded 12:00pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 18b
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 21 August 2025.

1	OD And Wellbeing Strategy	The Committee received a presentation on the new strategy which was approved by the Board at its last meeting in June, with key priorities including wellbeing, as well as the working environment or culture, and leadership and management development. Now prioritising the areas which will have the biggest impact but taking a balanced approach to the timeline for implementation. The focus is to ensure that it is meaningful for staff across the organisation and is informed by the feedback received from staff. The Committee considered the OD cycle in future implementation of the strategy and discussed the importance of taking an integrated approach to make effective changes, especially culture.
2	Workforce Plan 2025-28	The Committee received a draft of the Workforce Plan for 2025/28, with assurance that this was developed in line with national guidance, as well as the key workforce priorities for the hospital. It is aligned to the Medium Term Plan, and the key drivers internally and externally for the State Hospital. The intent is to be aspirational, with areas of improvement for the future. The Committee received this positively and discussed recruitment and retention of staff and as an employer of choice, linkages across NHSScotland, and the wider reform agenda particularly opportunities for innovation and future impacts on the workforce skill mix.
3	Workforce Report (including Exit Interviews Findings)	Reporting provided a summary of performance over the full range of workforce metrics, including attendance, recruitment, and retention as well as employee relations. Reporting also included a summary of findings from a survey conducted with staff who had recently left their employment at the State Hospital, in the context of low turnover. The Committee discussed the learning to be taken from the data sets, as well as how to encourage the uptake of exit interviews.
4	Maximising Attendance	Detailed data analysis was presented in respect of absence rates for the State Hospital and put in context of wider NHSScotland. There was a reported downward trend in sickness absence – with rates at just above 6% in the past three months. The Committee discussed the focused work that is being taken forward, including

		review meetings with services and pathway usage, and the potential to embed these approaches and make sustained improvement going forward. Further, analysis of trends to inform future actions to support staff as well as supporting line managers.
5	Health and Care Staffing	Assurance reporting received on the position for Quarter 1, showing positive progress made against the key performance indicators with the introduction of SafeCare/Optima being rolled out across the hospital, and potential benefits in terms efficiencies.
6	Workforce Equalities Group – Approach and Plan	The Committee received an update on the activities of the Equalities Group, and its focus on establishing key themes and priorities in terms of equalities prior to developing an annual action plan. This will include the organisation's anti-racism plan. The Committee discussed the lived experience survey carried out recently and the emerging themes. The Committee recognised the central importance of this workstream, and welcomed the work being driven forward.
7	Workforce Environment	The Committee received a verbal update on planned assurance reporting on the physical environment, as well as psychological safety. This will be aligned with the Health and Safety Committee and will be a further route through which to give voice to staff concerns should these arise. An update will be brought to the next meeting.
8	Non Executive Walkround Programme	Reporting noted that walkrounds were re-established in December 2024, and that four had taken place to date. The Committee received a summary of the walkround activity, and the feedback recorded on each occasion which came from both staff and patients. Reporting was linked to iMatter, showing that staff feel that senior leaders are not visible enough. The Committee discussed the benefits of this programme, and the ways in which it could be developed further including use of staff briefings prior to visit and a feedback loop, and to link to the OD strategy and wider communications. It was decided that this discussion would be part of an upcoming development session.
9	Corporate Risk Register - Staff Governance Risks	The Committee received reporting to highlight corporate risks related to staff governance, with five active risks for consideration including: Level 2 Prevention and Management of Violence and Aggression training, Agenda for Change (AfC)Job Evaluation process, Reduction in Working Week (AfC) and sickness absence levels and implementation of the changes in the PVG disclosure process.
10	Nurse Practice Development Update	The Committee received a six monthly update on activity including a one-year evaluation of the Clinical Care Policy and Training Needs Analysis Survey, impact of the introduction of a women's service, as well as Clinical Supervision and The Education programme for Health Care Support workers.
11	Occupational Health Annual Report	The State Hospital has a service level agreement in place with NHS Dumfries and Galloway for the provision of OH services. The Lead joined the committee to provide a summary of activity over the past 12 months, with assurance on performance against defined indicators. Further, on developments in physiotherapy and psychological therapies, nurse led clinic, management referrals and self-referrals from staff, and seasonal vaccination programme. The report demonstrated increasing confidence in the delivery of the service, and the support mechanisms available.
12	OD Learning and Wellbeing Report	The Committee received a quarterly update on activity in these areas, showing positive improvement in performance on Personal Development Planning and Performance (PDPR) compliance, as

		well as statutory and mandatory training. Reporting also included updates on the Staff Recognition Programme and Staff Support Systems. Further, there was a notable increase in pro-active team development. The Committee also received a summary of the iMatter survey for the past year.
13	Minutes:	The Committee received the minutes of meetings held in the past quarter from the Partnership Forum and the Workforce Governance Group.
14	Areas of good practice /Concerns	The Non-Executive Walkround Programme was highlighted as an area of good practice, as well as improvements in the delivery of the Occupational Health Service and the implementation of the OD and Wellbeing Strategy.

RECOMMENDATION

The Board is asked to note this update, and that the full meeting minutes 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 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:	28 August 2025
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive Officer
Author(s):	Corporate Business Manager/Head of Corporate Governance
Title of Report:	Feedback and Complaints Annual Report 2024/25
Purpose of Report:	For Decision

1 SITUATION

NHS Boards are required to produce annual reporting relating for both complaints and feedback, to comply with the Patient Rights (Scotland) Act 2011 and associated regulations and directions.

2 BACKGROUND

The Safety, Openness and Learning Unit within Scottish Government issues guidance each year, which sets out the required areas of reporting to be included. The guidance covers both feedback and complaints, and the key performance indicators which must be reported on. The guidance is prepared based upon the Good Practice Guide for NHS Complaints Handing led by the Scottish Public Services Ombudsman.

During 2024/25, the Patients' Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Amendment Directions 2024 came into force meaning that NHS Boards are required to submit their annual report within six months of year-end. Therefore, all NHS Boards are required to submit annual reporting by 30 September 2025.

Responsibility for publication of reporting of all feedback and complaints across NHSScotland is currently managed by Scottish Government, with the intention for this taken forward through Public Health Scotland in the future, in line with other NHS Statistical publications.

3 ASSESSMENT

In the State Hospital, the Head of Corporate Governance acts as Complaints Manager for the organisation, and this role is delegated from the Chief Executive Officer. Detailed reporting is presented throughout the year to the Clinical Governance Committee, to provide assurance on the implementation of the Complaints Handling Policy within the State Hospital, as well as on the range of issues raised through the process, and the learning taken as a result.

Until 2024, reporting of feedback and complaints had been submitted separately, but changes in the organisational structure supported a move to streamlining this into one report. This has been accepted positively, and this move has helped in the preparation of this report. At the same time,

the complaints department has undergone a refresh within the Corporate Services Team both in terms of resourcing and the approach taken.

This report has been prepared to provide a summary of activity for the year 1 April 2024 to 31 March 2025, in line with the national guidelines. Section 1 outlines the steps undertaken to encourage and gather feedback, and places this within the context of the challenges of doing so within the State Hospital given its unique patient cohort. The report also highlights the central importance of the Patient Partnership Group, as well as the development and implementation of the Carers Strategy. There are some examples of the types of feedback received during the year.

The next section is focused on the handling of complaints and provided a range of metrics including numbers received and the time taken to resolve at each stage of the complaints process. Whilst resolution at the early stage does meet the target timeline, there is work to be progressed to improve response times to Stage 2 complaints.

There is further background relating to the outcomes of complaints, on how to take learning from complaints linking this to quality improvement in the delivery of services. This is further developed in Section 5 providing some examples of this, and placing this within the context of the main issues raised and any themes arising from these.

The report acknowledges the involvement of the Patients' Advocacy Service, who support patients through the process to resolution.

The report provides background on staff awareness, training and development especially given the way in which the management of feedback and complaints can be a component reflecting the culture of an organisation. Finally, the report summarises the governance and accountability arrangements in place to ensure that patients and carers can share their views and influence the delivery of care within the State Hospital.

4 RECOMMENDATION

The Board is asked to:

1. Note assurance on delivery of the model complaints handling policy, especially the focus on quality improvement and learning from complaints.
2. Approve the report for submission to Scottish Government by the due date of 30 September.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	The CHP introduced a standard approach to managing complaints across NHS Scotland which complies with the Scottish Public Services Ombudsman (SPSO) and meets all the requirements of the Patient Rights (Scotland) Act 2011. Reporting measures performance and delivery.
Corporate Objectives Please note which objective is linked to this paper	**Better Care:** Be accessible to patients, their family and visitors ensuring their views and experiences are reflected in service improvements, implementing the Carer Strategy 2025/28. Work with stakeholders and Scottish Government representatives to enhance the reputation and healthcare 'profile' of the State Hospital **Better Value:** 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	There are no associated workforce implications, and training and support for staff is reported on within the report.
Financial Implications	There are no associated financial implications.
Route to Board	Requested by Board through workplan as part of annual reporting requirements.
Risk Assessment (Outline any significant risks and associated mitigation)	There are reputational risks associated with not meeting the MCHP target response times, as well as the risk of systemic failure to respond to concerns raised.
Assessment of Impact on Stakeholder Experience	Reporting captures stakeholder views and how these are responded to by the organisation for service improvements.
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)	Not applicable
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

Feedback and Complaints Annual Report 2024/25

Contents

Introduction

The State Hospital's Board for Scotland Board is one of NHS Scotland's National Health Boards and is a high secure forensic mental health facility, providing care and treatment for up to 140 male patients during 2024/25. In July 2025, the hospital opened an interim service for women.

The State Hospital is committed to understanding the impact of service delivery and focuses on taking learning from feedback and complaints. This report provides details of feedback and complaints received during the period 1 April 2024 to 31 March 2025, reviewing performance in relation to managing feedback and complaints (incorporating compliments, comments, concerns and complaints) aligned to the NHS model Complaints Handling Procedure (CHP).

The CHP supports a person-centred approach to complaints handling across NHS Scotland, adopting a standard process, ensuring staff and people using NHS services have confidence in complaints handling and encouraging NHS Boards to learn from complaints and feedback to support ongoing service improvement based on experiential learning.

Given the unique nature of the care provided at the State Hospital, eliciting feedback and managing the aspirations of complaint outcomes for this patient group is complex, and can often be linked to mental health presentation

Section 1

Encouraging and Gathering Feedback

The State Hospital is committed to creating an organisational culture in which stakeholders are recognised and meaningfully involved as equal partners in service delivery. Feedback is welcomed from patients and carers as this data enables the Board to improve its services. Patients can experience a range of difficulties relating to the impact of mental health conditions which impact their ability to communicate effectively.

The State Hospital has a wide range of well-established methods through which stakeholders are actively supported to share their views. The Person-Centred Improvement Team are pivotal to this, and link to patients and to carers in a number of ways.

This includes the Patient Partnership Group (PPG) which supports patients to discuss and provide feedback on a wide range of issues impacting their lives. The State Hospital also recognises the knowledge and the experience that carers offer to support the recovery journey. In 2024/25, a Carer Experience Questionnaire was conducted eliciting feedback which helped to inform the development of the Carer Strategy 2025/28.

Visiting arrangements take place in the dedicated Family Centre Building. Carers' experience of this aspect of service delivery is closely monitored with feedback actively sought to support ongoing learning.

The State Hospitals Board for Scotland received three stakeholder presentations throughout 2024/25, this included from a patient about how important participating in sports had been to

his care journey, and from a carer about their reflections on how their role changed over the longer term and the patient's move from high secure to a lower secure facility.

The Datix system is used to record any additional feedback, which is collated by the Complaints Team.

Welcoming and Supporting Feedback from all Equality Groups

In recognition of the challenges of enabling this very vulnerable patient group and their carers to engage, the Person-Centred Improvement Team (PCIT) has a specific remit to ensure that patients and carers understand that their views are important and welcomed. A proactive approach is adopted to ensure that stakeholders are supported to contribute to organisational learning.

Prior to admission, the Specific Needs Assessment process highlights any barriers to communication which indicate that a patient may have some challenges in sharing their views from the outset. The PCIT has ongoing awareness of patients who have been assessed as having specific communication needs (e.g. Intellectual Disability, Dementia, Autism, sensory impairment, literacy skill deficits, language barriers). A wide range of additional support mechanisms are used to elicit feedback (e.g. translators, interpreters, Graphic Facilitation, Talking Mats). A tailored approach is adopted when required to ensure that 'hard to reach' patients, whose mental health is of significant concern, are supported to engage on a 1:1 basis within the ward environment.

Feedback Received

The PPG has continued to be facilitated with patient representatives from all wards in the hospital. Group members are tasked with collating and sharing feedback received from peers within their ward. The group meet weekly, using creative feedback, where appropriate, to share their views and engage in solution focussed sessions relating to a range of topics. During this year, topics included digital inclusion, the Supporting Healthy Choices project and the catering service. In 2024/25, the group noted that there had been a decrease in the number of concerns communicated via this forum and the consensus of the discussion was that patients are choosing to communicate these at a more local level via ward and hub community meetings.

The Carers Experience Questionnaire identified four key priorities: reviewing the Triangle of Care Standards, communication, the visiting experience and development of a carer pathway.

Feedback was also received about a range of wider issues including opening times for the Charity Shop, visiting arrangements and video visits. Carers raised a number of concerns about difficulties experienced when bringing food and drink items into the hospital for in person visits.

There were a number of compliments received mostly about improvement in visiting in the Family Centre and patient and carer festive activities, and about positive engagement through the PPG. One patient, who had moved on from the State Hospital, wrote to express his thanks to his care team for the positive impact they had had on his rehabilitation journey.

Recording Feedback

Stakeholders sharing feedback are advised how their feedback will be used and asked whether they would like to be appraised of the outcome of actions taken to respond to their feedback. This feedback is shared with service providers which enables learning and the potential for improvement.

Feedback is reported quarterly through Feedback and Complaints Reporting and this is shared with the Clinical Governance Group as well as the Organisational Management Team to ensure that there is awareness across the organisation, and an opportunity to take action where appropriate.

Section 2

Encouraging and Handling Complaints

The model CHP introduced a standard approach to managing complaints across NHS Scotland, which complies with the Scottish Public Services Ombudsman (SPSO) and meets the requirements of the Patient Rights (Scotland) Act 2011. The two-stage model enables complaints to be handled:

- Locally, allowing for ***Early Resolution*** (**Stage 1)** within 5 working days.
- Or for issues that are more complex, by ***Investigation*** (**Stage 2**) within 20 working days.

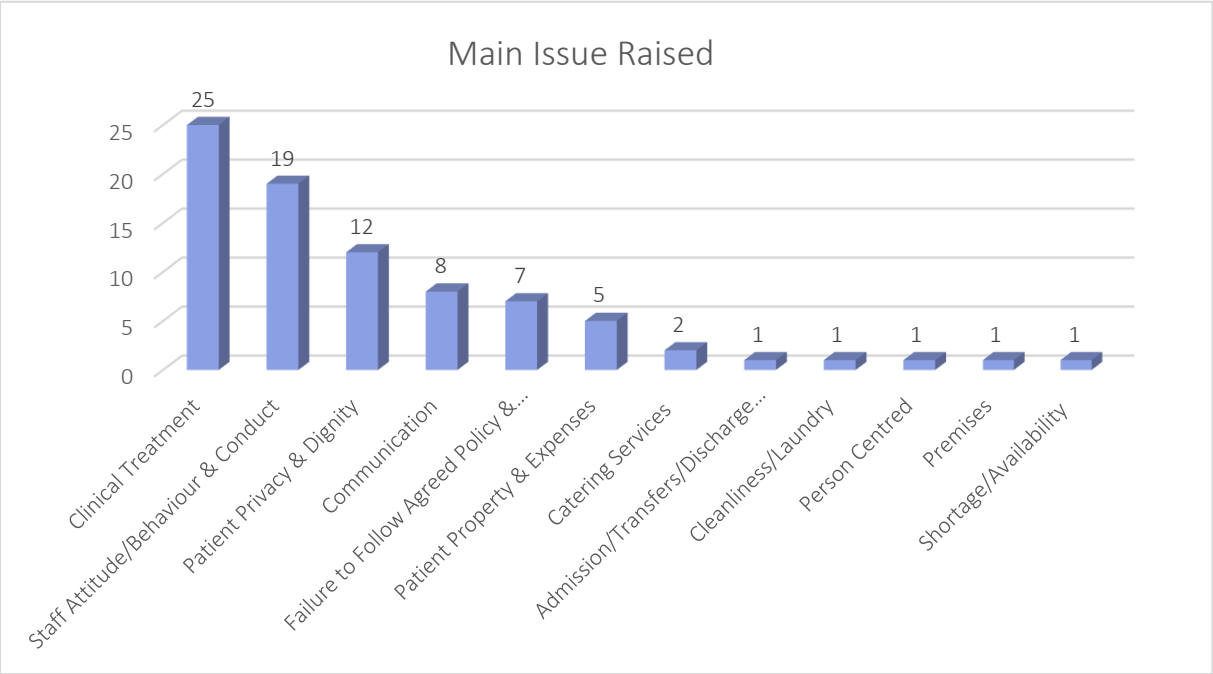
Complaints Received

The hospital received **83** new complaints this year showing a decrease of 11% on the previous year. The table below shows the number of complaints received, the average number of patients, and the number of complainants over the last three years.

Number of Complaints Received	**2022/23**	**2023/24**	**2024/25**
Total Number Received	87	95	83
Average number of patients throughout the year	110	103	101
Number of Complainants	41	40	44

Due to the nature of the environment as a long-term health care setting, it is expected that patients will make more than one complaint during their time with us. During the year 17 stakeholders made more than one complaint, compared to 16 in 2023/24 and 20 in 2022/23.

The chart below shows the main issue raised in each complaint.



Involving the Complainant in Early Resolution

The 5-day early resolution stage continues to be a positive step in resolving issues quickly and continues to be welcomed by staff and patients.

60% of complaints were resolved through early resolution this year.

The independent Patients' Advocacy Service (PAS) continues to provide a valuable service in supporting patients who wish to make a complaint and may require support, or do not wish to do so directly.

PAS are based on site and regularly support patients to resolve issues through early resolution. They also provide support and guidance to patients who wish to escalate their complaint. PAS work closely with the Complaints Team and the PCIT to highlight themes and identify opportunities to share best practice in relation to learning emerging from complaints and feedback. This year **68** patient complaints were supported by PAS, which represents **82%** of all complaints received.

The Complaints Team works closely with PAS, meeting regularly, to share best practice in complaints handling and to discuss learning emerging from complaints. These relationships further strengthen the advocacy route through which patients can raise concerns.

We remain mindful of how challenging it can be for patients in a long-term health care setting to speak up. Particularly where it relates to the staff providing their care and with whom they are in daily contact, and how this can deter patients from raising issues.

To encourage and support patients to provide feedback and to make complaints, patients can choose if they would like to meet with staff locally themselves, meet with staff locally supported by PAS or the Complaints Officer, or have no direct involvement with staff during the early resolution process and receive a written or verbal response directly from the Complaints Officer or through PAS.

These options continue to work well and there has been more uptake from patients when presented with these options. Patients are also encouraged to identify what outcome they are seeking when making a complaint, which is beneficial in managing their expectations.

Complaints Closed

A total of **73** complaints were closed this year. Of these, **44** complaints (60%) were resolved at Stage 1.

The table below shows the number of complaints closed at each stage this year and, for comparison purposes, the previous two years.

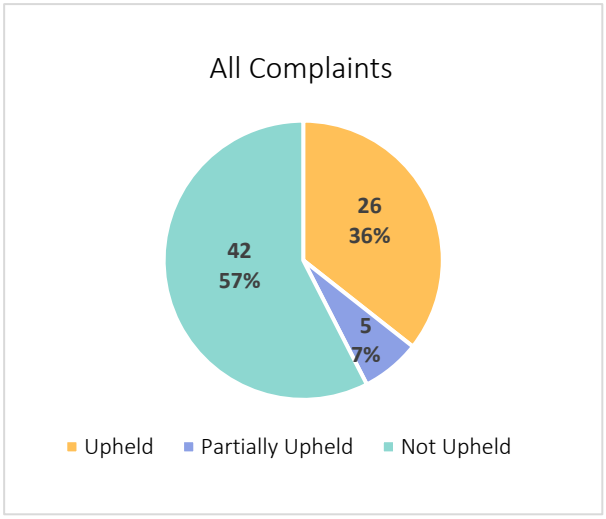
Complaints Closed	**2022/23**	**2023/24**	**2024/25**	**% of all closed**
At Stage 1 (Early Resolution)	65	59	44	**60%**
At Stage 2 (Investigation)	13	12	17	**23%**
After Escalation to Stage 2 (Investigation)	7	11	12	**17%**
Total	**85**	**82**	**73**	**100%**

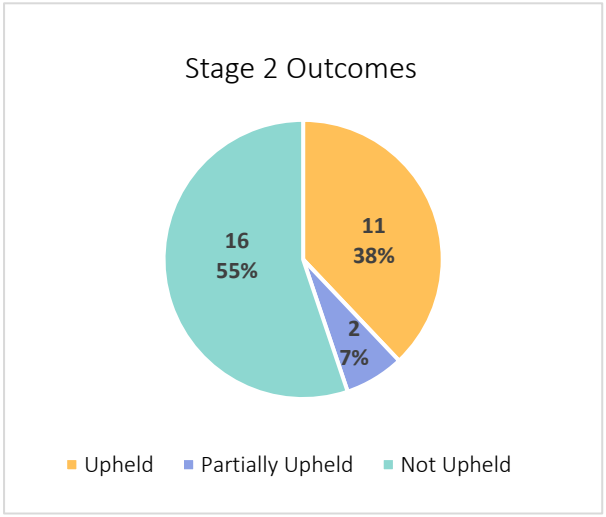
Complaint Outcomes

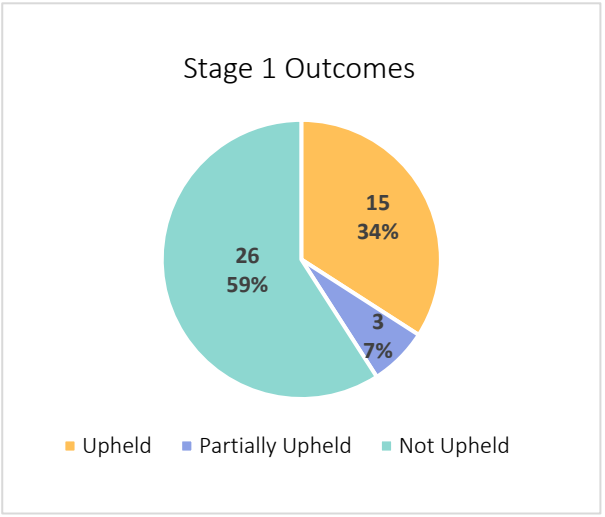
Complaints closed are categorised as either being upheld, not upheld or partially upheld. Outcomes continue to be sense checked through the Complaints Manager, and random audits are carried out on complaint files. This helps to review both the quality of responses provided as well as recognising that the culture of an organisation may impact on the way that it responds to complaints. The focus is on the need for transparency and openness, as well as an ability to apologise if service delivery has fallen short of the accepted standards.

The chart below provides data relating to the outcomes of complaints closed this year.

All Complaint Outcomes 2024/2025







Average Response Times

The State Hospital continues to aim to adhere to the CHP targets timescales for resolving complaints within five working days at Stage 1, and 20 working days at Stage 2. Although this was achieved at Stage 1, this target was not reached at Stage 2, with the average days to respond being 28 days. This was related both to the complexity of some individual complaints, as well as challenges in staff availability, and time taken to provide the background information required for a fully detailed response.

The table below shows the average number of days taken to respond to complaints this year and for comparison purposes, the previous two years.

Average Number of Days	**2022/23**	**2023/24**	**2024/25**
To resolve at Stage 1	5	4	**5**
To respond at Stage 2	31	26	**28**
To respond escalation to Stage 2	18	19	**27**

A key target for 2025/26 is to improve response times at Stage 2 whilst maintaining the good performance evidenced at Stage 1. There has been a refreshed approach to staff resourcing within the Corporate Services Team in support of this aim.

Responding within Timescales

The tables below show our performance in responding to complaints at each stage within the CHP target response times. Whilst extensions to the response times should be an exception, the Complaints Team works to ensure that the response fully address all of the issues raised. Therefore, in some instances an extension has been required to allow a more comprehensive response to be provided.

The SPSO has confirmed that there is no prescriptive approach about who should authorise an extension – only that decisions should be proportionate and made at a senior level. The Complaints Manager takes this responsibility within the State Hospital.

Closed within timescales

Complaints **Closed within the target timescales**	**2022/23**	**2023/24**	**2024/25**
Closed at **Stage 1 within 5** working day target	46	48	**32**
as % of the total number closed at Stage 1	71%	81%	**73%**
Closed at **Stage 2 within 20** working day target	12	13	**7**
as % of the total number closed at Stage 2	60%	57%	**24%**

Extensions to timescales

Complaints that **required an extension**	**2022/23**	**2023/24**	**2024/25**
Closed at **Stage 1 after 5** working day target	19	11	**12**
as % of the total number of Stage 1 closed	29%	19%	**27%**
Closed at **Stage 2 after 20** working day target	8	10	**22**
as % of the total number of Stage 2 closed	40%	43%	**76%**

This year has seen an increase in the number of complaints requiring an extension at Stage 2. In some instances, this was attributed to staff availability to respond but was also due to an increase in the complexity of the issues raised. Whilst being mindful of meeting timescales it is important that a full investigation is completed before a final response is issued. Where delays occur, complainants are kept informed of this and the reasons for the delay.

Focus on Quality

An internal quality assurance process has been established to ensure compliance with the requirements of the CHP. As detailed within this report, performance timescales and recording of outcomes are quality checked by the Complaints Manager.

Stage 2 investigation responses are also checked by the Complaints Manager to ensure the quality of the response and that it answers all of the concerns raised. The Director(s) responsible for the service(s) involved are asked to review and approve the content, before a proposed draft is provided to the Chief Executive for finalisation. This process is aimed at ensuring directorate accountability, as well as bringing focus on learning opportunities and identifying trends in respect of the issues raised.

Scottish Public Services Ombudsman

As the final stage of the CHP, complainants who remain unhappy with the response to their complaint at Stage 2 can ask the SPSO for an independent external review.

No complaints escalated to the Scottish Public Services Ombudsman during this year.

Section 3

Culture, Staff Awareness, Training and Development

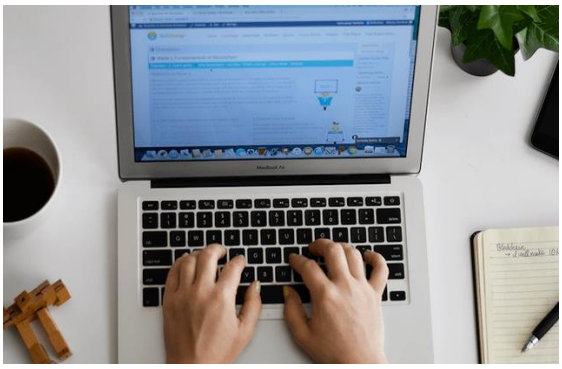
Our Values and Aims; are the core values of NHS Scotland:

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality and teamwork

Our primary twin aims are the:

- Provision of high quality, person centred, safe and effective care and treatment.
- Maintenance of a safe and secure environment that protects patients, staff and the public.

Staff Awareness and Training



All staff are required to complete the national e-learning Feedback and Complaints training modules. A total of 98% of staff members had completed the e-learning modules at the end of March this year. In addition to the online modules, a complaints awareness session formed part of the induction programme for all new staff and student nurses.

A Complaints awareness session is also delivered at Corporate Induction Days by the Complaints Manager.

Supporting staff to respond to complaints investigations, with refreshed training in this area for newly promoted staff, remains a key area of focus for the Complaints Team.

Full support is also provided to managers resolving issues locally and senior managers investigating complaints at Stage 2.

Section 4

Learning from Complaints and Feedback

When any aspect of a complaint is upheld or partially upheld, we look to identify if improvements can be made with a view to preventing a reoccurrence.

The majority of complaints were resolved at Stage 1 during this year (60%). Most were resolved on an individual basis locally with the staff who provide the service and did not involve implementing improvements or changes to policies, services or ways of working across the hospital.

However, an apology is always offered to the complainant where appropriate and a reminder issued to staff to reflect on behaviours or adherence to policies / procedures.

When any aspect of a complaint is upheld or partially upheld, we look to identify if there are any improvements, changes or actions that will prevent the same thing happening again.

Themes Emerging

33% of issues investigated related to **Clinical Treatment**. A wide range of issues were considered such as involvement in care plans, medication, grounds access, lack of progression, rehabilitation outings and the use of restraint. The majority (63%) were found to be not upheld.

31% of issues related to **Staff Attitude/Behaviour/Conduct.** Although 88% of issues were not upheld, in order to further explore the reasons for this issue frequently being raised the Complaints Team is working with senior nursing colleagues and the PPG to see how this can be addressed. Where appropriate staff were reminded of the need to adhere to policy/ procedure and the importance of ensuring clear and professional communication at all times.

11% of issues related to **Communication.** Oral communication accounted for 75% of the issues raised. 63% of the complaints were upheld or partially upheld and were attributable to staff not communicating effectively and provided an opportunity for additional staff training.

8% of issues related to **Failure to follow agreed procedure**. All were upheld. Half were around carer's experience in the reception area prior to visiting and the inconsistent approach in terms of what items were permitted into family visits. This prompted a multi department review of the protocol for visitors bringing food on site to address the issues raised. The reviewed protocol was shared with carers and will be monitored going forward.

8% of issues related to **Patient Privacy/Dignity**. The majority were from patients who had experienced a temporary disturbance to their routine and ward environment due to the behaviour of a peer. These concerns were acknowledged but not upheld as the clinical team managed the situation appropriately and it was resolved quickly.

6% of issues related to **Patient Property & Expenses**. Half of the complaints were upheld or partially. Nursing colleagues have been asked to review the process for managing patient property.

Actions taken or improvements made as a result of Complaints

Some complaints do result in changes in practice and examples of these are shown below.

Issues Raised	Findings	Learning/Action Taken Output
Vegetarian meal option not provided.	Vegetarian meal was sent, but it was suspected that the sticker to indicate the meal type most likely fell off due to the heat in catering trolley.	Catering staff now write the meal 'type' on box to prevent this happening again.
Lack of information regarding progress of grounds access application.	Delay in processing grounds access application was identified.	Improved process through moving from paper to electronic system. Clinical teams to ensure applications are closely monitored.
Multiple complaints received regarding inconsistencies in food/fluid items permitted into visits.	Inconsistencies were highlighted in the way the security team implement the food and fluid restriction policy which affected the visitors on several occasions.	The protocol for visitors bringing food on site was reviewed, and an active re-fresh with staff implementing it, to ensure a consistent approach was taken going forward.

Complaints Experience Feedback

Although making a complaint may be the result of a difficult experience, it is the aim of the Complaints Team to ensure that all complainants have a positive experience when contacting the service. To ensure we can capture learning from this, a feedback form is available to help to seek the views from everyone who uses the service. Historically, this has had a poor response rate.

Although only two forms were returned this year, the Complaints Officer attended the PPG every month to support a more informal approach to seeking patient feedback.

The forms received were both positive about the experience of making a complaint within the State Hospital.

In addition, a review of the feedback template was undertaken in collaboration with the PPG, and the feedback form was reformatted to be more engaging for patients and to try to encourage more returns.

Section 5

Accountability and Governance

The Chief Executive is accountable for the delivery of the CHP within The State Hospital, including supporting a culture of transparency and openness in complaint investigation. This supports the organisation's ability to listen and respond to concerns raised, as well as to take learning from complaints.

The Board has oversight of complaints and receives annual reporting. This follows quarterly reporting to the Clinical Governance Committee, which takes oversight of the issues raised, findings, outcomes and any learning identified. Quarterly reporting is also routed through the Organisational Management Team which is comprised of service leads.

There is continued focus on delivering the aims of the CHP in terms of each of the Key Performance Indicators, as well as a focus on quality and making a contribution to service improvement. In addition to other established patient engagement work streams the CHP is another route through which stakeholder voices can be heard, and the organisation can measure its performance on the delivery of its key aims.

Summary

The State Hospital is committed to encouraging stakeholders to share their views and ensure support mechanisms are in place to enable patients and carers to make use of a wide range of methods, through which they can share their feedback.

The Board embraces the CHP in terms of supporting the organisation to enhance processes which support early resolution of issues which are of concern to stakeholders. This process, in addition to ensuring negative feedback is addressed, enables The State Hospital to effectively record and share the positive feedback we receive about staff and the delivery of excellent patient care.

If you have any questions about this report, please contact the Complaints Team on 01555 842200 or by emailing: TSH.ComplaintsAndFeedback@nhs.scot

If you require this report in an alternative format, please contact the Person-Centred Improvement Team on 01555 842072 or by emailing: TSH.PersonCentredImprovementTeam@nhs.scot

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Information Governance and Data Security Officer
Title of Report:	Information Governance Annual Report 2024-25
Purpose of Report:	For Noting

1 SITUATION

In order for the Board to have an overview of the work carried out by Information Governance, an annual report is provided for consideration. The Annual Report highlights the activities during 2024/25.

2 BACKGROUND

The Information Governance Group, chaired by the Senior Risk Information Owner (SIRO) is responsible for progression of attainment levels in relation to Information Governance Standards – reporting to the Finance, eHealth and Audit Group.

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.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2024-25.

Key areas of work addressed included:

- Information Governance Standards (DPCT)
- Information Governance.Risk Assessments
- Information Governance Training, including national events
- Category 1 or 2 investigations, as required
- Personal Data Breaches
- Electronic Patient Records
- Information Governance Walkrounds
- FairWarning
- Records Management

- Freedom of Information
- Subject Access Requests
- MetaCompliance

Actions for the next twelve months include the on-going monitoring of the ICO audit action plan, the continuance of all of the above aspects under an increasing national scrutiny and focus, plus additional work in the following areas:

- Public Health Scotland statistical returns system review
- Implementation of Business Classification Standards
- Redaction software utilisation
- Reconfiguration of MyCompliance

4 RECOMMENDATION

The Board is asked to **note** the progress outlined in the attached report for the year 2024-25 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP	The Report follows good practice and also links in with national Information Governance developments and requirements.
Corporate Objectives Please note which objective is linked to this paper	Better value (3g) – Ensure delivery of a cohesive approach to information governance and records management standards, including delivery of the newly formulated Records Management function.
Workforce Implications	None
Financial Implications	None
Route to Committee Which groups were involved in contributing to the paper and recommendations.	Information Governance Group eHealth Subgroup
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

THE STATE HOSPITALS BOARD FOR SCOTLAND

INFORMATION GOVERNANCE ANNUAL REPORT

APRIL 2024 – MARCH 2025

(Including Health Records)

Lead Author	Director of Finance and eHealth / Senior Information Risk Owner
Contributing Authors	Records Services Manager Information Governance and Data Security Officer
Approval Group	The State Hospitals Board for Scotland

Effective Date	April 2025
Review Date	April 2026
Responsible Officer	Director of Finance and eHealth / Senior Information Risk Owner

CONTENTS

1 INTRODUCTION AND HIGHLIGHTS OF THE YEAR

The Information Governance Group is responsible for progression of attainment levels in relation to Information Governance Standards. The 2024/25 reporting year has seen continued progress in strengthening Information Governance across The State Hospital. The Group has maintained its commitment to ensuring compliance with data protection legislation, improving records management, and promoting a culture of accountability and transparency.

The Group through its regular meetings has received and scrutinised regular reports all areas of governance, including the following – RiO audits, records management, risk assessments, training, Freedom of Information (FOI), data protection and Information Governance incidents and outcomes – as well as reviewing those items on the Corporate Risk Register relevant to the Group's remit.

Key highlights from the year include:

- 100% compliance with statutory timescales for Freedom of Information (FOI) requests, alongside a 28% increase in request volume.
- Completion of 91% of the ICO audit action plan.
- Continued development of the Electronic Patient Record (EPR) system, including integration with prescribing and access approval processes.
- Introduction of a new category for Subject Access Requests to better track requests from discharged patients.
- A revised approach to policy awareness, with plans to reinstate the PC lock mechanism following a drop in engagement with the self-service portal.

Despite some challenges, including reduced meeting frequency due to workload pressures, the IGG has remained focused on delivering its objectives and adapting to evolving requirements.

This report is submitted on an annual basis to the Board, through the State Hospital's internal governance and approval structure.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital. We encourage staff to adopt good Information Governance standards through a number of measures undertaken by the group, and to complete mandatory online Information Governance learning modules.

2 INFORMATION GOVERNANCE GROUP

2.1 INFORMATION GOVERNANCE GROUP MEMBERSHIP

Director of Finance and eHealth (Chair)

Associate Medical Director/Caldicott Guardian

Head of e-Health

Head of Procurement

Clinical Admin Representative

Information Governance and Data Security Officer

Senior Information Analyst & Information Technology Security Officer

Lead Nurse

Health Records Manager

Psychology Representative

Security Information Analyst

Finance Representative

Social Work Representative

Human Resources Representative

Health Centre Representative

Pharmacist Representative

AHP Representative

Risk Management Representative

Business Manager Corporate Services

Forensic Network Representative

Information Asset Owners

2.2 ROLE OF THE GROUP

The group has a wide-reaching remit, being responsible for all matters in respect of Information Governance within the Hospital as the title suggests. The membership of the group is purposely broad. This allows the group to be representative of staff groups and departments from across the hospital.

2.3 AIMS AND OBJECTIVES

- Ensure compliance and development of Information Governance overall as monitored by the Data Protection Compliance Toolkit (DPCT).
- Address issues arising in the hospital in relation to Data Protection.
- Address issues arising in the hospital in relation to Records Management including structure, filing, storage, and archiving.
- Address Caldicott issues including monitoring DATIX reports and ensuring relevant training for staff.
- Provide a forum for the various staff groups within the hospital to raise any Information Governance issues and to receive feedback from Information Governance on such matters.
- To monitor requests made in relation to Freedom of Information and Data Subject Rights Requests.

2.4 MEETING FREQUENCY

The group meets on a quarterly basis to discuss any issues as outlined above, however the terms of reference include the option to hold ad-hoc meetings should the group require to meet outwith the quarterly cycle. Following agreement from the wider group, a small subgroup – the Information Governance DPCT Group – meets 6 monthly in order to concentrate on the assessment of the current attainment levels and supporting evidence required for the DPCT. In addition, another small subgroup also meets 6 monthly to review the Information Governance risk register (see para. 3.2).

2.5 STRATEGY AND WORK PLAN

As noted in previous reports, the Caldicott principles have now been integrated within the initiatives and standards developed by NHS QIS for Information Governance. The Information Governance Toolkit and Data Protection Compliance Toolkit (DPCT) are completed twice yearly in order to monitor the performance of the hospital in relation to Information Governance.

The schedule of work for the subgroup is compiled in such a way as to allow the group to review progress with DPCT. This monitoring allows the group to develop an action plan of work to be undertaken by the group members. In addition, meetings are used to address the issues that may arise such as filing, relevant training, confidentiality issues etc..

2.6 MANAGEMENT ARRANGEMENTS

The Information Governance Group reports annually to the State Hospitals Board for Scotland through the Information Governance Group Report. The Information Governance Group also reports to the Corporate Management Team as relevant.

3 KEY PIECES OF WORK UNDERTAKEN BY THE GROUP DURING THE YEAR

3.1 INFORMATION GOVERNANCE STANDARDS

The Information Governance standards was retired at the end of 2021 and was replaced with the Data Protection Compliance Toolkit (DPCT). It has been developed from ICO's accountability framework, which supports the foundations of an effective privacy management programme. The toolkit is divided into 10 categories, within each category there are a set of statement and questions that are rated on a 1 – 4 scale

Level	DPCT Status
1	Expectations not met
2	Expectations partially met
3	Expectations met without review cycle
4	Expectations fully with review cycle

Category	Level 1	Level 2	Level 3	Level 4	Status
1. Leadership and Oversight	0%	10%	42%	48%	**Level 3**
2. Policies and Procedures	6%	35%	24%	35%	**Level 3**
3. Training and Awareness	0%	14%	24%	62%	**Level 4**
4. Individuals' Rights	17%	34%	9%	40%	**Level 2**
5. Transparency	31%	35%	19%	15%	**Level 2**
6. Records of Processing and Lawful Basis	25%	50%	25%	0%	**Level 2**
7. Contracts and Data Sharing	7%	39%	50%	4%	**Level 3**
8. Risks and DPIAs	3%	31%	28%	38%	**Level 3**
9. Records Management and Security	10%	44%	40%	6%	**Level 2**
10. Breach Response and Reporting	16%	76%	3%	5%	**Level 2**
Overall Rating (2025)	12%	39%	27%	22%	**Level 2**
Previous Rating (2024)	13%	45%	41%	1%	Level 2
Change	**-1%**	**-6%**	**+15%**	**+21%**	**=**

The DPCT shows a range of attainment with some categories showing improvement on previous levels.

Work continues in conjunction with the recommendations from ICO's audit to improve the organisations compliance status. It is also recognised that there has been improvement in some categories due to completing a review cycle as processes and polices are becoming embedded.

Changes have been made to the structure of Group meetings – rather than having full membership expected to attend all meetings, two meetings are arranged annually to have a full oversight review of the DPCT, with meetings in between with targeted attendance to focus on specific areas. In 2024-2025 the Group met in November – unfortunately due to leave and pressures of workload this was the only full meeting. However, discussions were held with relevant staff to focus on specific areas of the Toolkit, ensuring that some monitoring was carried out. Full Group meetings are scheduled to take place on 10 September 2025 and 11 March 2026.

3.2 INFORMATION GOVERNANCE RISK ASSESSMENTS

Information Governance risks assessments are undertaken by a subgroup of the IGG – the IG Risk Assessment Group – comprising of staff from IG, IT Security, Risk Management and eHealth as well as the Caldicott Guardian. Unfortunately there has been fewer meetings than had been planned due to other workload and absences impacting on time and resources – meetings in September and February having to be cancelled. The Group last met in December 2024 and further meetings are scheduled for 10 June 2025, 9 September 2025, 9 December 2025 and 10 March 2026.

At the meeting in December 2024 a total of twelve Information Governance risk assessments on the risk register were discussed. These covered a variety of risks (e.g. failure to communicate a change in access requests to eHealth in a timely manner and inappropriate viewing/deletion/processing of information contained in shared drives). All twelve risks are currently at or below their target risk rating of medium. A review of Datix incidents from the previous 6 months flagged up that there are some issues with the internal mail service and with staff sending emails to the wrong email address. New risk assessments will be completed for these issues. A number of Datix reports were noted to be in relation to slow response to FairWarning alert emails and this has been raised through OMT.

The Risk Assessment Group continues to work through registered risks to update them to reflect new technologies and working practices such as Teams and remote working. The Group continues to work to be proactive rather than reassessing out of date risks and this is proving to be beneficial.

3.3 INFORMATION GOVERNANCE TRAINING

The majority of Information Governance training is delivered online through the LearnPro platform. All training modules are mandatory for all staff members. Completion rates are monitored by the Training & Professional Development Manager, with oversight provided by the Information Governance Group (IGG).

The table below shows completion rates for each module over the past four years:

Module	Mar 2022	Mar 2023	Mar 2024	Mar 2025
IG: Essentials (Target >80%)	76%	95%	85%	75%
IG: Series (Target >85%)	-	-	87%	93%
Confidentiality	98%	98%	-	-
Data Protection	97%	98%	-	-
Records Management	98%	98%	-	-

In 2024, the Confidentiality, Data Protection, and Records Management modules were reviewed and updated. Following this review, they were consolidated into a new combined module known as the IG: Series. This change has streamlined reporting and reflects a more integrated approach to staff training in key areas of information governance.

3.4 CATEGORY 1 & 2 INVESTIGATIONS

There were no Category 1 or Category 2 investigations relating to Information Governance during the year.

3.5 PERSONAL DATA BREACHES

Under the UK General Data Protection Regulation (UK GDPR), organisations are required to record all personal data breaches. Where a breach poses a high risk to the rights and freedoms of individuals, it must be reported to the ICO within 72 hours of discovery.

At the State Hospital, all potential personal data breaches are recorded using the Datix incident management system. The table below summarises the number of breaches recorded and those reported to the ICO over the past four years:

	2021/22	2022/23	2023/24	2024/25
Reported Breaches	56	35	24	16
Notified to ICO	0	0	0	1

In 2024/25, 14 of the 16 recorded breaches were attributable to The State Hospital, representing a continued year-on-year reduction. Two incidents were not attributable to the organisation:

Incident 1: Involved Occupational Health files affected by a cyber incident at NHS Dumfries and Galloway. Due to the potential severity, this was reported to the ICO within the required 72-hour timeframe. The ICO confirmed that The State Hospital was not responsible for the information affected by the breach.

Incident 2: Reported by the Mental Welfare Commission (MWC), this involved the loss of CPA and SPO1 documents for a State Hospital patient by an individual carrying out work on behalf of the MWC. The MWC reported the incident to the ICO. As the breach did not originate within The State Hospital, it was logged for record-keeping purposes, and no further action was required.

Area	Percentage
Internal Email Disclosures	36%
Information Disclosed Internally (non-email)	29%
Information Disclosed Externally	21%
Others	14%

The majority of breaches involved communication channels, particularly email and physical post.

The State Hospital continues to promote high standards of Information Governance across the organisation. Staff are regularly reminded of best practices through guidance shared in the Staff Bulletin, and Information Governance Walkrounds provide opportunities for informal engagement and on-the-spot advice.

3.6 ELECTRONIC PATIENT RECORDS

The Electronic Patient Record (EPR) RIO, has continued to be further developed since the major upgrade in March 2022. The project specific RIO Group continue to meet on a weekly basis to ensure developments are progressing well, and to resolve any issues that have arisen or been reported. A multidisciplinary project approval group (Rio Oversight and Development (ROAD) Group) continues to meet monthly to review ongoing requests to improve RIO as well as look at future developments. A further upgrade was successfully made to the system in October 2024.

Regular audits continue to be carried out on various areas within Rio, with documentation and guidance updated as required. Issues are discussed at the Information Governance Group, or the ROAD Group.

A robust system is in place for Requests for Change to RiO – this may involve a quick assessment and authorisation by the system owner, or a more thorough review by members of the team including IG checks and workability.

RIO is now fully integrated with the medication prescribing system (HEPMA) and processes such as for grounds access approval and now embedded in the system. A large piece of work which is still ongoing is the integration of the CPA process and documentation with Rio. This is planned for live testing in April/May

3.7 INFORMATION GOVERNANCE WALKROUNDS

Introduced in 2015 as a recommendation from the NHS Scotland Information Assurance Strategy (CEL 26, 2011), Information Governance Walkrounds have continued to build on their success in previous years. These unannounced visits take place at random intervals throughout the year and cover all areas of the organisation where personal information is handled.

Walkrounds are assessed using a consistent grading system to ensure comparability across visits:

Grade	Description
Excellent	No issues found
Very Good	1 – 3 minor issues found
Good	4 – 8 minor issues and/or 1 significant issue found
Improvements needed	9 - 14 minor issues and/or 2 significant issues found
Action Plan required	more than 15 minor issues, more than 2 significant issues and/or 1+ suspected breaches of legislation

Staff conducting the walkrounds consistently observed high standards of Information Governance across the organisation.

During the reporting year, 11 areas were inspected. Of these, nine were graded 'Good' or better, with the majority achieving a 'Very Good' rating. Two areas were assessed as 'Improvements Needed', but all identified issues were promptly addressed following engagement with the relevant staff and managers.

Walkrounds complement the organisation's Records Management Plan and broader Information Governance objectives. They also provide an informal and supportive opportunity for staff to ask questions, seek clarification, and increase their awareness of good information handling practices.

3.8 FAIRWARNING

The Group receives exception reports detailing the volume and nature of FairWarning alerts, which monitor access to personal information. A dedicated subgroup is responsible for maintaining appropriate alert thresholds to ensure a proportionate and effective audit process.

Overall, alert levels remained consistent with previous years, taking into account fluctuations in the patient population. A continued increase in alerts related to multiple staff accessing a single patient's record within a single day was observed. Upon review, this trend was attributed to changes in clinical practice. As a result, the trigger point for this alert was adjusted to reduce notifications generated by routine and appropriate access.

The Group remains satisfactorily assured that there are no concerns regarding inappropriate access to personal information.

3.9 RECORDS MANAGEMENT

This year has again been extremely busy but positive for the Records Services Department. Staff have undertaken work in three separate areas – health records, records management and information governance – which has been challenging at times however staff have undertaken this change in workload well. However, it has been noted that as all of these areas are growing due to additional legislation and expectation on the organisation, it may be better to focus staff on specific areas of expertise and this was put in place in January 2025. The first three months of this went well, and a more permanent way of handling workload will be explored in 2025.

The State Hospitals Board for Scotland submitted its first Records Management Plan (RMP) to the Keeper of the Records in December 2016. The Plan was agreed and accepted by the Keeper with some elements graded as amber, and having work outstanding. As records management has changed and become more at the forefront in the State Hospital, a new RMP was submitted to the Keeper of the Records of Scotland in December 2024. This work was carried out with input from various disciplines throughout TSH led by the Records Services Manager, with a large volume of evidence being submitted. There is a known backlog of Plans awaiting assessment by the Keeper therefore a response is not expected before June 2025.

The Records Management Group was responsible for the oversight of the resubmission of the RMP as well as meeting to discuss other records issues. There have been no meetings since December 2024 due to staff absence, however future meetings are scheduled with one of the main tasks being to work on the introduction of the National Business Classification Schedule (BCS) to TSH. The BCS will also be a foundation of the move to using MS SharePoint therefore it is important that this structure becomes familiar to staff.

3.10 FREEDOM OF INFORMATION

The Information Governance Group continues to receive regular updates on all Freedom of Information (FOI) requests, including performance against statutory response times. In 2024/25, the number of FOI requests increased by 28% compared to the previous year.

The majority of requests originated from the general public (37%), followed by businesses (18%) and the media (17%).

Number of Freedom of Information Requests

	2020/21	2021/22	2022/23	2023/24	2024/25
Requests made	262	172	145	242	310
Completion rate within timescales	89%	99%	91%	95%	100%

In 2024/25, 100% of FOI requests were responded to within the statutory timeframe, reflecting a strong commitment to transparency and accountability.

Where information was held, a full response was provided in 76% of cases.

Number of Freedom of Information Reviews

	2020/21	2021/22	2022/23	2023/24	2024/25
Requests for review made	3	4	2	1	1
Upheld without modification	3	4	2	1	1
Upheld with modification	0	0	0	0	0
Substituted a different decision	0	0	0	0	0
Reached a decision where no decision had been reached	0	0	0	0	0

The number of FOI reviews remained consistent with the previous year, with one review conducted in 2024/25. The review concluded that the original response issued by the State Hospital was appropriate and required no changes.

3.10.1 FREEDOM OF INFORMATION SELF-ASSESSMENT

The FOI Committee continues to lead a cycle of continuous improvement, guided by the Scottish Information Commissioner's self-assessment toolkit. This toolkit supports public authorities in evaluating their performance across six key areas of FOI compliance.

Each module is assessed using a four-point scale:

Ratings	Meaning
Excellent	Greatly exceeds the requirements of FOI
Good	Exceeds the requirements of FOI
Adequate	Meets the requirements of FOI
Unsatisfactory	Below the requirements of FOI

Public authorities, including The State Hospital, are expected to achieve at least an 'Adequate' rating, taking into account their specific operational context.

Standards and Criteria	2021/22	2022/23	2023/24	2024/25
1. Responding on time	Good	Good	Excellent	Excellent
2. Searching for, locating and retrieving information	Good	Good	Good	Good
3. Advice and assistance	Adequate	Good	Good	Good
4. Publishing information	Adequate	Adequate	Adequate	Adequate
5. Conduct of Reviews	Good	Good	Good	Excellent
6. Monitoring and managing FOI performance Standards and Criteria	Good	Good	Good	Good
Overall	Adequate	Adequate	Good	Good

The 2024/25 assessment confirms that FOI management within the organisation now exceeds the statutory requirements of the Freedom of Information (Scotland) Act.

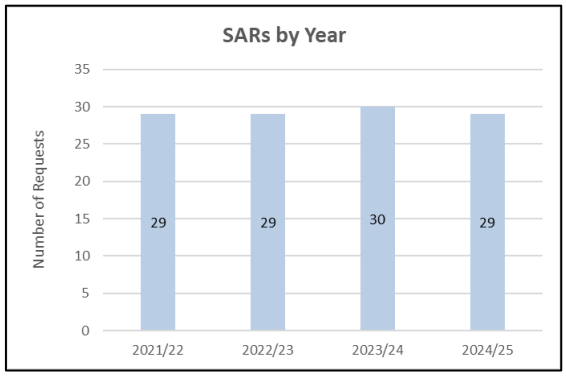
While the overall rating is typically determined by the lowest score across the six modules, the assessment framework allows for local context to be considered. In particular, the criteria for Publishing Information assumes stakeholders have ready access to information and services that are not appropriate in a high-

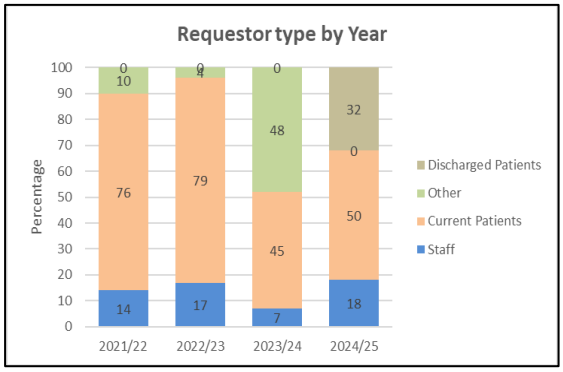
security hospital setting. As such, provided this module is not rated 'Unsatisfactory', it is excluded from the overall rating calculation.

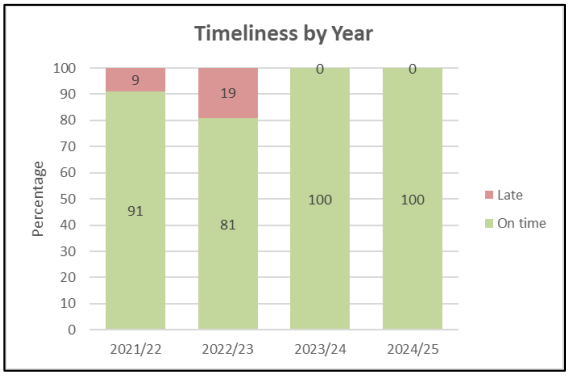
3.11 SUBJECT ACCESS REQUESTS

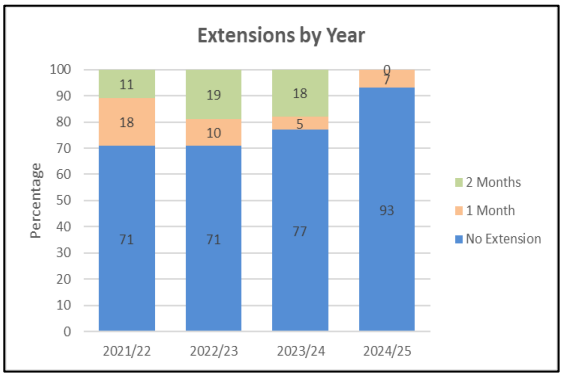
The volume of Subject Access Requests (SARs) received during 2024/25 remained consistent with previous years and within expected levels. The organisation maintained its strong performance in responding to all requests within the statutory timescales, while also achieving a reduction in the number of extensions required to complete responses. This reflects ongoing improvements in internal processes and resource management.

Following an observation in the previous reporting year that a significant proportion of SARs were being submitted by discharged patients, a new category was introduced to specifically record and monitor these requests.









3.12 METACOMPLIANCE / MYCOMPLIANCE

In 2024/25, the organisation transitioned from the legacy MetaCompliance platform to MyCompliance as its new policy awareness system. This platform was introduced to ensure that all staff are informed of key organisational policies, with the aim of supporting understanding and compliance across the workforce.

It was anticipated that the self-service portal within MyCompliance would offer a more user-friendly and less disruptive experience—allowing staff to review and acknowledge policies at their convenience, rather than through the previous method which locked users' PCs until policies were accepted.

However, uptake of the self-service approach was significantly lower than expected. As a result, staff policy awareness dropped to 39%, a sharp decline from 93% the previous year.

In response to this outcome, the Policy Approval Group decided to reinstate the PC lock mechanism in the upcoming reporting year, aiming to improve staff engagement and ensure greater compliance with policy acknowledgements.

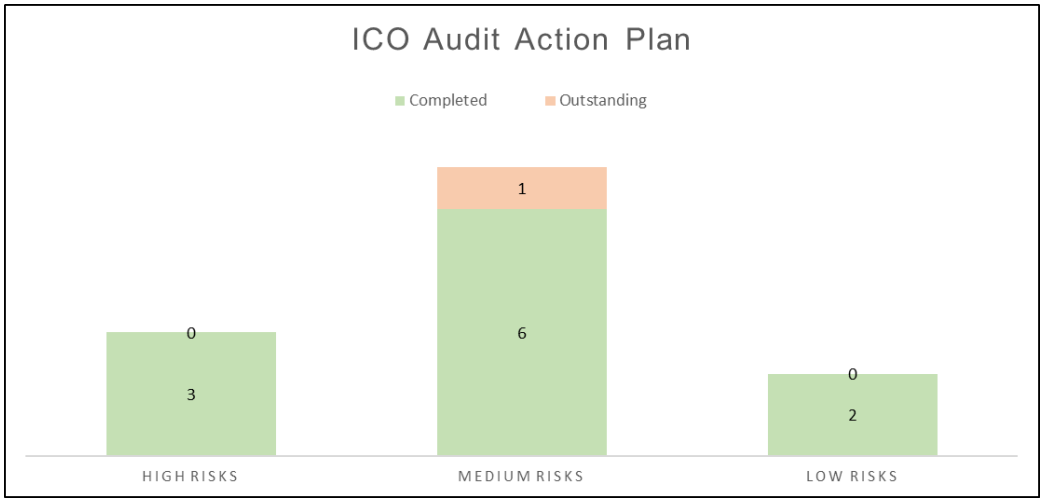
4 INFORMATION COMMISSIONER'S OFFICE AUDIT

In November 2022, The State Hospital underwent an audit by the Information Commissioner's Office (ICO). The purpose of the audit was to assess:

- The organisation's compliance with data protection legislation,
- Its use of ICO guidance and best practice resources, and
- The overall effectiveness of its data protection governance and activities.

The audit concluded with a high assurance rating, reflecting a strong level of confidence in the hospital's data protection practices.

While the findings were largely positive, the ICO identified several areas for improvement. In response, and in consultation with the ICO, the hospital developed a 12-point action plan to be implemented over a two-year period.



As of this reporting year, 91% of the action plan has been successfully completed, with only one action remaining. The outstanding item relates to the training of Information Asset Administrators, and work is currently underway to schedule these training sessions

5 IDENTIFIED ISSUES AND POTENTIAL SOLUTIONS

During the reporting year, several challenges were identified that impacted the delivery and oversight of Information Governance activities. These include:

- Reduced frequency of IG Risk Assessment Group meetings, due to staff absences and availability.
  A revised meeting schedule has been agreed for 2025/26 to ensure regular risk reviews are maintained.
- Initially low engagement with the newly-introduced MyCompliance self-service portal, resulting in a significant drop in policy awareness.
  The previous method of locking PCs will be reinstated
- Delays in progressing some elements of the ICO action plan, particularly around Information Asset Administrator training.
  Training sessions are currently being scheduled with the relevant staff to address this final outstanding action.
- Challenges in managing growing workloads across Records Services, due to increasing legislative and operational demands.
  A new staffing model was introduced in January 2025 to allow staff to focus on specific areas of expertise, with early results showing positive outcomes.
- Emerging risks related to internal communications and email errors, identified through Datix incident reviews.
- New risk assessments are being developed, and awareness-raising measures are being implemented through staff bulletins and IG Walkrounds.

The IGG remains committed to addressing these issues proactively and ensuring that robust governance arrangements are in place to support safe and effective information handling across the organisation.

6 FUTURE AREAS OF WORK AND POTENTIAL SERVICE DEVELOPMENTS

Work / Service Development	Timescale
Robust system to be in place to submit statistical returns to Public Health Scotland	July 2025
Further implementation of national Business Classification Schedule in shared drive areas	December 2025
Utilisation of software assisted redaction for subject access requests for clinical records	June 2025
Reconfiguration of MyCompliance	October 2025
Maintain 80% completion for the IG: Essentials learning module.	Ongoing
Maintain 85% completion for the IG: Series learning module.	Ongoing

7 NEXT REVIEW DATE

April 2026

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning and Business Support Corporate Planning, Performance and Quality Project Support Manger
Title of Report:	Q1 2025/26 Corporate KPI Performance Report
Purpose of Report:	For Noting

1 SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPIs) for quarter 1 (April 2025 to June 2025). Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are Psychological Therapies Waiting Times and Sickness Absence. Additional local 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) for 2025-26 which was approved by the Scottish Government in June 2025.

2 BACKGROUND

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

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

3 ASSESSMENT

The following sections contain the KPI data for quarter 1 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPIs that have missed their targets.

There is a total of twelve corporate KPIs. Nine KPIs have reached and / or exceeded their target this quarter and there are three KPIs which are off target, these are:

3.1. TABLE OF TARGETS ACHIEVED OR EXCEED AND OFF TARGET

achieved and / or exceeded their target	Off target
• Patients will be engaged in psychological treatment. • Patients will be engaged in off hub activities. • Patients will undertake an annual physical health review. • Patient will undertake 150 minutes of moderate exercise each week. • Staff have an approved PDR. • Patients transferred/discharged using CPA. • Patients requiring primary care services will have access within 48 hours. • Patients will commence psychological treatment less than 18 weeks from referral date. • Patients have their clinical risk assessment reviewed annually.	• Patients have their care and treatment plan documentation reviewed at six month intervals. • Patients will have a healthy BMI. • Sickness absence

3.2 PERFORMANCE INDICATOR OVERVIEW TABLE

Performance Indicator	Target	RAG Q2 24/25	RAG Q3 24/25	RAG Q4 24/25	RAG Q1 25/26	Actual Q1 25/26
Patients have their care and treatment plans reviewed at six monthly intervals.	100%	A	A	G	A	93.5%
Patients will be engaged in psychological treatment.	85%	G	G	G	G	98%
Patients will be engaged in off-hub activity centres *(This includes drop-in sessions which take place in hubs, grounds and Skye Centre).*	90%	G	G	G	G	95%
Patients will undertake an annual physical health overview by the Practice Nurse.	100%	G	G	G	G	100%
Patients will undertake 150 minutes of moderate exercise each week.	70%	A	R	R	G	69.67%
Patients will have a healthier BMI.	25%	R	R	R	R	6.33%
Sickness absence rate.	5%	R	R	R	R	6.70%
Staff have an approved Personal Development & Planning Review.	80%	G	G	G	G	91.5%
Patients transferred / discharged using CPA.	100%	G	G	G	G	100%
Patients requiring primary care services will have access within 48 hours.	100%	G	G	G	G	100%
Patients will commence psychological therapies <18 weeks from referral date.	100%	G	G	G	G	100%
Patients have their clinical risk assessment reviewed annually.	100%	A	G	G	G	95.30%

Definitions for red, amber and green zones:

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

3.3 INDIVIDUAL KEY PERFORMANCE INDICATOR DATA

NO 1: PATIENTS HAVE THEIR CARE AND TREATMENT PLAN DOCUMENTATION REVIEWED AND UPLOADED TO RIO AT SIX MONTHLY INTERVALS

Target: 100%
Data for current quarter: 93.5%
Performance Zone: Amber

This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance that patients who are resisted within the State Hospital for longer that twelve weeks receive intermediate and annual case reviews, with paperwork produced and uploaded onto the electronic patient record (RiO) one month after the review meeting. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next six months.

Chart 1: Percentgae of oatient have their care and treatment plan documentation reviewed and uploaded to RiO

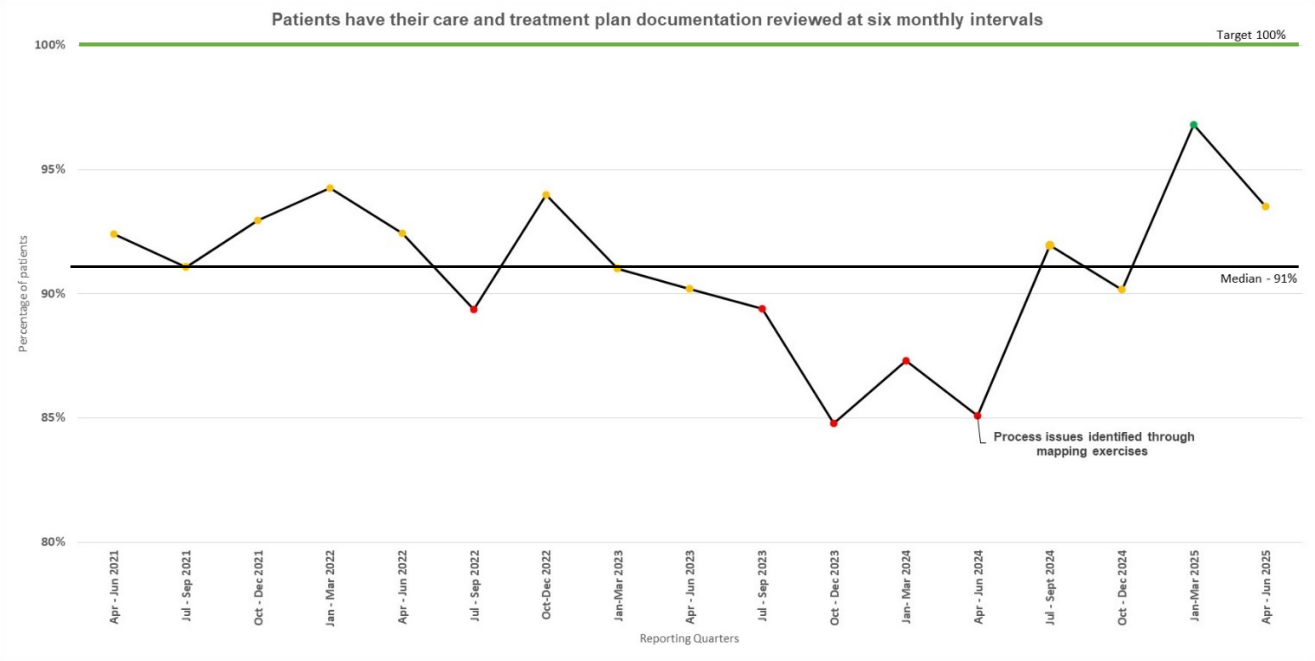


Chart 1 shows in April 2025 the compliance was 92.4%, May 2025 was 95.6% and in June 2025 compliance was 92.5% giving a quarterly compliance of 93.5%. This indicator moved from the green zone through quarter 4 2024/25, to the amber zone in quarter 1 of 2025/26.

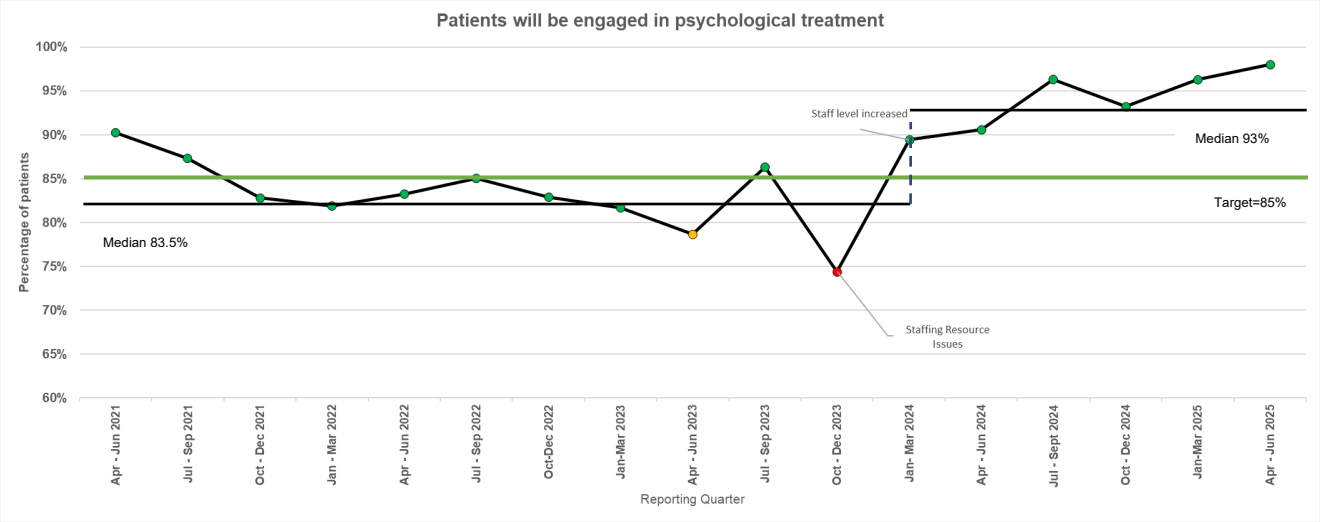
Improvement work began in July 2024 whereby a process map was developed to identified processing issues within the system around uploading of documents. Since then, these issues continue to be rectified, and although it is too early to show trends in the data, there has been a significant improvement within the areas over the last three quarters. It is also anticipated that further improvement will be evident with the introduction of the new CPA process. The Corporate Planning, Performance and Quality team will continue to monitor and liaise with Health Records and identified data owners should compliance decrease below the median line of 91%.

NO 2: PATIENTS WILL BE ENGAGED IN PSYCHOLOGICAL TREATMENT

Target: 85%
Data for current quarter: 98%
Performance Zone: Green

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

Chart 2: Percentage of patients engaging in psychological treatments



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This indicator has remained in the green zone. Since the increase in staff resources in January 2024, this indicator has continued to increase in compliance and has remained above the target of 85%.

NO: 3: PATIENTS WILL BE ENGAGED IN OFF-HUB ACTIVITY CENTRES

Target: 90%
Data for current quarter: 95%
Performance Zone: Green

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

Chart 3: Percentage of patients participating in off hub activities

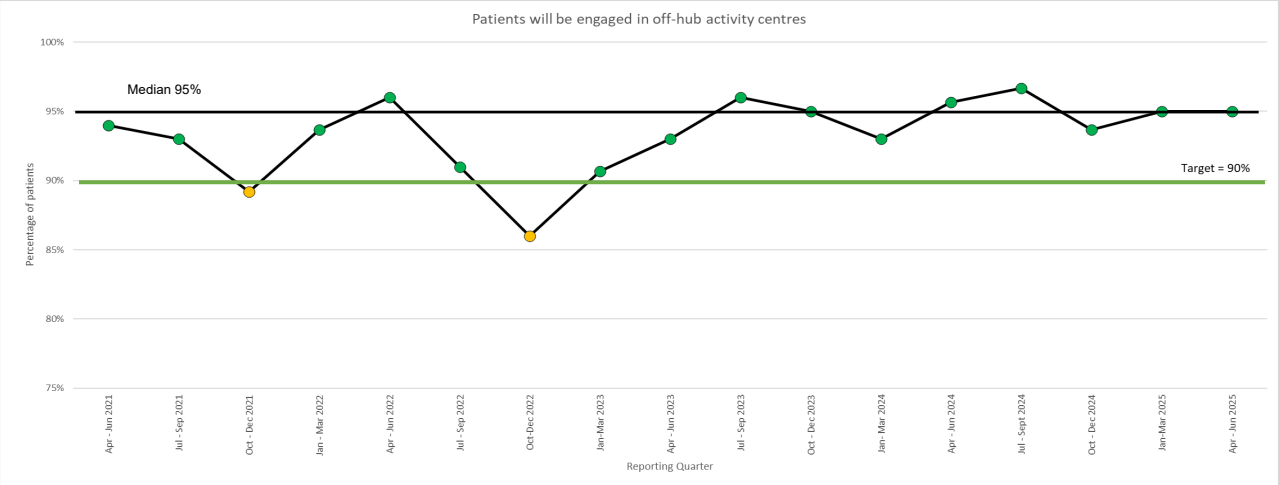


Chart 3 data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. This KPI remains in the green zone and has remained above the target of 90% since Q4 2022/23.

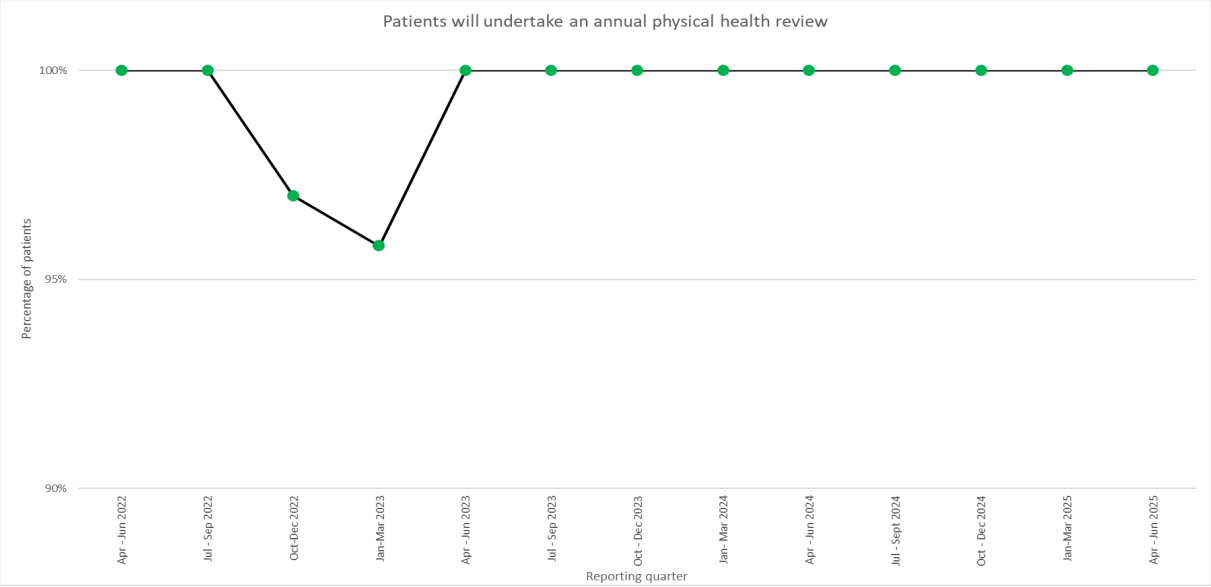
NO: 4: PATIENTS WILL UNDERTAKE AN ANNUAL PHYSICAL HEALTH OVERVIEW BY THE PRACTICE NURSE

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

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator measures the uptake of the annual physical health review.

This KPI charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse then refers appropriate patients on for face to face review by the GP. The GP conducts these consultations to complete the physical assessment of the annual health review.

Chart 4 – Percentage of completed physical health overview by the Practice Nurse



NO 5: PATIENTS WILL UNDERTAKE 150 MINUTES OF MODERATE EXERCISE EACH WEEK

Target: 70%
Data for current quarter: 69.67%
Performance Zone: Green

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

This data is recorded and calculated when patients participate for more than 10 minutes of moderate exercise and does not include patients being escorted / or using grounds access to and from the Skye Centre (unless it has been agreed by the patient's keyworker). It does include all other types of exercise, as per the patients timetable entries e.g. escorted walks, grounds access, football, hub gym.

Chart 5 – Percentage of patient undertaking 150 minutes of moderate exercise each week

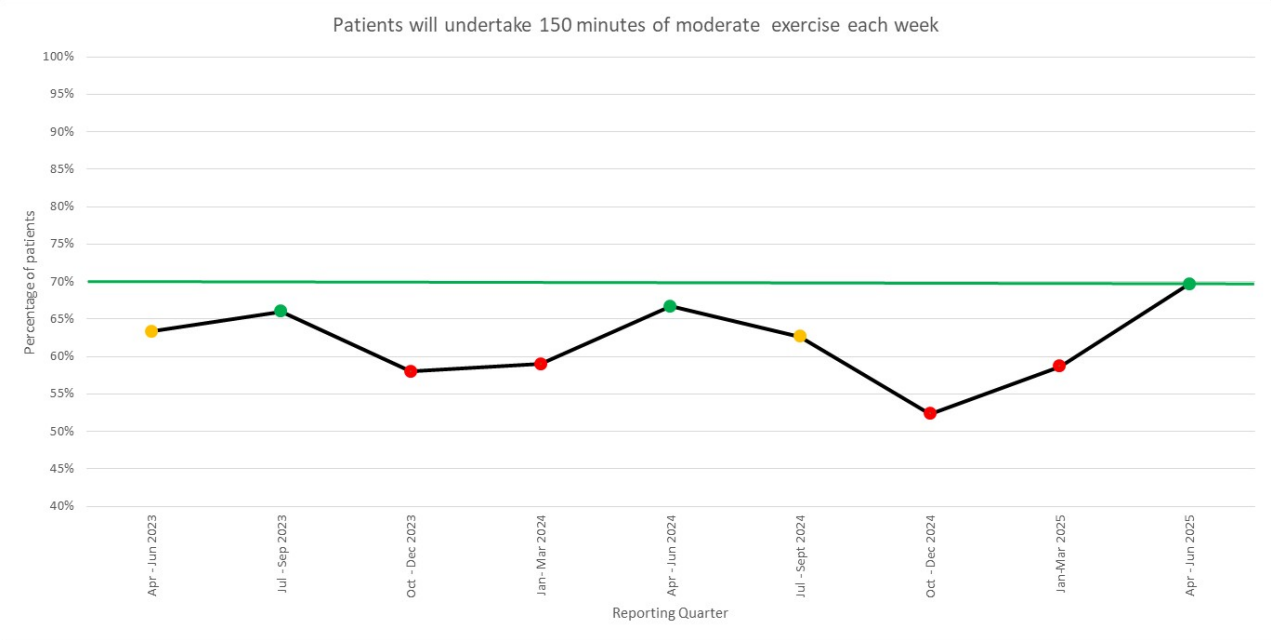


Chart 5 shows that in Q1 of 2025/26 there has been an 11% increase in the percentage of patients who engaged in a 150 minute moderate exercise since Q4 of 2024/25. This is the highest recorded percentage since the target was increased to 70% in Q1 of 2023/24. The highest compliance of 79% of patents being reached during May 2025.

During the review period there have continued to be various contributing factors and initiatives taking place which may have impacted patient uptake in physical activity such as prolonged sunny weather, TSH3030 and patients training for a Couch to 5k event.

The Board requested in June 2025, that detail is also provided at service level to demonstrate the numbers of patients achieving 150 minutes within the Admission, Treatment & Recovery, Transition and ID service, as significant variation exists across these services.

Chart 6 – Admission Service patients achieving 150 minutes exercise

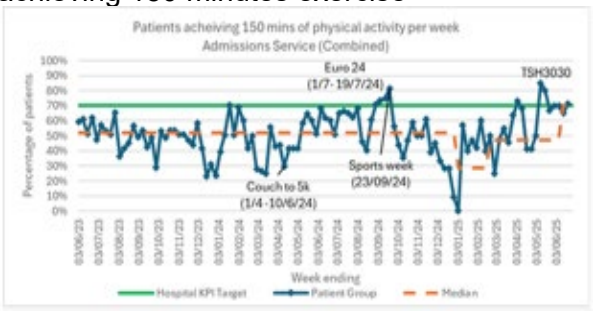


Chart 7 – Treatment and Recovery Service patients achieving 150 minutes exercise

Chart 8 – Transitions Service patients achieving 150 minutes exercise

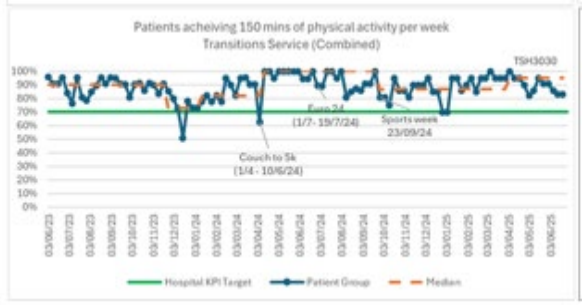
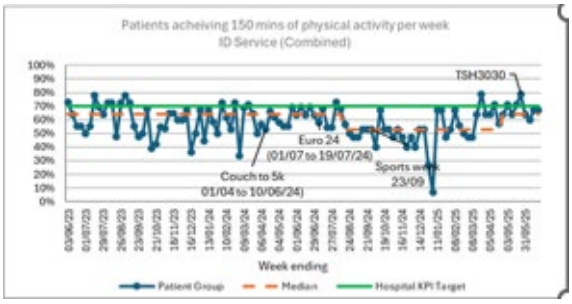


Chart 9 – ID Service patients achieving 150 minutes exercise



From Q1, charts 6,7,8 & 9 show that all services have achieved the hospital target of 70% of patients engaged in 150 minutes of moderate exercise at some point during the last quarter. Medians for Admissions (70%), Treatment and Recovery (67%), Transitions (95%) and the ID (64%) Services have all increased over the quarter. This information is provided by Clinical Quality Department for discussion at each of the Service Leadership Team Meetings.

NO 6: PATIENTS WILL HAVE A HEALTHIER BMI

Target: 25%
Data for current quarter: 6.3%
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 the patient group.

Chart 10 – Percentage of patients with a healthy BMI

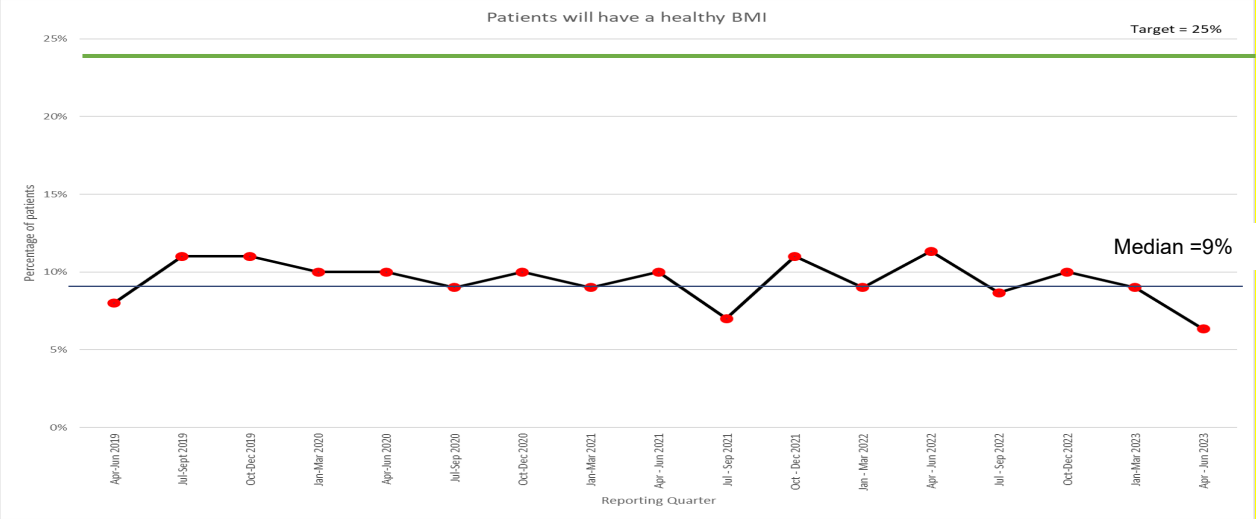


Chart 10 data shows an average across the three months in the quarter. This KPI remains in the red zone, decreasing by 2.67% since the Q4 2024/25. This KPI has never reached the agreed target of 25%. The median for this KPI sits around 9%, which is lower than the agreed target of 25%.

The monthly collections for the quarter are that in April 2025, 5% of the patient population has a healthy BMI, in May 6% and in June 8%.

Development of improvement projects via Supporting Healthy Choices group (SHC) is continuing. In parallel, the SHC group is reviewing the current Corporate Key Performance Indicator (KPI) related to Body Mass Index (BMI), with a view to identifying more meaningful and sensitive measures. The aim is to establish revised metrics and targets that will better support weight management initiatives and provide clearer assurance to the Board on progress in this area.

While BMI will continue to be recorded and used for clinical purposes, it is proposed that the existing Corporate KPI be replaced with an alternative assurance measure that more accurately reflects improvement efforts and outcomes.

Local KPI
In relation to the monitoring of 5% of patient weight gain across the first 12 months following admission, for the current review year (April 2024 to March 2025), there have been 9 patients that have completed a 12 month stay. Two of these patients remained within the 5% weight gain limit. Further data will be available as we near March 2026 given the requirement for review of a full 12 months following admission.

For the year April 2023 to March 2024, of 21 admissions 16 (76%) patients completed a 12 month stay. Of these 16 patients, 4 (25%) remained within the 5% weight gain limit. Two patients gained 4.5% and 3.8% 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). This shows an increase in achievement of target by 3% compared with the previous review period.

For the previous year (April 2022 to March 2023), of 31 admissions 23 (74%) patients completed a 12 month stay. Of these 23 patients, 5 (22%) remained within the 5% weight gain limit. One patient gained 2.9% of their admission body weight during the 12 months whilst the remaining 4 patients lost weight (1.1%, 4.2%, 4.5% and 4.9% reduction of their admission body weight).

NO 7: SICKNESS ABSENCE

Target: 5%
Data for current quarter: 6.70%
Performance Zone: Red

This relates to the National Workforce Standards and measures how many staff are absent through sickness. This now includes COVID-19 related absences, these had been measured / reported separately until 31st March 2024, and from 1st April 2024 these are now part of the overall absence figure. The State Hospital uses the data provided from SWISS for this KPI to align with all NHS Scotland Boards to ensure valid comparisons across Scotland can be achieved.

The figures provided via SWISS data slightly differ from SSTS figures; this is due to the SWISS contractual hours being averaged over the 12-month period and the figures from SSTS are based on the contractual hours available within that month.

Chart 11

Levels of absence remain a significant priority for Scottish Government, in terms of reducing levels of absence to 5% in the case of the State Hospital (and 4% across the broader NHS).
In response, we have continued to focus and utilise a number of Maximising Attendance Initiatives with particular focus on red, amber, green (RAG) status meeting with Senior Charge Nurses within the Nursing Hub to focus on activity within their areas, and the development of absence pathways to shorten and streamline processes.

We have seen a significant decrease in absence over the last 3 months and also reflected over the last 3 quarters.

We remain focused on setting a lower bar as our starting point prior to an anticipated winter peak, supporting sustainable improvement in attendance across the full year.
Our approach remains 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 08: STAFF HAVE AN APPROVED PDR

Target: 80%
Data for current quarter: 91.5%
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.

Chart 12 – Percentage of staff with a completed, indate PDPR

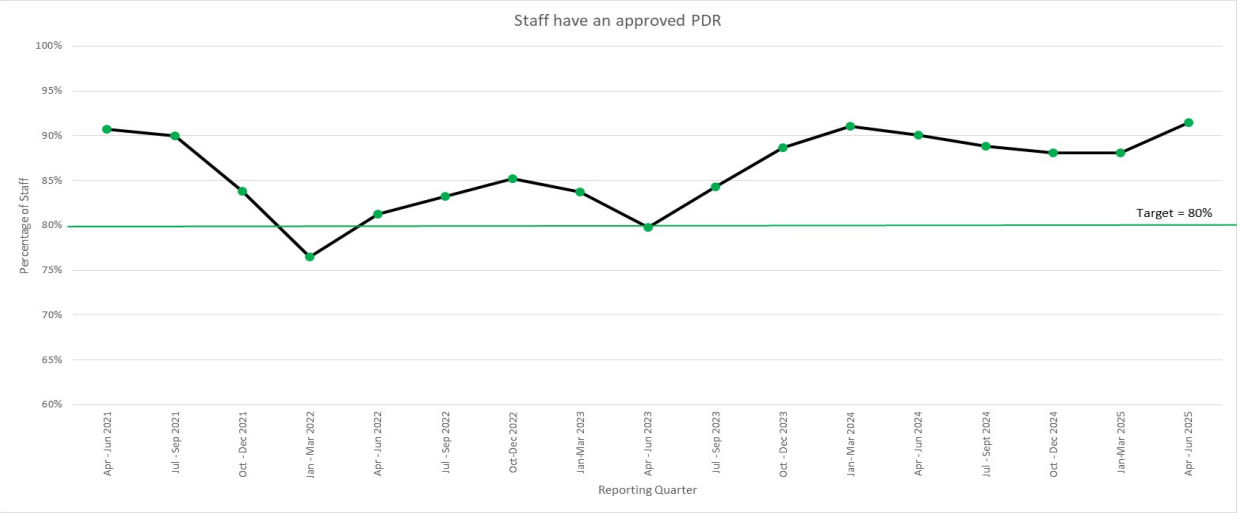


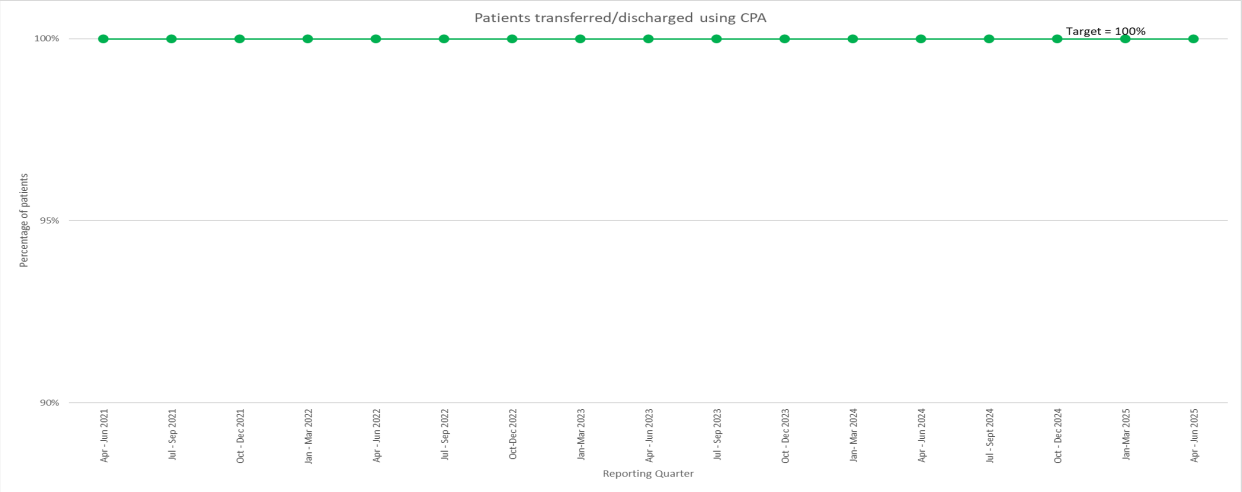
Chart 12 shows an average across the three months in the quarter. In April 2025 the compliance was 91.1%, May 2025 was 91.9% and June 2024. This indicator remains with the green zone and exceeding the currently target of 80%.

NO 09: PATIENTS ARE TRANSFERRED/DISCHARGED USING CPA

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

The indicator is linked to the Mental Health Act 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.

Chart 13 – Percentage of patients transferred out using CPA process

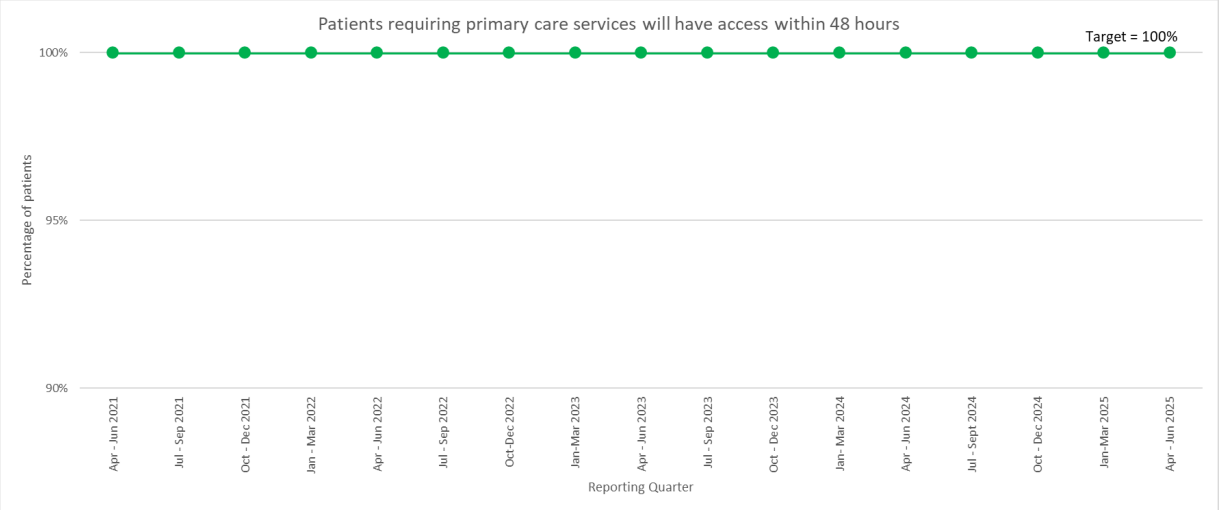


NO 10: PATIENTS REQUIRING PRIMARY CARE SERVICES WILL HAVE ACCESS WITHIN 48 HOURS

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

This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.

Chart 14 – Percentage of patients requirng primary care service will access this wihtin 48 hours

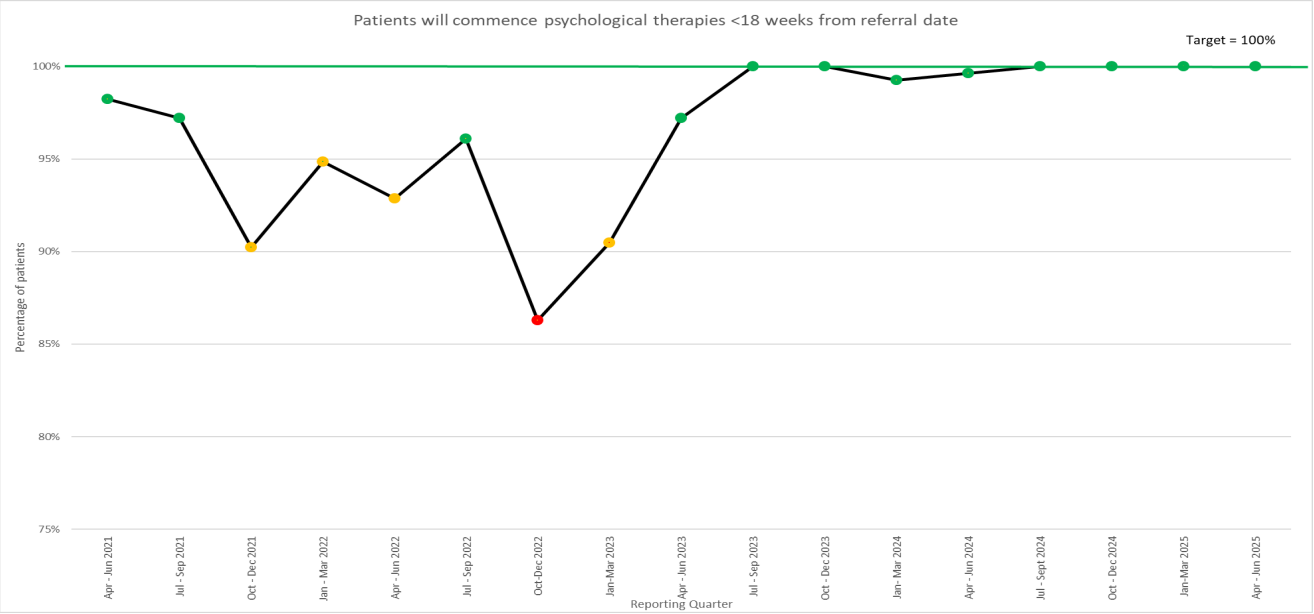


NO 11: PATIENTS WILL COMMENCE PSYCHOLOGICAL THERAPIES <18 WEEKS FROM REFERRAL DATE

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

The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy. The data required for this calculation are the number of patients waiting to engage in a psychological intervention to which they were referred who has not already completed another psychological intervention whilst waiting.

Chart 15 – Percentage of patients waiting less than 18 weeks to access psychology therapy



NO 12: PATIENTS HAVE THEIR CLINICAL RISK ASSESSMENT REVIEWED ANNUALLY

Target: 100%
Data for current quarter: 95.30%
Performance Zone: Green

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.

Chart 16 – Percentage of patients who have the clinical risk assessment reviewed annually

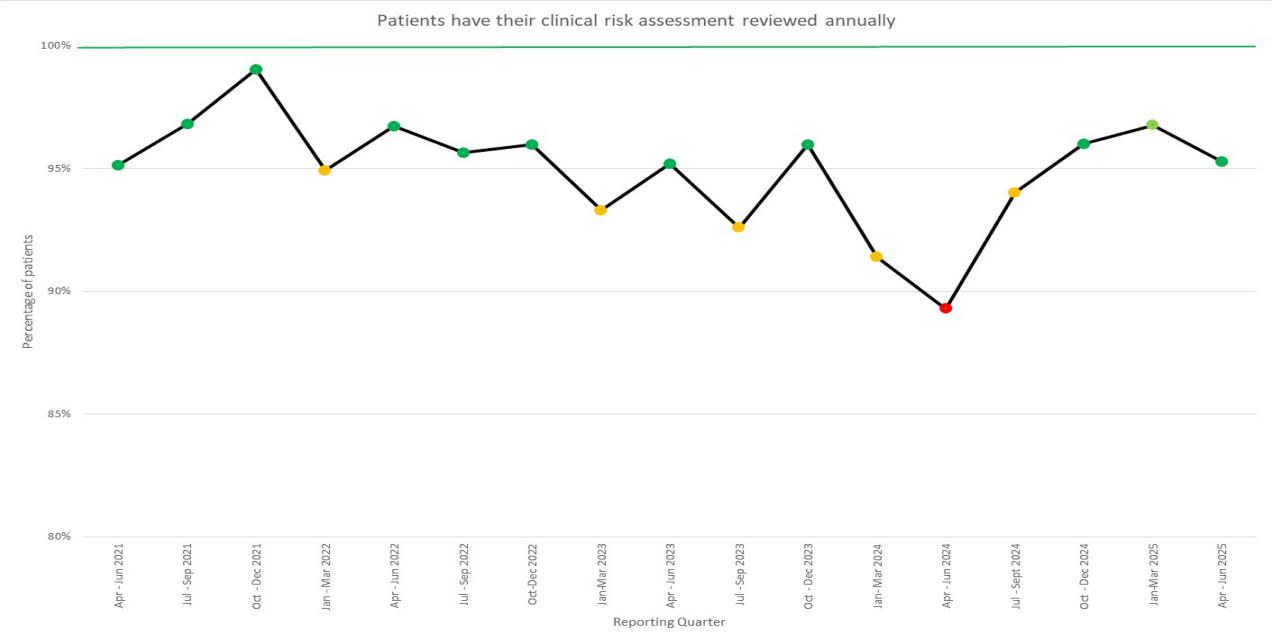


Chart 16 shows a compliance in Q1 of 95.30%, this is a slight decrease of 1.47% from Q4 2024/25 compliance. For Q1 the monthly compliance was April 2025 94.6%, in May 25 96.7% and in June 25 this compliance was 94.6%. The compliance remains in the green zone and has done since Q3 2024/25.

NO 13: PROFESSIONAL ATTENDANCE AT CPA REVIEW

Target: Individual for each profession

Local priority area set out in within CPA guidance. The reasoning behind this indicator is that if patients have all the relevant and important professions in attendance, then they should receive a better care plan overall.

Chart 17 – Percentage of professional in attendance at case reviews

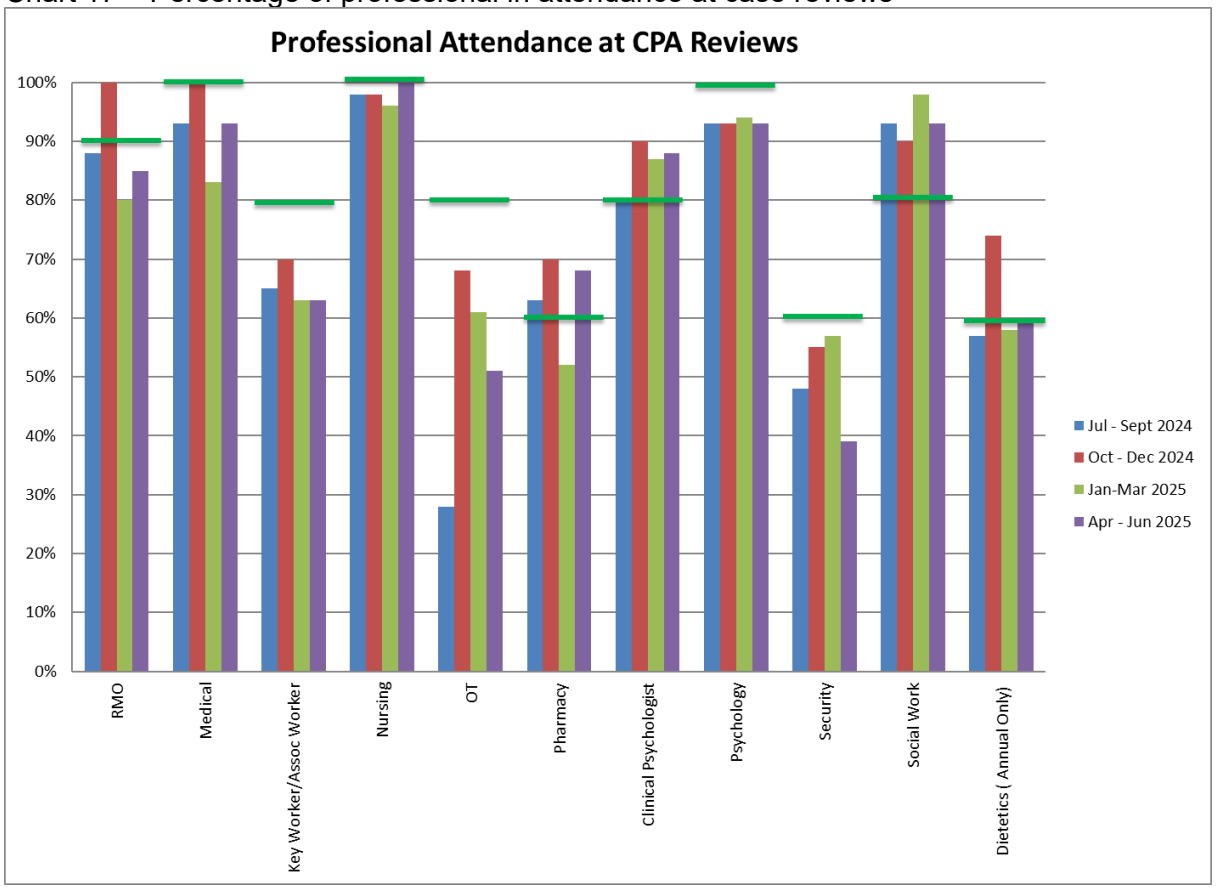


Table 2 Q1 broken down into months attendance

Profession	Apr 25 (n=13)	May 25 (n=13)	Jun 25 (n=15)
RMO	92.3%	69.2%	93.3%
Medical	100%	76.9%	100%
KW/AW	61.5%	69.2%	60%
Nursing	100%	100%	40%
OT	53.8%	30.8%	66.7%
Pharmacy	53.8%	61.5%	80%
Psychologist	84.6%	100%	80%
Psychology	92.3%	100%	86.7%
Security	30.8%	46.2%	40%
Social Work	92.3%	92.3%	93.3%
Dietetics	40%	28.6%	100%

The targets for attendance are set to reflect what is reasonable to expect from each discipline and were reviewed in 2024 to ensure they are achievable. Attendance at case reviews was recorded as both physical and virtual attendance.

RMO (Target 90%) – Attendance for this profession has increased from 80% in Q4 2024/25 to 85% in Q1 2025/26. This indicator moves from the amber to the green zone.

Medical (Target 100%) – Attendance for this profession has increased from 83% in Q4 2024/25 to 93% in Q1 2025/26, this is an increase of 10% over the quarter and this indicator moved from the red to the amber zone.

Key Worker/Associate Worker (Target 80%) – Attendance figure remains the same from Q4 2024/25 and Q1 2025/26 of 63%. This indicator remains in the red zone.

Nursing (Target 100%) – Attendance for this profession has increase in Q1 to 100% attendance. This indicator remains in the green zone.

OT (Target 80%) – Attendance has decreased in Q4 to 51%. This is a reduction of 10% from Q4 2024/25 attendance figures. This profession remains in the red zone and has since Q3 2023/24.

Pharmacy (Target 60%) – This profession's attendance has increased from 52% in Q4 2024/25 to 68% in Q1 2025/26. This indicator remains improved by changing from the amber to the green zone.

Clinical Psychologists (Target 80%) – Attendance figure remains slightly from 87% in Q4 2024/25 to 88% in Q1 2025/26. This indicator remains in the green zone.

Psychology (Target 100%) – This professions attendance for Q1 2025/26 was 93%. This indicator remains in the amber zone.

Security (Target 60%) - attendance has decreased significantly over the last quarter. Attendance in Q4 2024/25 was 57% and has decreased to 39% in Q1 2025/26. Security moves from the amber zone into the red zone. The reason recorded within the VAT form was staff sickness.

Social Work (Target 80%) –. Remains above target at 93% in Q1 2025/26

Dietetics (Target 60%) – attendance is only recorded for annual reviews. Attendance remains in the green zone and for Q1 2025/26 achieved the target of 60%.

4. RECOMMENDATION

The Board is asked to **note** the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of the State Hospital Key Performance Indicators links to both the State Hospital corporate objectives and the Annual Delivery Plan 2025-2026. The KPIs provide assurance to the State Hospital Board on key areas of performance. Some of the KPIs are national targets which the State Hospital is held accountable for performance nationally, others are local priorities for the State Hospital Board. The State Hospital Performance Framework proves an overview of how performance is managed across the State Hospital. Scottish Government will receive this report following approval from the State Hospital Board as an indicator of the State Hospital performance.
Corporate Objectives	**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:** 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.	Via Strategic Planning and Performance Group

Risk Assessment (Outline any significant risks and associated mitigation)	If KPI's are off target the improvement plan to address this is detailed in the paper
Assessment of Impact on Stakeholder Experience	Not formally assessed
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 22
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

As previously reported to the Board, the project is in the final stages, with the majority of works complete and operational. Discussions have commenced with Securitas about the works required to achieve contractual completion and it is hoped that agreement will be reached on those items in the near future.

2 BACKGROUND

Previous papers have outlined the various meetings taking place in order to provide governance and oversight. Plans to scale down this structure in line with the reducing size of the project have begun. The Project Oversight Board continues to meet monthly and Strategic meetings take place with TSH and Securitas senior management every two weeks. The Project Oversight Board meeting last took place on 21st August 2025.

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 will be established through the ongoing discussions with Securitas. The projected final cost overspend is contained in Finance – Project Cost below. As above, at the time of writing discussions are ongoing regarding the need for the contractor to address final issues and the timing of those works relative to Practical Completion. As these discussions are commercially sensitive commercial sensitivity and are potentially subject to rapid change a full verbal update will be given to in the Board's Private Session.

b) Project Timescales

The most recently received draft programme revision is Revision 71. This has not been fully reviewed and is not accepted. It contains works that may not be required, so the actual completion date is inaccurate. The likely completion of those works that are required is late September.

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).
- A small number of works that need to be addressed before Contractual Completion can be awarded.

c) Progress

Site Acceptance Testing (SATs) took place between 10th March and 10th April 2025 and successful retesting of the elements awarded a "C" took place on the 29th of May. Some elements were not able to be tested as works continued to address problems preventing full testing. The small number of remaining tests are expected to be completed on the 14th August.

d) Finance – Project cost

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 £1,048k. This has increased by 87k since the June 2025 report to the Board. The increase is entirely composed of TSH costs for Lead Advisors, management and escort staff. Other than the contractual retention the remaining amount due to Securitas is currently £2.5k.

The key project outline at 09th August 2025 is:

Project Start Date:	April 2020
Planned Completion Date:	September 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 09/08/25:	£9,844,721
Total costs to date (exc. VAT & retention) at 09/08/25:	£9,776,913
Total costs to end of project (Exc. VAT & retention)	£ 67,808

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 09/08/25 is:

Securitas	£ 7.299m
Thomson Gray	£ 1.300m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 1.090m
Miscellaneous	£ 0.002m
Income	-£ 0.114m
Total	**£ 9.780m**

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)	Previously reported, delays in completion incur additional capital cost
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 Scotland 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.

Paper No. 25/82

The State Hospitals Board For Scotland

ANNUAL SCHEDULE OF MEETINGS - 2026

BOARD AND SUB-BOARD

MEETING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD*		Thursday 26.02.26 9.30am		Thursday 23.04.26 9.30am		Thursday 18.06.26 12.30pm		Thursday 27.08.26 9.30am		Thursday 22.10.26 9.30am		Thursday 17.12.26 9.30am
AUDIT & RISK COMMITTEE	Thursday 29.01.26 9.30am		Thursday 26.03.26 9.30am			Thursday 18.06.26 9.00am				Thursday 01.10.26 9.30am		
CLINICAL GOVERNANCE COMMITTEE		Thursday 19.02.26 9.30am			Thursday 14.05.26 9.30am			Thursday 13.08.26 9.30am			Thursday 12.11.26 9.30am	
STAFF GOVERNANCE COMMITTEE		Thursday 12.02.26 9.30am			Thursday 21.05.26 9.30am			Thursday 20.08.26 9.30am			Thursday 19.11.26 9.30am	
REMUNERATION COMMITTEE*		Thursday 05.02.26 9.30am				Thursday 11.06.26 9.30am			Thursday 03.09.26 9.30am		Thursday 05.11.26 9.30am	
BOARD DEVELOPMENT DAY	Thursday 22.01.26 9.30am			Thursday 30.04.26 9.30am				Thursday 06.08.26 9.30am		Thursday 29.10.26 9.30am		

*The Board and Remuneration Committee may also meet as and when required

2026 PUBLIC HOLIDAYS

New Year: Thursday 1 January & Friday 2 January
Easter: Friday 3 April & Monday 6 April
Autumn Holiday: Friday 25 September & Monday 28 September
Christmas: Friday 25 December & Monday 28 December

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	28 August 2025
Agenda Reference:	Item No: 24
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Board Approval for Approved Medical Practitioner Status
Purpose of Report	For Decision

1 SITUATION

It is necessary for the Board to consider the approval of Approved Medical Practitioner status for one of our Consultant Forensic Psychiatrists.

2 BACKGROUND

In order for the Consultant Forensic Psychiatrist to perform their full role within the Hospital they require to be approved as an Approved Medical Practitioner (AMP) and placed on the State Hospitals Board for Scotland list of AMPs. An Approved Medical Practitioner (AMP) is a medical practitioner who has been approved under section 22 of the Act by a NHS Board or by the State Hospitals Board for Scotland as having special experience in the diagnosis and treatment of mental disorder.

3 ASSESSMENT

The Consultant Forensic Psychiatrist has completed the pre-requisite Section 22 training in line with the Mental Health (Care and Treatment) (Scotland) Act 2003. A copy of the training certificate is included for information.

4 RECOMMENDATION

The Board is invited to agree the following recommendation:

The approval of Dr Leanne Duthie as Approved Medical Practitioner in line with the Mental Health (Care and Treatment) (Scotland) Act 2003 and that she is formally placed on the TSH Board's list of Approved Medical Practitioners.

NHS Education for Scotland

TURAS Learn

Certificate

This certificate is presented to:

Dr Leanne Duthie

Approved Medical Practitioner update training : forensic

Course ID - Delivery ID: 70334 - 99025

Date Attended: **17/01/2024**

Learning Aims	The aim of the workshop is to consider how the Mental Health Act and other related legislation should be applied in support of the care and treatment of mentally disordered offenders living in Scotland.
Learning Outcomes	On completion of this course, participants will.... be reminded of the breadth of applicable legislation; consider proposed legislative changes; through cases and discussion, consider appropriate application of the legislation; have explored relevant caselaw.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	N/A
Workforce Implications	N/A
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Via Medical staffing
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).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	☐ **There are no privacy implications.** ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included.