THE STATE HOSPITALS BOARD FOR SCOTLAND

MENTAL HEALTH PRACTICE STEERING GROUP

ANNUAL REPORT 2025

Contents

1 CORE PURPOSE OF SERVICE / COMMITTEE

The main purpose of the Mental Health Practice Steering Group (MHPSG) is to promote continuous improvement in the mental health of State Hospital patients and the highest standards of clinical care, and to deliver on specific pieces of mental health work commissioned by the Clinical Governance Group.

2 SUMMARY OF CORE ACTIVITY FOR THE LAST 12 MONTHS

This year's core activity for the MHPSG has been:

- Proving ongoing governance and oversight of core State Hospital processes.
- Reviewing National Clinical Guidelines and Standards.
- Completing the pilot programme for proposed Outcome Measures for patients' Mental Health.
- Implementing the changes to the CPA (Care Programme Approach) document and associated processes.

3 COMPARISON WITH LAST YEAR'S PLANNED QUALITY ASSURANCE (QA) / QUALITY IMPROVEMENT (QI) ACTIVITY

Key Areas of Work	**Update**
Finalise the new CPA documentation and implement associated changes to the Care Programme Approach process.	• The CPA documentation and associated RIO processes were completed and signed off by the Project Board within the agreed timescale of end of Q4 2024-25.
Working with the Hospital Project Management to execute the CPA project. This took place during Q3-Q4 of 2024-25 and will be completed before the end of Q1 2025-26.	• Roll-out commenced mid-April 2025 with shepherding of all clinical teams through one new CPA lead-up, meeting and follow-up. Roll-out is now complete. • Feedback has been positive to new document and processes with inevitable teething problems that are being addressed (e.g. Formulation work regarding MDT and Psychology). • Work ongoing to constitute Peer Review Panel but Terms of Reference complete and agreed for this. • Patient / Carer feedback will commence post roll-out.
Pass the Forensic Outcome Measure (FORUM) and Clinical Global Impressions Scale (CGI) outcome measure report to the new Working Group tasked with looking at Outcome Measures by end of Summer 2024.	• Report submitted to the Working Group. • This is feeding into the Patient Outcome Project Group (POP). This has met three times to establish a draft set of measures for patient outcomes and is hoping to feedback to the Working Group later in Summer 2025.

Key Areas of Work	Update
Structured Clinical Care (SCC) - the group intends to complete a needs analysis in relation to SCC at the State Hospital. This will help direct our intentions with this after the completion of the CPA project. The group accepts that only one larger project can be managed at a time so hopes to start this during Q1 of 2025-26.	• SCC is part of the medium-term plan for the State Hospital. • As discussed previously, there has been agreement that the MHPSG can only complete one large project at a time. • The hope is that work on SCC can begin in Q3 of 2025-26 – the first step will be a needs analysis.
Family Interventions: the group intends to pull together a scoping exercise around what is currently delivered in this domain and compare this with best practice. This will be a focus for Q1 of 2025-26.	• As per the report, the scoping exercise for this will begin in Q1 of 2025-26. • Scoping exercise of what family work is currently undertaken in the hospital is underway. • Literature review of family interventions in forensic services has commenced. • Discussions regarding how the MHPSG can contribute to the Carers Strategy have occurred with the Person Centred Improvement Lead due to attend the group to discuss further.
Continue to support, as required, the development and implementation of the Clinical Model.	• The MHPSG continues this work.
Trauma-Informed Care.	• Work has been completed to increase the pool of trainers who can deliver Level 1 trauma training. An additional six people have been trained across Nursing Practice Development (NPD) and Psychology. • Between July 2024 and July 2025 17 staff have been trained in Level 1 trauma training and 48 staff have been trained in Level 2 trauma training. • Trauma training has been delivered to staff who would be working in the new women's high secure service.
Pre-Admission Needs Assessment Questionnaire.	• MHPSG will continue to monitor the completion of this routinely for now, but the intention is to hand this over to the Admissions Senior Leadership Team (SLT) in due course.
Quality Assurance Work.	• A core function of the MHPSG is to ensure quality assurance across a variety of clinical domains at the State Hospital. This work has been ongoing with no identified problems.

Key Areas of Work	Update
Oversee the audit process surrounding the new Grounds Access (GA) electronic system.	• This is now a routine part of MHPSG's monitoring. The time from application to getting Grounds Access has improved but there is a wide variance still between individual cases. • MHPSG will be re-auditing this in December 2025. • We note that the GA policy is due for review though there is an extension for this from the Policy Approval Group (PAG).

4 QUALITY ASSURANCE ACTIVITY

4.1 Reviewing and monitoring of National Clinical Guidelines and Standards

Over the last review period (1 May 2024 to 30 June 2025) the MHPSG was involved in the review of 13 guidelines / standards, all of which were considered relevant. Eleven guidelines / standards had varying degrees of relevancy to mental health services within the hospital and were reviewed for information purposes. There were Evaluation Matrices required for two guidelines / standards, and these are in the process of being completed.

Table 1 – Standards and Guidelines reviewed

Guidelines/Standards Body	No. of publications reviewed	No. applicable to the State Hospital	Evaluation Matrix required
Mental Welfare Commission (MWC)	12	11	1 in progress
National Institute of Health & Care Excellence (NICE)	1	0	1 in progress

Table 2 - The two guidelines / standards that requ ired evaluation matrices and which are in progress are:

Body	Title	Current Situation	Date Issued
MWC	Significantly impaired decision-making ability in individuals with eating disorders.	Agreement reached for content to be reviewed. Review meeting to be arranged incorporating Dietetic representative.	May 2025
NICE	Gambling-related harms: Identification, assessment and management.	Matrix completion in progress by Psychology – delayed due to prioritisation of implementation of Women's service.	Jan 2025

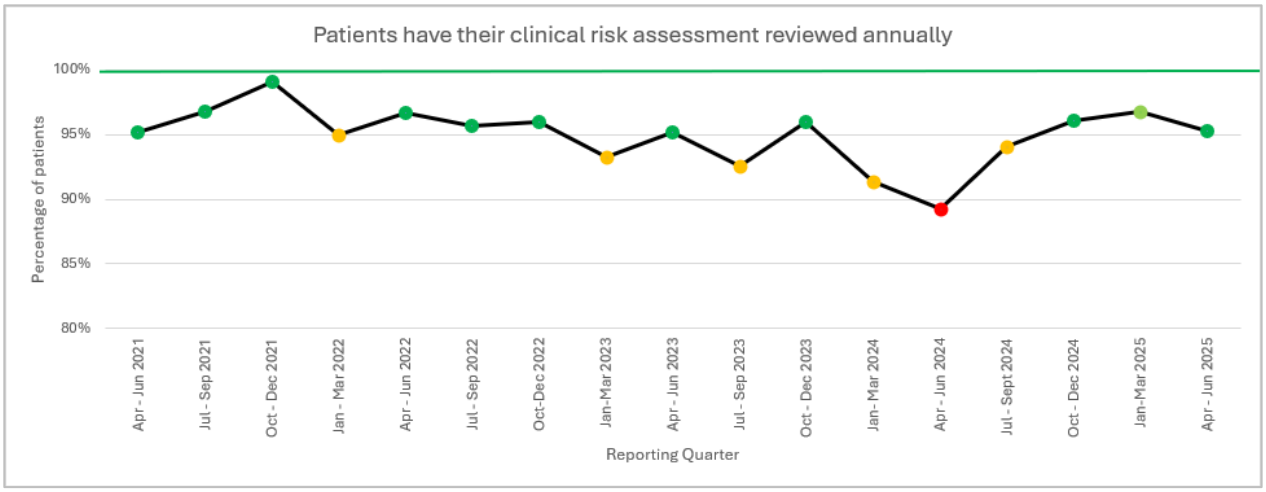
An Action Plan detailing work ongoing from outstanding recommendations is attached to this report (see Appendix 2). Two recommendations have been achieved during the review period from NICE and MWC guidance.

4.2 Risk Assessment Completion

This information is collated by Health Records on a monthly basis and monitored as part of the hospital's Key Performance Indicators (KPIs). The hospital KPI standard for risk assessment completion is 100%. In addition, the MHPSG has historically monitored this bi-annually. Due to issues in Q1 2024 with the percentage of risk assessments being reviewed, MHPSG will monitor this quarterly in tandem with KPIs, and any issues will be taken back by Psychology representation on the group to implement an improvement plan.

The definition of the KPI has been brought in line with the timings of the new CPA processes – this will mean that there is now a 30-day window after the CPA date for the HCR-20 to be completed. A new RIO report will be available soon to monitor these time periods which will make auditing the process significantly easier.

Graph 1 – Clinical Risk Assessment reviewed annually

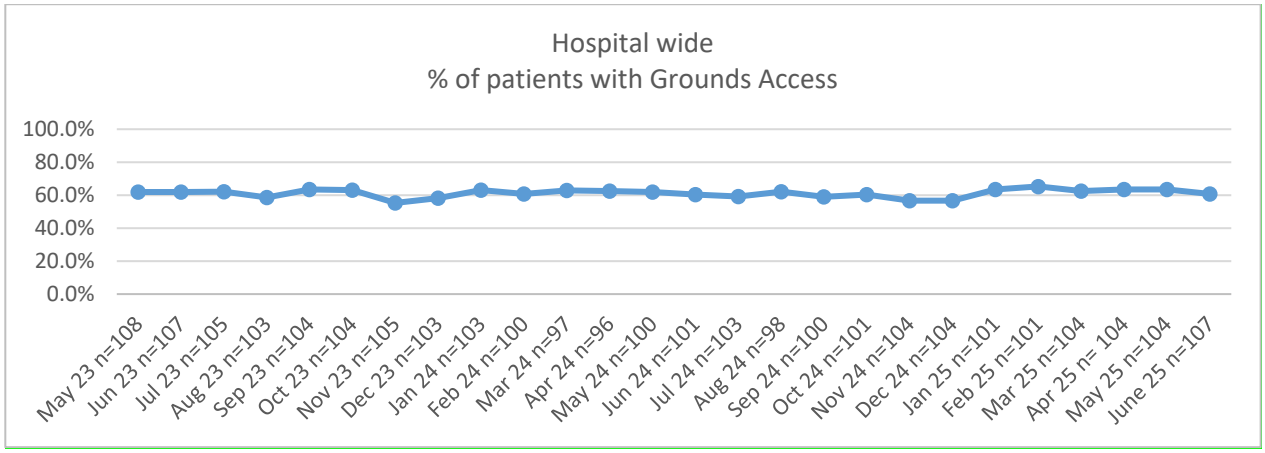


After discussion at the Clinical Governance Group on 30 July 2025, it was agreed that governance of this KPI would now be handed over to the Psychological Therapies Governance Group (PTGG).

4.3 Grounds Access

Grounds access is monitored by the MHPSG on a six-monthly basis and information on this is provided to the Service Leadership Teams on a monthly basis. This information is also routinely provided to the Physical Health Steering Group (PHSG).

Graph 2 – Percentage of patients with grounds access



The graph above shows Grounds Access has remained in control over the last 12 months to June 2025.

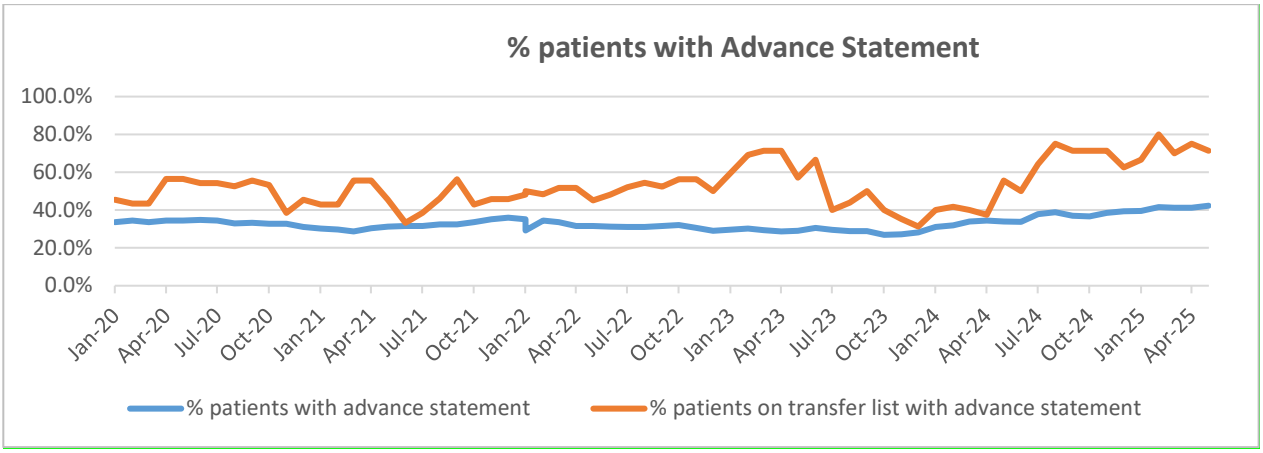
The Grounds Access Policy is currently due for review but an extension until December 2025 has been placed on this due to staff absence. This was authorised by PAG.

Clinical Quality will carry out a spot check in December 2025 to study the length of time from patients being referred for grounds access and final sign off.

4.4 Advance Statements

Advance Statements are monitored by the group on a six-monthly basis and either reviewed or discussed with the patient on a six-monthly basis at the patient's annual and intermediate case reviews.

Graph 3 - Percentage of patients with Advance Statement



The graph above reports on the percentage of patients with an Advance Statement. The graph shows the percentage of patients with an Advance Statement is very high relative to other services in Scotland, with some limited variance over time. A key stage for patients to create an Advance Statement is prior to them leaving the State Hospital for another hospital setting. The graph also shows the percentage of patients on the transfer list, moving to a hospital setting with an Advance Statement. In the period June 2024 to May 2025 this has ranged from 50% to 80% which is an improvement on previous years.

The MHPSG continues to work closely with Advocacy to ensure that patients are given the opportunity to produce an Advance Statement. In addition, as part of the new CPA process and documentation, the question of whether a patient has an Advanced Statement is explicitly asked. The hope is that this will keep this issue on a watching brief for clinical teams.

As part of the Medicine's Committee, consent to Treatment Audit, RiO was checked to ensure that the information regarding patients' Advance Statements correlated with the information recorded on the T3B form.

Has the Designated Medical Practitioner (DMP) completed the section on the Advance Statement?

On all 53 (100%) occasions, the section on the Advance Statement was completed by the DMP. This has been the case since 2023.

Table 3 – DMP completion of Advance Statement section

	2020 No	2020 %	2021 No	2021 %	2022 No	2022 %	2023 No	2023 %	2024 No	2024 %
Yes	57	98.3%	60	98.4%	53	96.4%	52	100%	53	100%
No	1	1.7%	1	1.6%	2	3.6%	0	0	0	0

Further investigation was carried out to ensure that the information on the T3B regarding Advance Statements was accurate.

- On six occasions the T3B audited was in place prior to the Advance Statement.
- On nine occasions it was correctly reflected within the T3B that the patient has an Advance Statement.
- On three occasions the Advance Statement was overridden. On all three occasions a letter was written to the patient, copying in the Responsible Medical Officer (RMO) and Mental Welfare Commission (MWC) acknowledging this.

4.4.1 Advance Statement Overrides

As the result of an audit by the Clinical Quality department and one Resident Doctor, it was established that there are still a number of Advance Statement Overrides. With the move away from a paper system, whereby the Advance Statement was held as a paper copy next to the paper Kardex, there was less of a prompt to prescribers to consider the Advance Statement. This led to overrides occurring. The MHPSG, in conjunction with the Pharmacy Department, have initiated a system to ensure there is a colour-coded note on the Hospital Electronic Prescribing and Medicines Administration system (HEPMA) to alert prescribers to the presence of an Advance Statement. In addition guidance was reiterated to Medical staff in respect of notifying Health Records when an Advance Statement override occurs – data from Health Records notes no Advance Statement overrides since Sept 2024

This audit process will be added to the Clinical Quality Audit Plan to establish if there is a positive change with the addition of this new system. Currently, this plan states that it will monitor Advance Statement Completion and also Advance Statement Overrides annually; the results from this will be reported to the MHPSG.

5 QUALITY IMPROVEMENT ACTIVITY

5.1 Clinical Outcomes Pilot Report

In consideration of the information and experience generated through the Pilot process, the MHPSG saw clear benefit in recommending the use of the FORUM outcome measure as part of the CPA review process within the hospital. This recommendation is also in line with the Royal College of Psychiatry 2024 report “Outcome Measures in Psychiatry” which in reference to outcomes measurement within Forensic Psychiatry concluded that patient outcomes should be routinely measured and that this measurement should include the use of validated instruments reported by both patients and clinicians.

This has been fed back into the work of the Patient Outcomes Project Group, which is ongoing.

5.2 Motivation of new patients and ensuring positive engagement

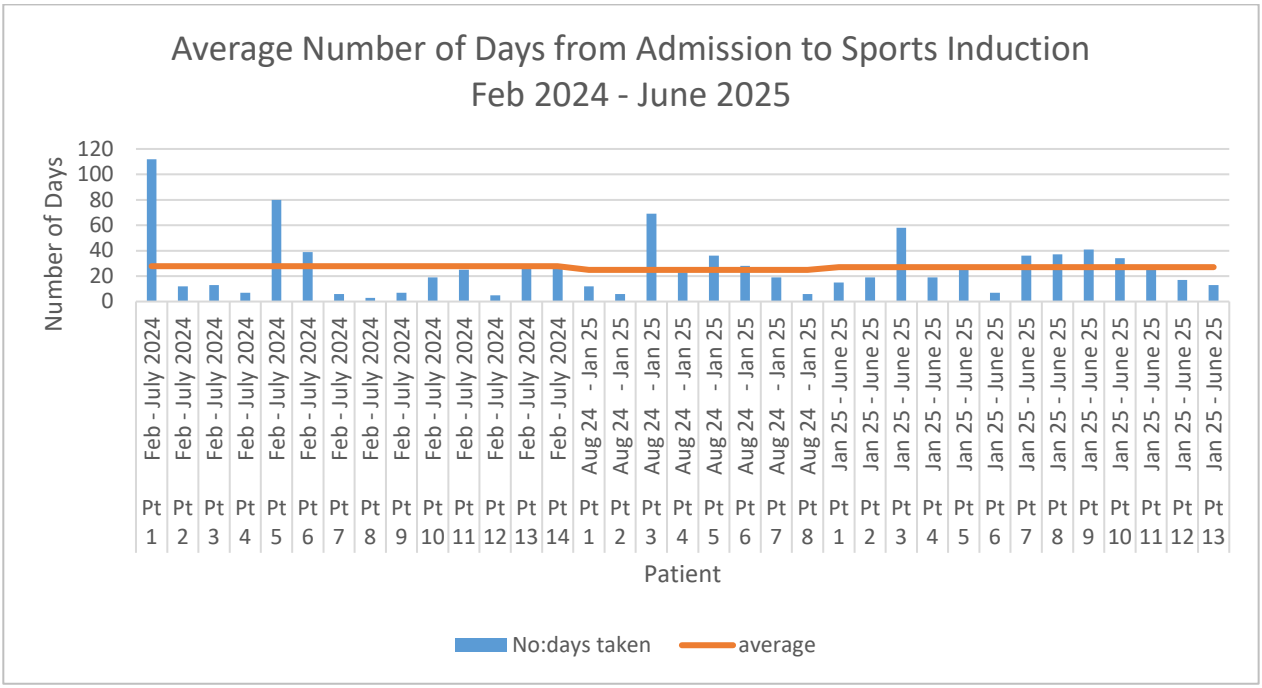
The Skye Activity Centre provided a report to the group on the new ways of working with newly admitted patients to ensure engagement with Skye Activity Centres.

This included:

- Access to Hub induction.
- Access to Sports induction.
- Access to Skye Centre induction.
- Admission Service sessions – Friday am and Tuesday pm.

The graph below shows the number of days from admission to Sports induction – the data shows random variation – this variation is due to the presentation of patients on admission.

Graph 4 – days from admission to sports induction



The following table shows the average time and range between admission and Sports induction. As can be seen the average remains similar over the last three periods but the range shows improvement.

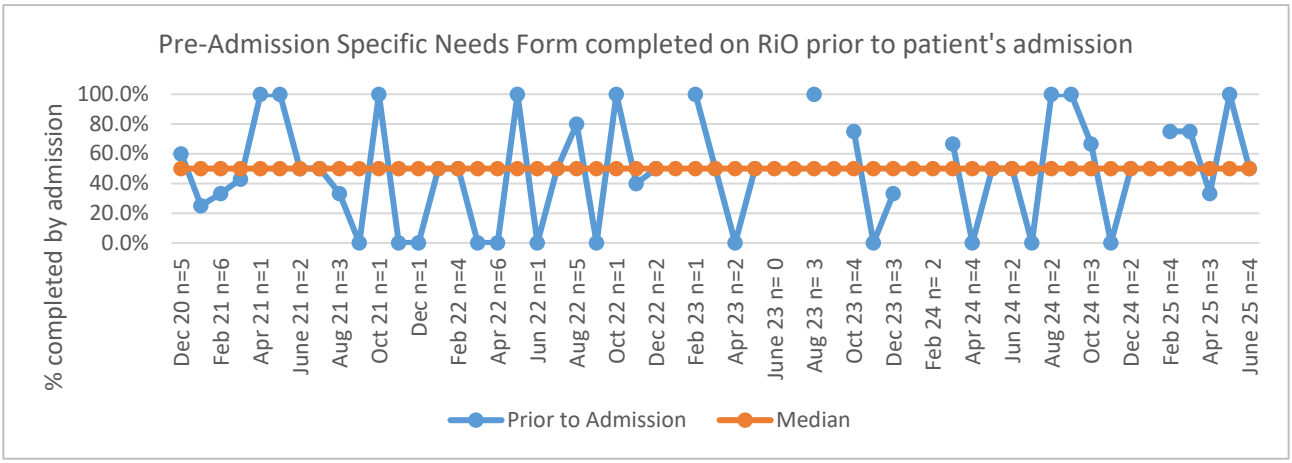
Table 4 – average and range of times from admission to Sports induction

Time period	Number of admissions	Average time from admission to Sports induction in days	Minimum days	Maximum
Feb-Jul 24	14	27.3	3	112
Aug-Jan 25	8	26.7	6	69
Jan – June 25	13	26.8	7	58

5.3 Pre-Admission Specific Needs Assessment Form

Pre-Admission Specific Needs Assessment data is routinely reported to MHPSG and the Admission and Assessment Service Leadership Team. Referring organisations must complete the form once a patient is accepted for admission. Although the State Hospital continues to circulate the forms, completion remains inconsistent due to variable engagement from external services. To improve oversight, the Admission Service will now monitor the process, as they are better positioned to drive change.

Graph 5 - Pre-Admission Specific Needs form completed prior to admission



5.4 Finalising and Operationalising of CPA Document and Associated New Process

The new CPA documentation was approved for rollout during Q3 of 2024-25. It was agreed that we would use a staggered rollout process with shepherding of all clinical teams through one new CPA lead-up, meeting and follow-up. This rollout is now completed.

Feedback has been positive to the new document and processes. There have been inevitable teething problems that are being addressed with a view to a modified set of improved processes in October 2025. This will include the provision of a new form for a Strengths, Protective Factors and Needs list that can be completed by the MDT and shared with the patient. We are also considering the addition of a Patient History Form to accompany the CPA document to allow an ongoing narrative document to be available for clinical teams.

The Peer Review Panel Chair has been selected as David Hamilton, Social Work Lead for South Lanarkshire and he is assembling a multidisciplinary team of personnel to help him progress this work.

Clinical Quality has consulted with heads of professional departments and the Clinical Governance Committee, and has agreed the replacement process for the existing Variance Analysis Tool. This work will both feed into and run alongside the Peer Review Panel's work. Patient and Carer feedback will commence too with this.

The project is due to sign off at the final Project Board meeting on 4 September 2025.

5.5 Relational Approaches to Care Group (RATC)

5.5.1 Bi-monthly Workshop

The RATC continues to deliver the half-day workshop on *Relational Aspects of Care* every two months. It is led by the Consultant in Medical Psychotherapy, supported by colleagues from NPD and other RATC members. This workshop is part of the training plan and is delivered through the Learning Centre with organisational support. Unfortunately, a few sessions had to be cancelled over the past year due to nursing staffing challenges.

5.5.2 Input to Induction Programme for the new Female Service

On 18 July 2025, we delivered the workshop to 25 multidisciplinary staff as part of the induction programme for the new female service. Feedback from the session was very positive.

5.5.3 Development of Online Module

Building on the same training framework as the workshop, and with support from the Head of Learning, we have been developing a new online module titled *Essential Relational Aspects of Care*. This module is designed to complement the workshop by offering additional context and detail, while also functioning as a standalone resource. Although the writing, editing, and formatting process has taken some time, we are pleased to report that a final draft has now been formatted as an interactive online module. The Consultant in Medical Psychotherapy will complete final proofing during August 2025, with a planned launch in September 2025.

5.6 Trauma Informed Care (TIC)

The MHPSG notes that Trauma Training has remained a priority. There are two levels to this, Level One ("Trauma Informed" – awareness training) and Level Two ("Trauma Skilled" – to help staff feel confident in recognising and understanding how to work with trauma). These are both components of the National Education for Scotland (NES) National Trauma Training Programme.

Work has been completed to increase the pool of trainers who can deliver Level 1 trauma training. An additional six people have been trained across NPD and Psychology.

Between July 2024 and July 2025 17 staff have been trained in Level 1 trauma training and 48 staff have been trained in Level 2 trauma training.

Level 2 Trauma training was delivered to staff who would be working in the new Women's High Secure Service in July 2025.

A schedule for future training has now been organised by Donal Campbel and Laura Young with monthly sessions from August 2025 to March 2026 now in place. The sessions will be co-facilitated by Psychology and NPD and will alternate between Level 1 and Level 2 training.

We have agreed that the governance of TIC will sit with MHPSG.

5.7 Naloxone Provision and Training for Staff

As part of its routine quality assurance activity, it was noted that there was no Naloxone available in the State Hospital for emergency situations that might require it. In addition, there was no formal training provided in its need, use or administration.

As a result of this our NPD member, Hannah McAllister, has organised for Naloxone to become available in emergency bags, and training will be provided routinely as part of standard life support training at the State Hospital.

6 STAKEHOLDER EXPERIENCE

6.1 Stakeholder Feedback

Updates relating to the work of the Person Centred Improvement Team (PCIT) is provided by the Skye Centre Senior Charge Nurse, who is responsible for overseeing the line management of the staff within this service. Information includes patients' presentation and progress related to the PCIT activities i.e. visits and carers, volunteer role in the Nu2U charity shop, Spiritual and Pastoral Care, and the Patient Partnership Group (PPG).

Ward / Hub Community meetings continue to be facilitated however it was recognised that processes related to sharing information between the PPG and the wider patient group could be improved upon. The group participated in the TSH3030 initiative taking forward a project which aimed to develop a structured and timely process for sharing key updates and feedback from the weekly PPG, whilst ensuring effective monitoring of implementation at ward level. The group members developed a structured template to improve consistency in communication. At the end of the 30 days the PPG project was given a Highly Commended Award in the “Most Patient Impact” category. Plans are in place to continue to test these improvements using further Plan-Do-Study-Act (PSDA) continuous improvement cycles.

The State Hospital Carer Strategy has been developed, and a presentation outlining the four priorities and the associated action plan was provided to the MHPSG by the Skye Centre Manager. It was acknowledged that there were key aspects of the action plan that group members could be involved in. In particular it was agreed that members of the group could support the progress of the priority related to the development of a Carer Pathway. The actions related to this will provide support for both patients and carers to navigate the transitional points within our care environment and prepare our carers for their loved ones’ discharge through established links with the wider Forensic Network.

7 PLANNED QUALITY ASSURANCE/QUALITY IMPROVEMENT FOR THE NEXT YEAR

The MHPSG will focus on the following key areas of work over the next twelve months:

- Finalise the new CPA documentation and implement associated changes to the Care Programme Approach process. This should be completed by September 2025.
- The modified processes for the CPA project should be onstream by October 2025.
- Structured Clinical Care - the group intends to complete a needs analysis in relation to SCC at the State Hospital. This will help direct our intentions with this after the completion of the CPA project. The group accepts that only one larger project can be managed at a time so hopes to start this during Q2 of 2025-26.
- Family Interventions: the MHPSG has made links with the team delivering the Carer Strategy and will liaise with them regarding any pieces of work from this that the MHPSG can assist with taking forward.
- The MHPSG will continue to audit the Grounds Access electronic system.
- The MHPSG will continue its core business of quality assurance work at the State Hospital.

8 CHANGES TO MEMBERSHIP

There have been some changes to the group membership over the last year.

9 NEXT REVIEW DATE

The Mental Health Practice Steering Group will report to Clinical Governance Committee in August 2026.

APPENDIX 1: GOVERNANCE ARRANGEMENTS FOR COMMITTEE

Committee membership:

The MHPSG is attended by a group of multidisciplinary staff from across all disciplines working in the hospital.

Membership in 2024-25

Dr L Kennedy, Consultant Forensic Clinical Psychologist (Chair)
Dr J Patrick, Consultant Forensic Psychiatrist (Co-Chair)
Jamie Pitcairn, Research & Development Manager
Kim McLelland, Senior Charge Nurse
Stuart Lammie, Lead Nurse
Hannah McAllister, Senior Nurse in Nurse Practice Development
Lindsey Young, Social Worker
Alex MacLean, Senior Charge Nurse
Morven Grant, Occupational Therapist
Julie McGee, Clinical Quality Facilitator
Minute Secretary: Barbara Howat

Role of the Committee

The main purpose of the MHPSG is to promote continuous improvement in the mental health of State Hospital patients and the highest standards of clinical care. More specifically the remit includes:

- Promoting continuous improvement in the mental health of the patients, incorporating the highest standards of clinical care.
- Increasing the proportion of care that is evidence based or best practice, and providing guidance on mental health interventions.
- Ensuring that clinical and non-clinical staff have a voice in the redesign, development, planning and prioritisation of mental health services through the health planning process and the optimum allocation of resources to benefit patients.
- Monitoring and driving improvement in the effectiveness and efficiency of overall service delivery for mental health needs.
- Providing a forum for consultation, discussion and debate, drawing on expertise within and outwith the hospital.
- Contributing to work streams emerging from stakeholder feedback.

Aims and Objectives

To establish and maintain systems to gather, assess and implement (where appropriate or required) evidence based and best practice guidance in mental health as published by NHS, Healthcare Improvement Scotland (HIS), NICE, Mental Welfare Commission (MWC) and other bodies, including:

- Standards (mandatory).
- Mental Health Strategy.
- Clinical Outcome Measures.
- Health Technology Assessments.
- Safety Action Notices / Patient Safety Alerts.
- SIGN Guidelines.
- Best Practice Statements.
- National Audits.
- NICE Technology Appraisals.
- MWC Guidance and Investigations.

- And NICE guidelines
- To prioritise and oversee a programme of clinical audit and clinical policy development, review and implement to enable the delivery of optimum care to patients.
- To deliver on specific pieces of mental health work commissioned by Clinical Governance Group.

Meeting frequency and dates met

Meetings are held monthly on the third Thursday of the month. There has been one cancelled meeting this year because of not being quorate during the school holidays.

Management arrangements

The group reports directly to the Clinical Governance Group every twelve months.

APPENDIX 2 - MHPSG GUIDELINES AND STANDARDS ACTION PLAN

MHPSG - Guidelines & Standards Action Plan – Achieved actions from previously completed gap analysis

Title	Guideline & Outstanding Recommendation	Evidence Level	Person Responsible	Update (inc date)	Projected Completion Date
NICE – Self Harm: Assessment, management and preventing recurrence / RCP – Supporting mental health staff following death of a patient by suicide Reviewed by MHPSG – May 2023	1.14.1 Training for all staff who work with people of any age who self- harm should: • Involve people who self-harm and where appropriate, their families or carers, and staff in the planning, delivery & evaluation of training • Be available in a range of formats including interactive role play, online, face to face & through provision of resources. • Explore staff attitudes (including non-healthcare staff), values, beliefs & biases • Be appropriate to the level of responsibility of the staff member. • Be provided on a regular on ongoing basis	-	H McAllister	07/24 - Suicide awareness training has been scheduled for a half day of training for all nursing staff. The Suicide Awareness and Prevention Policy is under review by the NPD team. 11/24 – Suicide Awareness training has commenced with one session having taken place and a further two sessions planned over the coming months. The Suicide Awareness and Prevention Policy is under review and will go to PAG for approval in January. 01/25 - The suicide awareness training has commenced, and we have dates forecast. The training will remain on our NPD training agenda. Policy to go out for consultation.	Jan 2025
MWC – Investigation into the death of Mrs F	Review assessment and clinical risk screening and management documentation and processes.	-	H McAllister, M McKinlay, K McLelland	09/24 – Suicide screening to be reviewed in conjunction with current policy updating. 11/24 - The review of current risk screening is still in early process; this is being reviewed in line with the policy and current national guidelines. The policy will be tabled at MHPSG for discussion at the next meeting on 21 November. 01/25 – Process reviewed as part of policy review which has been completed with consult period due to start.	Jan 2025