THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 18 DECEMBER 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 23 October 2025	For Approval	TSH(M)25/09
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 25/106
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**Patient Story: Patients' Rights Day** Introduced by the Director of Nursing and Operations	For Noting	Presentation
8.	**Patients' Advocacy Service Annual Report** Introduced by the Director of Nursing and Operations	For Noting	Paper No. 25/107
10.20am	**RISK AND RESILIENCE**		
9.	**Corporate Risk Register** Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 25/108
10.	**Finance Report – to 30 November 2025** Report by the Director of Finance & eHealth	For Noting	Paper No. 25/109
10.40am	**CLINICAL GOVERNANCE**		
11.	**Nursing Resource Strategy 2026/27** Report by Director of Nursing and Operations	For Noting	Paper No. 25/110
12.	**Daytime Confinement (DTC) Report** Report by Director of Nursing and Operations	For Noting	Paper No. 25/111
13.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/112
14.	**Clinical Governance Committee:**	For Noting	

	Approved Minutes of meeting held August 2025		CGC(M)25/03
	Report of meeting held November 2025		Paper No. 25/113
15.	**Clinical Forum: Minutes**	For Noting	CF(M) 25/04
11.20am	**BREAK**		
11.30am	**STAFF GOVERNANCE**		
16.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 25/114
17.	**Staff Governance Committee:** Approved Minutes of meeting held August 2025	For Noting	SGC(M) 25/03
	Report of meeting held November 2025		Paper No. 25/115
11.50am	**CORPORATE GOVERNANCE**		
18.	**Climate change and Sustainability Annual Report 2024/25** Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 25/116
19.	**Board Workplan 2026** Report by the Head of Corporate Governance	For Decision	Paper No. 25/117
20.	**Performance Report** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 25/118
21.	**Project Update for the National High Secure Forensic Healthcare Services for Women in Scotland** Report by the Programme Director	For Noting	Paper No. 25/119
22.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Programme Director	For Noting	Paper No. 25/120
23.	**Any Other Business**		Verbal
24.	**Date of next meeting:** 9.30am on 26 February 2026		Verbal
25.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
26.	**Close of Session**		Verbal

Estimated end at 12.30pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 25/09**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 23 October 2025.

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

Chair:	Brian Moore
Present:	
Employee Director	Allan Connor
Non- Executive Director	Stuart Currie
Non- Executive Director	Cathy Fallon
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Finance and eHealth Director	Robin McNaught
Non- Executive Director	Pam Radage
Non-Executive Director	Shalinay Raghavan
Medical Director	Lindsay Thomson
In attendance:	
Corporate Business Manager	Anne Donnelly
ST6 Forensic Psychiatry	Dr Simon Hall
Acting Director of Security, Estates & Resilience	Allan Hardy
Social Work Mental Health Manager	David Hamilton
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minute]
Programme Director	David Walker [Items 17 & 18]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone and noted apologies from Mr Gary Jenkins, Chief Executive Officer, Ms Caroline McCarron, Head of Communications and Dr Joe Judge, Chair of the Clinical Forum.

He also welcomed the newest member of the Communications team, Mr Caoimhin Watts and Dr Simon Hall who were in attendance to observe the meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 28 August 2025 were noted to be an accurate record of the meeting, with one minor amendment.

<u>The Board:</u>

1. Approved the minute of the meeting held on 28 August 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.

The Board:

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

5 CHAIR'S REPORT

Mr Moore provided an overview of his activity since the date of the last Board meeting, and this included a meeting of the NHS Board Chairs Group in September with Mr Neil Gray, Cabinet Secretary for Health and Social Care. This had been focussed on the reform and renewal agenda within NHS Scotland and the wider public sector, as well as the implementation of the Reduced Working Week for Agenda for Change staff. It was recognised that further engagement would be taken forward with staff, and Mr Moore was pleased to see that the State Hospital was in a positive position in this respect.

He also advised that NHS Chairs had held their annual away day which had considered the vision and purpose of the group, and how to work most effectively in a political landscape. He had also shared the recent correspondence from the Improving Population Health Group with colleagues, noting the importance of this within the State Hospital when considering patient physical health. The Minister for Mental Wellbeing and Social Care would be visiting the hospital to conduct the Annual Review on 24 November 2025, and this would be a good opportunity to highlight the hospital's remit in this respect.

NHS Chairs had also held their regular monthly meeting, and had discussed the public consultation about the role of NHS Delivery. NHS Chairs would not be submitting a singular response. Mr Moore noted that it would be the State Hospital's intention to do so, and that this would be discussed further as the forthcoming Board Development Session this month.

The Chair also spoke about Speak Up Week which had taken place at the end of September, and thanked everyone who had been involved in the endeavours to promote this.

He also noted that two members of staff had been nominated for their work in Global Citizenship at the Scottish Health Awards due to take place on 6 November, which was a credit to both individuals and the organisation.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

In Mr Jenkins's absence, this update was provided by Ms McCaffrey in her role as Deputy Chief Executive.

She began by noting updates in respect of key areas. Firstly, the changes cited nationally in Serious Adverse Event Reporting and confirmed that the State Hospital was on track in terms of compliance. In relation to the UK Supreme Court ruling relating to the Equality Act 2010, Mr Wallace was leading internally to ensure compliance. Further, a letter had been received from the Director of Mental Health Services seeking assurance on levels of mental health advocacy. Ms McCaffrey noted the positive position for the State Hospital presently.

She then advised that regarding Business Systems, Board Chief Executives had recently reviewed processes and next stages for the procurement of a national system and that key milestones had been agreed in this respect.

She also summarised key issues that had been discussed at the Board Chief Executives Group including the financial position of NHS Boards, developing a single approach to change, the Digital

Front Door programme update and the National Referral Protocol. Additionally, young persons' gender identity services, late-stage abortion and the Operational Improvement Plan and the Quality and Safety programme.

Locally, she confirmed that Mr Jenkins had held the annual Central Legal Office (CLO) performance review meeting with no issues to report. He had also participated in a CLO training event on handling criminal misconduct.

Along with Mr McNaught he had taken part in meeting with colleagues from Scottish Government and Northern Ireland (NI) in relation to charging for NI patients.

There had been an extraordinary meeting of the Partnership Forum about the Reduced Working Week, and reporting was on the agenda of today's meeting regarding this. Speak Up Week had taken place, and this was also on today's agenda.

There had also been an Organisational Development Session on 30 September, looking at systems and structures within the State Hospital with a view to simplification and greater local empowerment. Two feedback sessions had followed this, and a further in person development day was planned for 1 December.

Mr Currie referred to the public consultation about NHS Delivery and commented on the danger of group think in this respect. He said that NHS Chairs and Chief Executives would remain accountable on behalf of their own NHS Boards, which may each move at a different pace of change depending on their remits. There would be a responsibility to consider the opportunities for each Board which may produce differing views on the optimal way forward. He also noted that although the State Hospital had a very specific role in healthcare provision, the Population Framework did still have relevance within this. Mr Moore agreed and noted his understanding that each NHS Board would consider their own response in respect of NHS Delivery. He also referred to the Single Authority Model in respect of island communities, and that this was also an areas wherein there may be different views for the future. At the same time, he said that although NHS Boards may have different interests, the aspiration was the same across the system.

Ms Radage thought that the key would be both the amount and the scale of proposed change, and that this could be an opportunity for the State Hospital going forward. Professor Thomson noted the importance of the educational elements with NHS Educations for Scotland's remit, and the importance of not losing sight of that.

Mr Moore said he thought it likely that there would be significant change in the next five years across NHS Scotland and the public sector as a whole, and agreed that the State Hospital could be part of that. There was a need to consider and anticipate this change at the present time. This would be for further discussion at the Board Development Session, and in the coming months.

The Board:

1. Noted the update from the Deputy Chief Executive.

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 25/89) from the Acting Director of Security, Resilience and Estates in respect of the Corporate Risk Register. Mr Hardy led the Board through a summary of the content of the paper, which included risk movement and any recent updates. He advised that there were no new proposed risks for addition to the register, and summarised the position on the five risks which were graded as 'High'. In terms of risk distribution, he confirmed that whilst 14 risks on the register had reached their target level, 10 remained outwith this. The Risk Team were continuing to work with directorate colleagues in this respect.

In addition, a key focus was the implementation of InPhase software which would replace Datix as an incident management system. Mr Hardy also advised that the Risk Team were working with departments at a local level to monitor the Local Risk Register.

Ms Fallon asked about InPhase in terms of the need for staff training and what processes were in place. She also asked about how departments reviewed and came to a decision about risks at a local level, and determining what should be added to their local register. Mr Hardy confirmed that a training plan was being developed for staff in respect of InPhase, however, the change in terms of in putting an incident on the system was expected to be minimal. The system should provide additional scope for the investigation of incidents, with a need to equip senior staff to be able to utilise it fully. He also described the work conducted at department level with the Risk Team, in terms of recognising local risks and how these should be placed within the risk management system, including consideration of escalation to the Corporate Risk Register.

Mr Currie commented on reporting of risk movement, and the need to consider whether the initial risk grading had been achieved over time, and if subsequent experience had demonstrated if the initial grading had proved to be accurate. This was particularly important for risks that may not have achieved their target rating in terms of re-considering whether the target was a reasonable and achievable one.

Mr Hardy agreed with this point, and that the refresh of the Corporate Risk Register over the past 12 months had included this consideration providing the example of MD30 in relation to patient obesity, wherein the Key Performance Indicator (KPI) was currently under review and this would inform the assessment of the risk. More widely, he recognised the need to continue to review those risks that were not at their target rating in this context.

Ms McCaffrey underlined this point, noting those areas of risk which may sit outwith the direct control of the organisation, especially in terms of timescale. She added that in terms of the local risk registers, reporting to the Board was required to provide assurance at the right level on the processes in place and governance oversight. She also clarified a point made on the wording of Risk FD90 in terms of the financial position which was that there was currently an underspend in revenue, with an expectation of a break-even position at year end.

Mr Moore echoed the point on local risk register management and reporting; the Board was seeking assurance around the processes in place to give confidence that risks were being managed appropriately at all levels. Mr Currie agreed with Ms McCaffrey's point that it was important to recognise any areas over which it may be challenging to mitigate or control, and that risk assessments should reflect that so that the areas that were within organisational control could be better focused on.

Mr Moore summarised for the Board, noting agreement with the report's recommendations. He also noted the progress made in this area over the last two years and the need for future consideration on risk threshold and appetite within reporting, and that this would be routed through the development sessions initially.

The Board:

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

8 FINANCE REPORT TO 30 SEPTEMBER 2025

The Board received a paper (Paper No. 25/89) from the Director of Finance and eHealth, presenting the financial position to 30 September 2025 (Month 6). Mr McNaught provided an overview of reporting which demonstrated a small underspend and expectation of break-even position. He also highlighted the potential for unknown pressures in the coming period, and noted the impact of periods of clinical acuity and the women's service within nursing. Directorate meetings continued on a monthly basis, with close monitoring in this respect. He outlined wider financial pressures across NHS Scotland, and confirmed that Scottish Government remained content with the overall position for the State Hospital at this date.

In terms of the capital position, the budget for the current year was being fully utilised with additional funding having been provided for specific areas of maintenance in the estate. He advised that additional non-recurring capital budget of £380k had been granted by Scottish Government for a range of

maintenance work as detailed in reporting.

Mr McConnell asked about the Women's Service, and how capital and revenue spending was represented in the figures reported. Mr McNaught confirmed that this was aligned within directorate spend for the current year, and therefore part of the overall underspend figure included in the Women's Service. He highlighted that there was uncertainty about the future funding, and said that he would add additional detail into the forecast for future reports.

Mr McConnell also asked whether charging in the future for patients from Northern Ireland, would mean a consequential impact on the budget allocation, and Mr McNaught confirmed that this was an area in which meetings were taking place with Scottish Government and colleagues from Northern Ireland to agree the position going forward.

In response to a question from Ms Fallon about the detail reported on the costs of outboarding patients from the State Hospital for acute care, Mr McNaught clarified that although there had been costs in this respect during the current year, there were none at the present moment.

Mr Currie referred to the savings position in year, and asked about when confidence about achieving the target position could be taken. Mr McNaught said that this would be materially clearer by the end of Quarter 3. He also thought it important to note the potential for unexpected impacts in Quarter 4.

Mr Currie also asked about how the financial benefits of a reduction in sickness absence levels could be quantified and projected forward, and whether other aspects were relevant in this regard apart from overtime costs. This was also important in terms of decision-making for funding of wellbeing initiatives. Mr Wallace commented that reporting to the Staff Governance Committee which had explored this area, agreeing that there was a need to compare and align future work. Mr McNaught agreed that the financial aspects could be built upon with further analysis in future reporting.

Action – Mr McNaught

Mr Moore summed up for the Board, adding that it was helpful to see the funding for Agenda for Change costs also set out within reporting.

The Board:

1. Noted the content of the report.

9 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 25/90) which outlined quality assurance and improvement activities.

Ms Merson outlined the key aspects which encompassed clinical audits as well as high level reporting of the Hospital Wide Variance Analysis Tool (VAT). She also summarised activity within the QI Forum and capacity building. Further, she noted the work taken forward within Realistic Medicine, including the use of Team Based Quality Review tool within the Admissions and Assessment Service. Ms Merson noted the progress made within Evidence for Quality in terms of assessment of national and local guidance and standards. Lastly, she noted that the format of reporting had been refreshed so as to provide high level assurance for the Board, recognising the more detailed overview taken by the Clinical Governance Committee.

Ms Fallon welcomed the report, saying that it gave positive assurance. She advised that she had attended a recent Patient Partnership Group (PPG) meeting where patients had been discussing food, particularly fluid guidance, and asked if there were any particular area of concern in that regard. Ms Merson noted the point and advised that she would provide further feedback in this respect so that it could be fed back to the PPG.

Action – Ms Merson

Mr Moore said that the master table for clinical audits was helpful, and could help to analysis of any patterns or trends across wards in terms of overall performance. It would identify if there were any areas for concern that required additional support. Ms Merson commented on the work carried out by Clinical Quality which looked at presenting trends in detail which helped to identify and escalate any arising issues.

In response to a further question from Mr Moore about obesity guidance, Professor Thomson advised that the Supporting Healthy Choices Group were reviewing this currently. However, the State Hospital had reviewed the guidance from NHS England specific to forensic settings, to produce details guidance and this had been endorsed by Public Health Scotland.

Mr Moore thanked Ms Merson for reporting, noting the refreshed format which was welcomed.

The Board:

1. Noted the content of the report.

10 MEDICAL EDUCATION REPORT

The Board received a paper (Paper No. 25/91) from the Medical Director proving an overview of undergraduate and postgraduate training within TSH for the period 1 August 2024 to 31 July 2025. Professor Thomson led the Board through a summary of the content of the report, noting that it had been completed in accordance with the General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education.

She described the main aspects for each area of training, including the provisions made as well as the subsequent feedback received. In particular, she highlighted the return to in person forensic tutorials through Edinburgh University, as well as the work progressed to reinstate one day placements for next year, as logistics had prevented this from happening in the past year. She also noted the success in receiving allocation of ACT funding to support the undergraduate programme.

Professor Thomson outlined the successful implementation of the postgraduate programme, noting in particular the UK ranking position of fifth out of 11 on the Forensic Higher Training Programme of Scotland. She provided positive assurance to the Board for the provision of both undergraduate and postgraduate training over the past year.

There was agreement around the table that this was a very positive area of reporting. Mr McConnell asked about capacity in respect of the undergraduate programme and whether there as any headroom in this as it appeared close to capacity. Professor Thomson said that it would not be possible to continue expanding, as there was a limit in capacity; and that the key would be to focus on groups training rather than individual placements. She noted the positive benefit from the size of the consultant group to support training.

Mr McConnell also asked about the UK ranking position, and whether it was possible to analyse performance against other high secure hospitals in the UK, and Ms Radage echoed this and asked if there were any opportunities for improvement. Professor Thomson advised that it was not possible to do so due to the way it was structured i.e. this related to trainees across every level of security – the State Hospital therefore had limited direct control overall. At the same time, there was granularity in the data sitting below this figure, and this did provide means through which to identify any possible areas for improvement.

Mr Currie asked if the continuing uncertainty following publication of the reporting such as the Barron repot into forensic mental health care in Scotland had any impact, and Professor Thomson agreed that there would be impacts across forensic services, due to ongoing uncertainty.

Ms Raghavan asked about the spread of students, and how this had changed over time. Professor Thomson outlined the historical links with the University of Edinburgh, as well as the way in which geography could impact this. She noted that students had come from both the University of Glasgow and of Dundee recently, and from Aberdeen in the past. Ms Raghavan also asked about the impact of

increased part-time working, and Professor Thomson said that this was a growing factor across medicine generally. This wasn't a key concern for the State Hospital, but did impact workforce planning nationally.

Mr Moore invited Dr Hall to comment given his recent experience in this regard. Dr Hall commented that he had found his time at the State Hospital to have been positive with a thorough induction and a diverse range of experiences. He had very fully supported and appreciated the opportunity to link with the leadership structure such as attending the Board today.

Mr Moore summed up by noting the responsibility of the Board in this area, and the very positive assurance provided by reporting.

The Board:

1. Noted the content of the report.

11. MEDICAL APPRAISAL AND REVALIDATION ANNUAL REPORT

The Board received a paper (Paper No. 25/92) from the Medical Director representing annual reporting on Medical Appraisal and Revalidation as required by NHS Education for Scotland (NES).

Professor Thomson summarised the key aspects of the report, which gave assurance on the appropriate systems on place in this respect, with all medical appraisals and revalidations up to date.

Mr Moore thanked Professor Thomson for this report which made it clear that satisfactory arrangements were in place in this regard.

The Board:

1. Noted the content of the report.

12 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 25/93) providing an overview of workforce performance data to 30 September 2025.

Mr Wallace advised that whilst the majority of KPIs were in a good position, the main focus was on sickness absence rates. There had been some improvement in this respect during the year, but August and September had seen increases. Nursing, had experienced increased absence including in long term rates. Reporting provided analysis of seasonal trends as well as areas or department of specific concern in this regard as well as comparison to other NHS Boards. He also provided further background with regard to the work which was continuing to provide support to help staff back to work such as pathways reviews. Mr Wallace also detailed the position on recruitment, particularly the impact of the Women's Service.

Ms Fallon commented on recruitment timescales, as it would be positive to see an improvement in this respect . She also advised that on a recent walkround in the hospital, staff had discussed shift patterns and the potential impact of these on attracting new staff. She referenced the Short Life Working Group (SLWG) that was focussed on nursing recruitment and asked for some further background in this respect. Mr Wallace provided assurance that the timescales for recruitment and on boarding were under close scrutiny with a view to improve where possible. This was an area where the small numbers involved could mean that an individual case could impact adversely on the overall position.

He went on to say that that the SLWG was part of wider work to review the recruitment and retention strategy to ensure that the State Hospital was optimising the opportunities in this regard and further reporting would return within the next quarter.

Ms Raghavan noted that although long term sickness absence had risen in this period, it still compared

favourably to the figure from the same point in past years, and Mr Wallace agreed and highlighted the importance of ensuring that the right support was in place at the right level for staff which could have an impact and improve the position.

Ms Radage thought that it was important to remember the positive aspects within the report as well, referring to low staff turnover, as well as a much improved position on the management of job evaluation. Ms McCaffrey agreed, noting the difficulty in retaining staff across the national landscape. She also highlighted the success that the State Hospital had experienced in attracting returning staff.

Mr Moore noted that stark differences in performance across different hubs, showing that a variety of support mechanisms may be required. Mr Wallace echoed this, and said that there was now better understanding in place as to what was needed at a local level, as well as greater pro-activity and consistency by managers.

The Board:

1. Noted the content of the report.

13 WHISTLEBLOWING UPDATE – QUARTER 2/ SPEAK UP WEEK

The Board received a paper (Paper No. 25/94) from the Director of Workforce which confirmed that there had been no new cases received during Quarter 2 of this year.

Reporting also outlined the approach that had been taken forward with respect to Speak Up Week which ran from 29 September to 2 October. There were a variety of initiatives including dedicated staff communications promoting all of the routes available to staff, and linking to national approaches. The emphasis was on the importance of hearing the employee voice. There would be a Seminar Series about psychological safety, and re-advertising of confidential contacts.

As Whistleblowing Champion, Ms Raghavan offered thanks to everyone who had been involved in this, and thought that she had seen a marked shift in focus. During the week, she had been on site to offer a drop in clinic, and had received calls after this from staff. On one matter she had linked with Ms Smith in terms of ensuring that this was routed appropriately.

Ms Fallon added that it had been reassuring that during a walkround at the hospital recently, staff had felt able to discuss any local concerns they had which showed that they did feel safe to do so, and this reflected well on culture overall.

Ms Radage thought that reporting was helpful, and asked for further detail about the seminars. Mr Wallace advised that these were linked to the Organisational Development (OD) and Wellbeing Strategy encompassing working environment and culture and would be taken forward in the next quarter. The OD Lead had led a session for the workforce directorate which had been positively received. Ms Radage added that this may be something for the Board to participate in at a Board Development Session and there was agreement on this.

Action – Ms Smith/Mr Wallace

The Board:

1. Noted the content of reporting.

14 REDUCED WORKING WEEK

The Board received a paper (Paper No. 25/95) from the Director of Workforce to report on the current position in respect of the final stage of planning for the Reduced Working Week for Agenda for Change staff. This would see staff move to a 36 hour working week by 1 April 2026.

Mr Walace detailed the content of the report, providing assurance that the plan had been presented to

an extraordinary meeting of the Partnership Forum which had taken place on 24 September. This had been agreed, and meant that the hospital could implement this plan by the required deadline.

Mr McConnell asked about whether the hospital could meet this challenge within the context of service delivery especially relating to nursing resourcing. Mr Wallace advised that the planning in place represented what could be delivered sustainably, and that further advice was awaited form Scottish Government in terms of any areas of challenge in maintaining service due to the change and how this would be funded going forward.

There was agreement around the table that reporting provided assurance on the planning in place for this change.

The Board:

1. Noted the content of the report.

15 eHEALTH

- **ANNUAL REPORT 2024/25**

The Board received a paper (Paper No. 25/96) from the Director of Finance and eHealth, and Mr Best joined the meeting at this point.

Reporting included details across a number of workstreams, and Mr Best summarised the highlights by detailing the work taken forward by each team: Information Team, Infrastructure team and Project Management.

It had been a busy year for the department overall and at times being a small team could be challenging. However, at the same time there was a benefit in each team being integral to the State Hospital and being able to deliver its services in a focused and creative way. He also summarised the involvement that the department had with national workstreams.

Mr McConnell asked about opportunities for further collaboration across NHS Scotland, for example use of Co-pilot. Mr Best confirmed that this was nationally led and that the department did ensure that the State Hospital was in a position to benefit from national workstreams whenever possible, especially in new and evolving areas.

Ms Radage asked for more details in respect of Co-pilot, and Mr Best confirmed that this was led by NHS National Services and was an AI tool that could be helpful especially in supporting administrative services. All NHS Boards were being allocated a number of licenses which would be rolled out across appropriate staff groups. He confirmed that this was being taken forward in conjunction with the Information Governance Team to ensure appropriate usage and storage of information. Mr Currie noted the potential benefits in this regard, and the need to identify appropriate uses for AI proactively.

Ms Fallon thanked Mr Best for his report which reflected positively on his team, and asked about the Made Purple project as this had been discussed in enthusiastic terms at a recent PPG meeting she had attended. She was aware that it was a pilot and asked specifically about the next stage of it, especially if there was a risk to patients being disappointed should it be discontinued. Mr Best outlined the consultation that had taken place with patients prior to the pilot, to ensure their engagement and also understanding that it was temporary at this stage. If it was successful then a business case for additional funding would be required going forward.

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

The Board:

1. Noted the content of the report.

- **NETWORK AND INFORMATION SYSTEMS REVIEW**

The Board received a paper (Paper No. 25/97) from the Director of Finance and eHealth which provided an update on the next stage of review submission for the State Hospital in relation to Network and Information Systems (NIS) which was due this month.

Mr McNaught detailed the key points, noting that the last review in 2024 had been successful in achieving an extremely positive outcome with an overall rating of 78%. The State Hospital was recognised in being a strongly performing NHS Board in this area, and had met the targeted KPI compliance level of 60/60/0. The interim submission for 2025 had been completed and would be submitted in the next week.

The details for the full review due in 2026 were not yet known, with confirmation awaited of the compliance authority who would undertake the review.

Mr Moore noted the strong position that the Board was in and thanked Mr McNaught and his team.

The Board:

1. Noted the content of the report.

16 WHOLE SYSTEM INFRASTRUCTURE: BUSINESS CONTINUITY

The Board received a paper (Paper No. 25/98) from the Acting Director of Security, Resilience and Estates to confirm the present position for the State Hospital in respect of Whole System Infrastructure Planning.

Mr Hardy advised that the key development was that in May 2025, the State Hospital had received confirmation of additional funding in relation to three projects: Islay roof repairs, patient wander path upgrading and replacement of the Skye Centre animal shed.

In July 2025, a further application was made through a separate funding stream for sustainability projects and was successful with additional funding for LED lighting in specified areas within the hospital. Following that, funding was confirmed for replacement of fire alarms.

He went on to say that submissions in November 2025 could be on an exception basis only for new or emerging risks and there was no opportunity for the State Hospital in this respect. The next full submission would be in November 2026, and the State Hospital had commenced a Strategic Assessment for the development of a Central Treatment Hub for the Women's Service.

Mr Moore thanked Mr Hardy for reporting, and the Board noted the content of the paper.

The Board:

1. Noted the content of the report.

17 PROJECT UPDATE FOR THE NATIONAL HIGH SECURE FORENSIC HEALTHCARE SERVICE FOR WOMEN IN SCOTLAND

The Board received a paper (Paper No. 25/99) from the Programme Director to provide an update on the development of national high secure forensic healthcare for women within the State Hospital. Mr Walker joined the meeting and led the Board through the content of the paper.

He confirmed that following the opening of the interim service in July 2025, the Project Oversight Board was meeting on a bi-monthly basis. Further works were being taken forward presently relating to adaptations to bedrooms as well as the garden area. Going forward, governance oversight of the interim service would be through the clinical governance route.

Mr Walker advised that the Psychology Service were continuing to lead on the development of the Outreach Service.

In respect of Phase 2, relating to the Medium-Longer Term Service Model, Mr Walker noted that the proposal to develop the preferred option would commence at the end of October, and that a draft report was expected by January 2026.

Mr Currie who chaired the Project Oversight Board, said that the inclusive nature of the Stakeholder plan had helped to build confidence across the system, and positive working relationships with key stakeholders. Phase 2 would involve a considerable amount of funding, and it was important to ensure there was confidence going forward.

Mr McNaught noted that there was no further update in respect of future recurring funding at this stage, and there was discussion of the risk this would present to the Board in terms of achieving a balanced budget.

The Board:

1. Noted the update within reporting.

18 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report (Paper No. 25/100) to confirm the updated position on this project. Mr Walker asked the Board to note the key points within reporting, which confirmed that all systems were functioning with only small items to consider with the main contractor. Further reporting would be submitted to the private session of the Board.

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.

19 BOARD IMPROVEMENT PLAN

The Board received a report (Paper No. 25/101) from the Head of Corporate Governance providing an update on the plan. Ms Smith noted updates in three key areas: Risk Management, Engagement with Stakeholders as well as Influencing Culture.

She noted the progress made within the management and reporting of risk, with further focus on consideration of risk appetite and the management of controls at a future Board Development Session.

In respect of stakeholder engagement, she outlined some of the key developments that had been taken forward with patients and carers. She also summarised the engagement progressing with staff especially through development of the Workforce Plan 2025/28, and in a recent staff survey which had been conducted seeking feedback about equalities issues. This had identified key actions which would now be taken forward. This work was linked across to influencing culture within the organisation. More widely in this area, there had been a refreshed approach to the Whistleblowing Standards as had been evidenced in the recent Speak Up Week. There had also been engagement in terms of the recruitment of young people from the local area.

Ms Smith summed up that the Board had been focused on the plan, using it as a mechanism for continuous improvement and that it was in a positive position.

Ms Fallon thanked Ms Smith for the update and asked how the actions from the Staff Survey would be put in motion. Mr Wallace explained that work around culture was being taken forward by the Organisational Development Manager. This was being piloted within the Workforce Directorate, then it would be rolled out

to other services with a focus on the working environment.

The Board:

1. Noted the content of the report.

20 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting that took place on 19 June 2025 as well as a summary report (Paper No 25/102) of the key areas of reporting and discussion at the meeting which had taken place on 2 October 2025. As Chair of the Committee, Mr Mc Connell noted the key business that had been discussed at each meeting.

The meeting in June had been focussed on annual reporting as had then been presented and agreed at the subsequent board meeting. At the most recent meeting, there had been an internal audit in respect of Estates and Facilities Management which had not met the required level of assurance, and there were a number of key management actions points that had to be completed prior to the end of the financial year. A range of annual reports had been received, as well as a review of the Committees' effectiveness which had helped to highlight the benefits of governance oversight arrangements within a small NHS Board context.

The Board:

1. Noted the content of the approved minute of the meeting on 19 June 2025.
2. Noted the update in relation to the meeting held on 2 October 2025.

21 ANY OTHER BUSINESS

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

22 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 18 December 2025.

23 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.

24 CLOSE OF MEETING

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

The meeting ended at 12.27pm

ADOPTED BY THE BOARD _____

CHAIR _____

DATE _____

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	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	December 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. **August Update:** Reporting in terms of final elements due in October, and to be actioned on that basis. **October Update:** Update reporting on agenda which reflected that the project is not yet into final completion and further update at next meeting. **December Update:** Report on agenda (Item 20)
2	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. **October Update:** On Agenda [Item 15] and on Board Development Day 30 October **CLOSED**

3	August 25	Corporate Risk Register	(a) Include Local Risk Register reporting as part of the report to give assurance. (b) Add wider consideration of risk tolerance and control to Board Development Session	A Hardy A Hardy/ M Smith	October 25	**October Update:** (a) Update as part of reporting (Item 7). (b) Added to Board Development Session schedule for 2026 **CLOSED**
4	August 25	Quality Assurance and Quality Improvement Report	Review reporting to Board to ensure high level summary and compare/consider re committee route for reporting.	M Merson	October 25	**October Update:** Included as part of reporting on agenda (Item 9). **CLOSED**
5	October 25	Finance report	Request for review of further detail in respect of estimated costs of sickness absence	R McNaught	December 25	**December Update:** Information provided within reporting on agenda (Item 10).
6	October 25	QI and QA report	Feedback on food and fluid guidelines – are there concerns as there had been discussion within PPG	M Merson	December 25	**December Update:** No specific concerns are ongoing in terms of the guidelines. More widely, The Catering Manager attends Patient Partnership Group monthly. Any Issues raised are addressed straight away or before the next meeting. Actions are tracked and monitored.
7	October 25	Whistleblowing Update	Could a psychological safety session be arranged at a board development session	M Smith/ S Wallace	December 25	**December Update:** Added to Board Development schedule for 2026. **CLOSED**

Last updated – 09.12.25 MS

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 2025
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Patients' Advocacy Service Manager
Title of Report:	Patient Advocacy Service 12 Monthly Report – August 2024-July 2025
Purpose of Report:	For Noting

1 SITUATION

This report serves to provide assurance to The State Hospital (TSH) Board the Patients' Advocacy Service (PAS) continues to meet the needs of State Hospital patients, as set out in the Service Level Agreement (SLA).

2 BACKGROUND

We will highlight progress made within the service including improvements, achievements, and future plans. We also set out any challenges faced, and remedial action taken to overcome these. The following report highlights August 2024-July 2025.

3 ASSESSMENT

August 2024 – July 2025

- Achievements against the Key Performance Indicators (KPI) in the Service Level Agreement this year continue to be met to 91% with statistical reporting evidenced in section 4; the deficits relate in part to factors out with our control in relation to visiting patients within the 7-day timescale and is an improvement on last year's report.
- Full and effective use is being made of the budget allocated by the Hospital for the service.
- The additional recurring £20,000 funding received from the Scottish Government following the introduction of the Patients' Rights Bill continues to assist PAS to offer extra support required with hard-to-reach patients.
- Robust arrangements are in place for the growth, professional development and support of all Advocates.

- Positive communication between PAS and TSH continues to foster excellent working relationships beneficial to both organisations and patients.
- Continued increase in the number of contacts, issues and actions with patients in comparison to previous years highlighting the positive working relationships advocates have with both patients and TSH colleagues.
- Participation in both internal and external consultations, short life working groups and events.

Section 8 of the main report identifies both organisational and service developments planned for the next reporting period.

- Recruiting Board Members to increase the numbers and diversify experiences
- Hosting an AGM with the inclusion of meaningful presentations
- Host an away day for the board and staff to identify key priorities for the organisation
- Implementation of PAS specific talking mats for legal matters and CPA's
- Responding to consultations and attend short life working groups as appropriate, to champion the voice of our patients in their unique position
- Complete the annual questionnaire and take forward the views of patients on the PAS service
- Work towards more easy read and ID friendly documents such as advance statements
- Expansion of the TSH3030 project across the services 'Voices for Rights'
- Host a Patients' Rights Day with social work colleagues with a themed focus each year
- Expansion of the organisation to include the new Female Service whilst ensuring fair and equitable service is offered and no patients are negatively impacted by the increase in required provision
- Exploring staff wellbeing and the inclusion of reflective practice for the staff team

4 RECOMMENDATION

The State Hospital's Board for Scotland are asked to **note** this report.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP	Supports improving patient outcomes from their clinical experience and Learning from views of Patients, carers and Stakeholders.
Corporate Objectives Please note which objective is linked to this paper	Better Care & Better Health
Workforce Implications	none
Financial Implications	None covered by SLA
Route to Board Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	Feedback provided through engagement with PAS and PCIT.
Equality Impact Assessment	In Place
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

PATIENTS' ADVOCACY SERVICE

12-Monthly Report

1st August 2024 – 31st July 2025

1 Introduction

The Patients' Advocacy Service (PAS) aims to provide an independent, highly skilled, responsible, and professionally run service within The State Hospital (TSH). Whilst observing the safety and security of the Hospital, the service works independently within it to promote patients as individuals, support and enable them to be fully informed and involved in their care and treatment.

> *"Independent advocacy is about speaking up for, and standing alongside individuals and groups, and not being influenced by the views of others. Fundamentally it is about everyone having the right to a voice, addressing barriers and imbalances of power, ensuring that an individual's rights are recognised, respected, and secured.*
>
> *Independent advocacy supports people to navigate systems and acts as a catalyst for change in a situation. Independent advocacy can have a preventative role and stop situations from escalating, and it can help individuals and groups being supported to develop the skills, confidence and understanding to advocate for themselves.*
>
> *Independent advocacy is especially important when individuals or groups are not heard, are vulnerable or are discriminated against. This can happen where support networks are limited or if there are barriers to communication. Independent advocacy also enables people to stay engaged with services that are struggling to meet their needs."*

Scottish Independent Advocacy Alliance, Independent Advocacy, Principles, Standards & Code of Best Practice (2019).

The Mental Health (Care and Treatment)(Scotland) Act 2003 establishes the right to access Independent Advocacy for those experiencing a mental disorder. The purpose of this report is to inform and evidence the key performance indicators stipulated within the Service Level Agreement, by TSH. The report describes how the service provided by PAS has the ability to adapt to the ever-changing needs of the patient population, especially with the ongoing issues surrounding the staffing and the impending inclusion of the female service.

1.1 Highlights of the Year

This report relates to August 2024 – July 2025, reflecting on another successful, albeit challenging year, during which we continued to provide an Independent Advocacy service to all patients. Work included this year is as follows.

- Induction of our staff member to cover maternity leave
- Promotion for one of our advocates to volunteer co-ordinator
- Initialising the re-integration of the volunteer programme
- Welcoming our first patient to the female service

- Continued to connect with external advocacy providers including those based in other high secure services in the UK, as well as other independent advocacy services across Scotland
- Continued to champion the patient voice by responding to important consultations and engaging in short life-working groups relevant to the patient population
- Increased actions and contacts with patients to meet demand for the service
- Attendance at 95% of all patient meetings, 100% of those requested by patients
- Commissioning PAS specific talking mats on legal matters and CPA's
- Participation in the TSH3030 programme with 'Voices for Rights'
- Conducting sessions during the Skye Centre Induction to share the Get On Get Out book

In November 2024 PAS held the 15th Annual General Meeting (AGM) where we delivered our Annual Report for 2023-2024. It was well attended by internal and external colleagues and included a presentation from a charity using music to support those with dementia, offering a unique opportunity for TSH to explore how this may support patients.

2 Governance Arrangements

PAS has dual accountability. Firstly, as an independent company, limited by guarantee to PAS Board of Directors and secondly, as a service commissioned by The State Hospital. We report annually, and in doing so, provide assurance the service meets with the Key Performance Indicators highlighted in the service level agreement. The Person-Centred Improvement Steering Group (PCISG) receives quarterly written reports highlighting the progress with the set KPI's whilst Service Leadership Teams (SLT's) receive monthly reports relating to their areas. In addition, there is a bi-monthly meeting between the Nursing Director, a PAS Board Member and the Service Manager for information sharing purposes. Finally, this report, along with our annual report, is circulated throughout TSH to various groups and all TSH staff are invited to attend our AGM.

2.1 Finance

The annual cost of the service to the Hospital in the financial year April 2024 - March 2025 was £151,827 which includes recurring funding of £20,000 initially received in April 2012 from the Scottish Government following the introduction of The Patients' Rights (Scotland) Act, 2011.

2.2 Committee Membership and Role

The Board of Directors comprises:

- Michael Timmons, Chair
- Ruth Buchanan
- Laura Murphy

- Kirsty McVeigh
- Giles Porteous

During the year we also had a further board member who tendered their resignation:

- Monica Griesbaum

2.3 Board Meetings

The PAS Board of Directors held 5 Board Meetings during the year and an AGM. The AGM took place in person in Lanark Memorial Hall. We held 5 board meetings over the reporting period as well as a Board development session to identify KPI's for the year.

PAS remains committed to supporting our patient representative to meaningfully engage in our board meetings; the patients' voice is invaluable to the service, and it is helpful for PAS Board members to hear directly from the patient representative the issues being faced. Our patient rep had been involved since January 2021 and actively engaged in the Board meetings both by videoconferencing and in-person. Following successful referral to medium secure, he was instrumental in providing support to PAS on the identification and introduction to the PAS board and we now have 2 interested individuals who will be attending board meetings to see if this role would be right for them moving forward.

2.4 Workforce

To deliver our KPI's we have a small, dedicated and highly skilled staff team. Our knowledge and experience of engaging with a diverse group of patients continues to expand. Our team continued to provide a flexible, person-centred service to each patient, tailored to their needs. Securing and retaining skilled employees is challenging in such a unique environment, however in this period our staffing has remained static.

As of July 2025, the PAS workforce is as follows:

- 1 x Full time manager 35 hours
- 2 x part-time Advocates 28 hours each
- 1 x part-time Advocate 20 hours

During the period, one of our advocates was on maternity leave and we ensured a fixed term 12 month contract was in place to cover the deficit in advance of her beginning this leave.

The service faced numerous challenges this period with the increased patient contact and resulting actions. We saw changes to roles within the staff team and were able to offer the post of volunteer co-ordinator to one of our team. This move has allowed us to successfully recruit a volunteer who is currently working through the process. In addition,

we have built links with local organisations to highlight the voluntary roles available within PAS and look forward to welcoming further individuals to the team.

2.5 Working Relationships

The PAS Manager maintains regular contact with hospital professionals including the PCIL, PCIT, Lead Nurses, Senior Charge Nurses and Complaints Officer. This ensures effective communication, collaboration and joint working whereby issues are dealt with promptly and locally. In addition, the PAS manager attends other relevant meetings throughout the Hospital and attends each PAS Board meeting providing a report highlighting the work completed between meetings.

As per our last report, the bi-monthly link meeting with a PAS board member and director of nursing has continued to share relevant updates and discuss any issues.

2.6 Training

Staff continue to complete and keep up to date with all mandatory training specified by TSH, including LearnPro modules and in person training. PAS welcomes the opportunity to engage in training and development offered by The State Hospital. This enhances the knowledge and skills of our staff group, positively benefiting outcomes for patients. The PAS team engages in external training through the Scottish Independent Advocacy Alliance (SIAA) and other external bodies.
We actively encourage staff and volunteers to undertake training and continued professional development that will build on their personal development and contribute to improving the service we offer to patients. All staff have a learning plan where they are able to highlight training needs. These plans are reviewed and updated annually.

2.7 Policies and Procedures

Policies for PAS remain integral to the service operating effectively for both staff and patients. We adhere to all TSH policies and PAS specific policies continue to be reviewed when necessary, ensuring they are GDPR and data protection compliant. This was last updated with our HR colleagues in 2024 to ensure we are compliant.

2.8 Participation / Integration

PAS staff participated in several State Hospital groups to facilitate and support integrated ways of working benefitting patient care including:

- Person Centered Improvement Steering Group
- Patient Partnership Group
- Child & Adult Protection Forum
- Complaints and Feedback
- SLWG: Daytime Confinement (DTC)
- Admissions Processes Group

We also attended external events including:

- SIAA Managers Support Sessions
- SIAA Peer Support Sessions
- SIAA AGM
- SIAA: Prisons and Forensic Mental Health Group
- Advocacy Managers Group
- Mental Health Tribunal Service Users and Carers Group
- Meeting with Mental Welfare Commission
- Mental Health Tribunal Service Users and Carers Group

PAS remains involved with the Scottish Independent Advocacy Alliance (SIAA) providing the distinctive perspective of patients within a high secure environment ensuring this is included in any developmental work. The events attended by PAS over the reporting period can be seen above.

Consultations both internal and external we have responded to over the reporting period include:

- AWI consultation
- TSH Policy – Death of Patient

We are involved in the induction process of new TSH staff, including students from various departments. Over the reporting period, we hosted 11 staff induction sessions covering all disciplines.

3 Patient Questionnaire

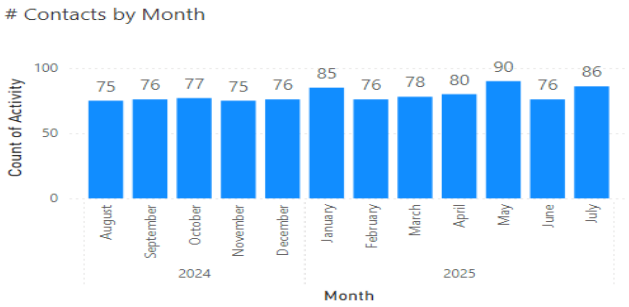
This year, we focused on further expanding the requests of patients to host the Skye Centre drop in. Initially, this was a 3 month pilot offering a 1 hour session each morning from Tuesday-Friday to ensure each shop morning had an advocate available in the Skye Centre. It was agreed we could have use of the Patients' Activity Centre (PAC) room for this time aside from a Tuesday where the charity shop operates, however, we were able to use a room at the back of the Patients' Learning Centre (PLC). Over the course of the pilot, we gathered feedback from patients on how they felt about the drop-in. Patients who had experience of the PAS drop in prior to covid, expressed they felt not having the drop-in room in the same way was disappointing. Further, those on a Tuesday who could only use a room at the back of PLC have declined to use this space as it is more evident they are meeting with independent advocacy and instead they choose to use the drop in session to express their wish to meet with independent advocacy at a different time. However, most patients expressed their desire to use the service and we have seen increased growth in the number of sessions in which patients have engaged

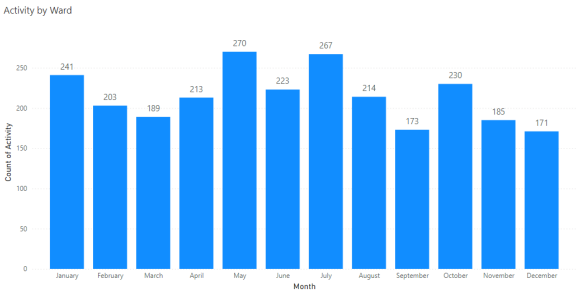
with us in this area. Over the course of the reporting period, 117 patients engaged during the Skye Centre Drop in with July 2025 being our best month with 41 patients choosing to meet with us.

We will continue to explore the options to enhance the drop in, respond to feedback and ensure all patients are offered the same accessibility options. In 2026, we look forward to specifically targeting feedback through the patient questionnaire for the Skye Centre drop in to identify where we can improve.

4 Key Performance Indicators

4.1 Contact

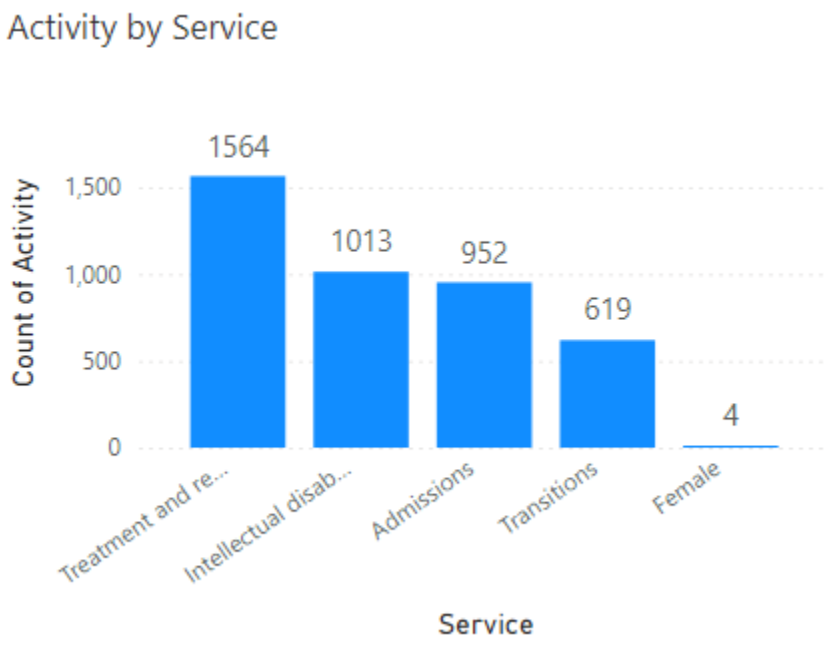




Overall, we made 2579 contacts, an increase of 7% from the previous year, with 130 patients. All patients within TSH are seen by PAS a minimum of twice per year as we ensure each patient is approached prior to their case review, of which they have 2 per year. The average number of contacts per patient throughout the period was 19 highlighting on average a 2-week discussion with each patient. These figures include 28 patients transferred to medium secure units, returned to prison or discharged to court. Sadly, there was 1 death throughout this period. There were also 32 admissions.

Overall, there was consistent activity with occasional spikes in January, May and July which relate to seasonal and associated operational factors in contact with patients, which is more prominently highlighted across the activity.

4.2 Major Mental Illness and Intellectual Disability Contacts

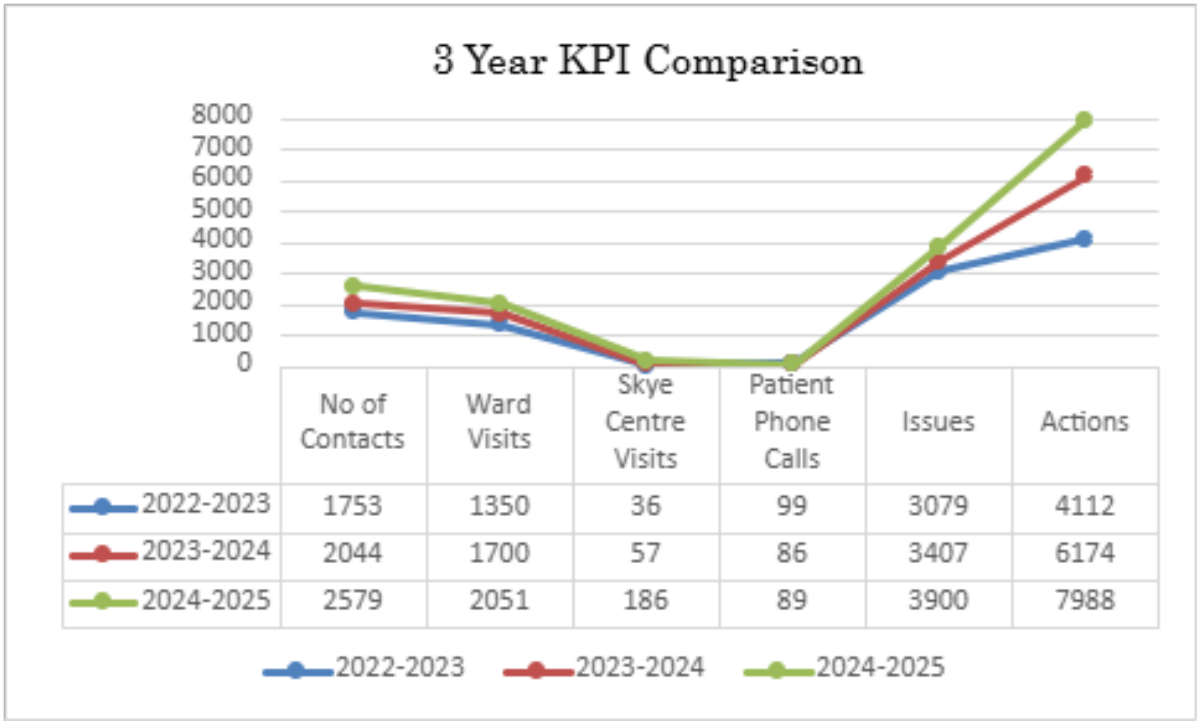


Within the service level agreement, it notes reporting on the number of contacts specifically with patients identified as having an intellectual disability (ID). Shown in the graph above are the number of contacts per month for those in each service. ID activity accounts for 25% of the work we engage in. Given this population equates to less than 25% of the patient population, it highlights the increased number of interventions provided to this group.

4.3 Ward Drop In

The service level agreement requires PAS to provide a monthly drop-in to each ward. This target was fully met during August 2024-July 2025. This was a focus of PAS given the KPI was not achieved over the previous years and we are pleased to note the efforts have ensured we achieved the goal.

4.4 3 Year Comparison (2022-2023, 2023-2024, 2024-2025)



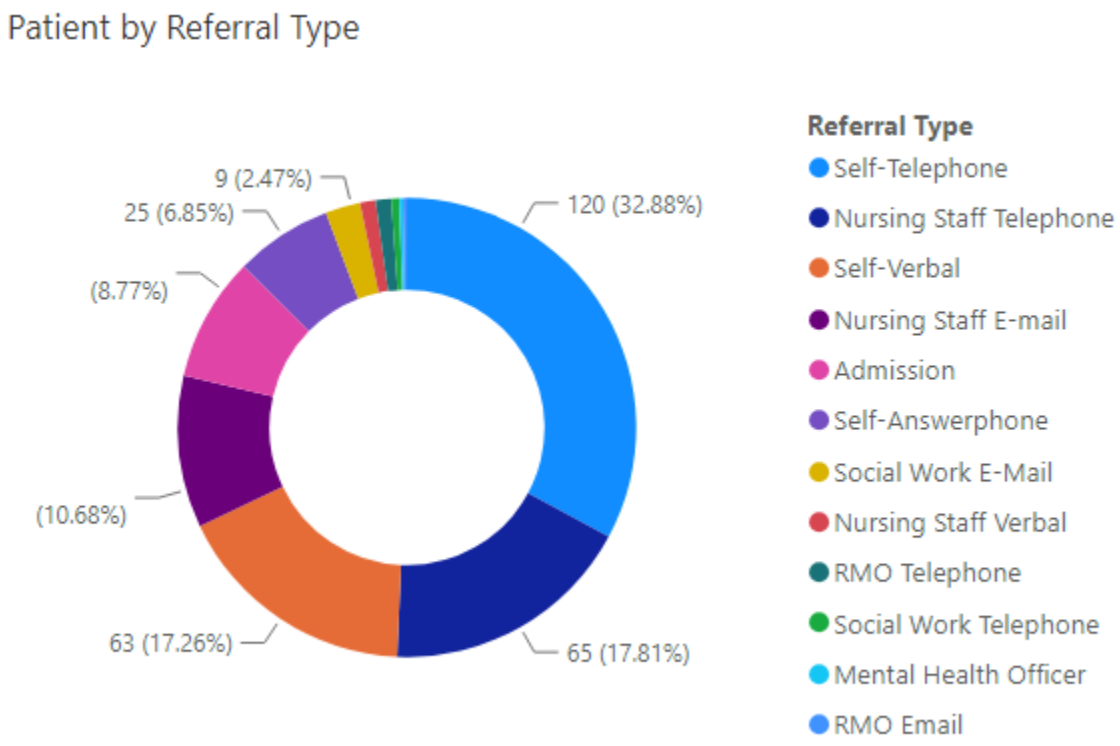
	No of Contacts	Ward Visits	Skye Centre Visits	Patient Phone Calls	Issues	Actions
2022-2023	1753	1350	36	99	3079	4112
2023-2024	2044	1700	57	86	3407	6174
2024-2025	2579	2051	186	89	3900	7988

The figures in the above graph shows an increase in all categories, excluding patient phone calls over the 3 years. The most notable increase relates to the number of Skye Centre visits which is due to the re-introduction of the Skye Centre drop in. Issues have gradually risen by 27% across the 3 year period, reflecting an increase in the number of issues patients raise with independent advocacy. Finally, the increase in actions shows a strong response to the issues raised.

"I can see a real difference in [the patient] today from having you sit in on this meeting. I am glad he asked you to be here as he seems far more relaxed and is opening up more than previous meetings. I think it would be beneficial for you to be there with him at court and any future solicitor meetings."

Solicitor

4.5 Formal Referral Routes

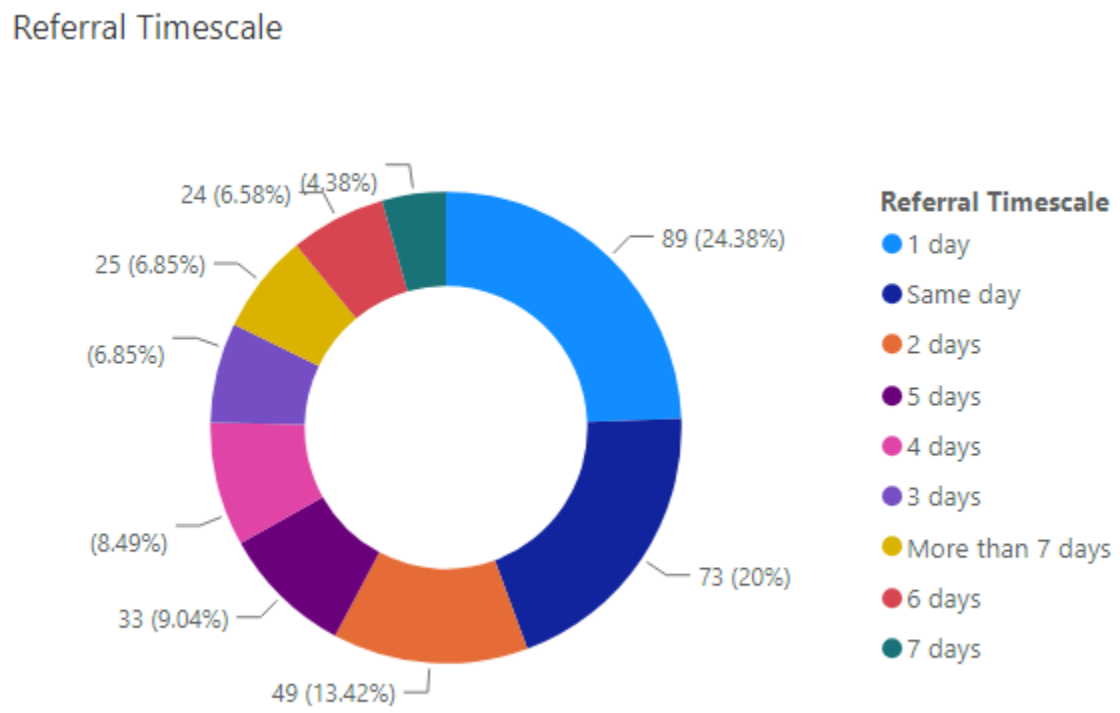


The above graph relate to formal requests to see an Advocate. 57% of referrals came directly from patients, a decrease of 20% from the previous report, which may be due to the increase in in-person discussions which take place with the re-introduction of the Skye Centre drop in. Hospital staff continue remain essential in supporting patients, contributing 31% of referrals through nursing staff, social work and registered medical officer (RMO) contacts. Around 9% relates to new admissions with a small proportion coming from other sources such as Mental Health Officers.

"I feel the relationship you have had with the patient has empowered him to have a voice."

MHO

4.6 Patient Referral Timescales

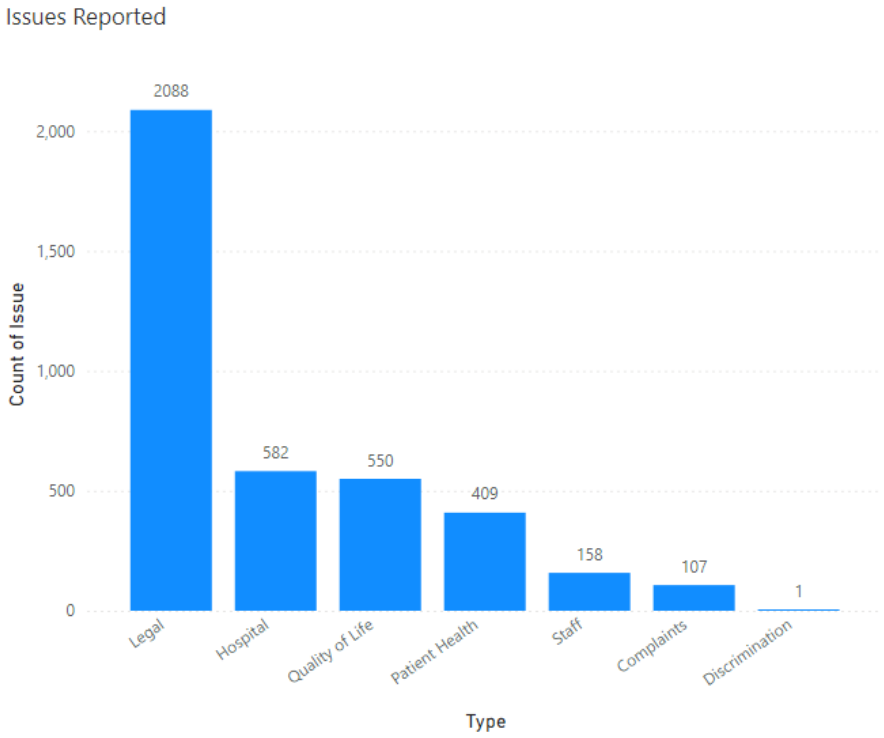


This graph relates to how quickly PAS responded to requests to see an advocate. As shown, 44% of patients were seen within 1 working day. When including those seen within 2 days (13%), this rises to 57% which is a significant improvement from last year's report of 37%.

Finally, almost 7% of patients were seen out with the 7 working day target, which remains similar to previous reports. These delays were primarily due to factors outside PAS' control, such as new admissions deemed too risky to visit, patients in isolation, those who were unavailable due to activity when independent advocates requested to visit or those who requested to wait for their designated advocate to return from annual leave. PAS continued to engage with nursing staff to monitor the patient status and determine when visits could safely occur.

> "Thank you for making it a priority to come and see him so quickly. I think it's helped to cool him down."
>
> ***Nursing Staff***

4.7 Issues



"You've done a power of work for me this week. Thanks for sorting it all."

Patient

The service dealt with 3895 issues over the reporting period, a gradual increase from the previous report. Overall the categories have remained largely consistent with the vast majority of issues raised being legal. However, one area of notable growth in this period as opposed to the previous report is the increase in discussions around patient health. This category reflects discussions relating to medication and treatment. Over the reporting period we noted an increase of patients discussing concerns over their medication or their rights in relation to their care and treatment.

4.8 Complaints and Outcomes

PAS recorded 85 complaints submitted which is an increase from 62 in the previous reporting period. These complaints related to a variety of factors, issues with staff accounted for 16 of the complaints whilst 3 of the complaint themes were collective amongst patients in one ward, one pertaining to facility time, another a broken tumble drier and the third in relation to one patient causing disruption on the ward. 7 complaints were retracted, some of these by the patients not wishing to proceed however, some were withdrawn as there was an active claim for reimbursement ongoing or it was processed through an alternative route in the hospital. 7 were resolved locally prior to formal complaint and there were 99 discussions of a potential complaint recorded. These discussions encompass informing patients of their right to submit a complaint or discussions about the process without proceeding to a formal complaint.

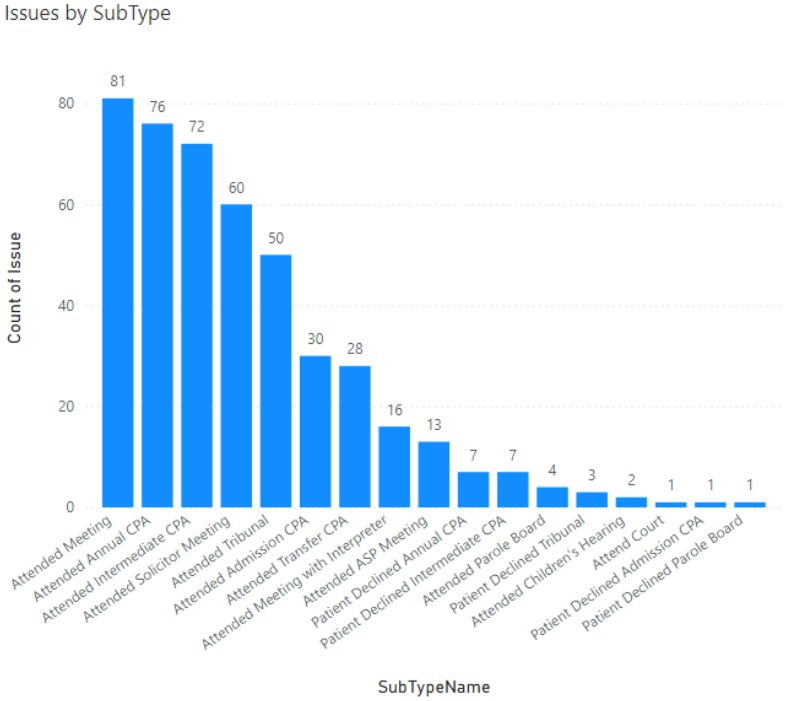
Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Discussion about a complaint	Patient able to express dissatisfaction and discuss their options in line with TSH Policy.	Locally resolved by complaint not being submitted. Patients' rights met.	99
Formal Complaint submitted	Patients' dissatisfaction expressed in line with TSH policy.	Patients' right to make a complaint upheld.	85

4.9 Legal Activity and Outcomes

Activity classified as legal is associated with support and attendance at formal meetings with patients, such as Care Programme Approach meetings (CPA), Adult Support & Protection Investigation (ASPI), Mental Health Tribunals, Parole Boards, Solicitor meetings and any other requested meeting focused on legal activity with the patient; all of which require support prior, during and following the meeting.

"I want you to come to the CPA because the notes you took at the last one helped me to get an answer about my medication"

Patient



"The information you provided [in the CPA] was invaluable"

Security Manager

As noted above, we attended the vast majority of legal meetings throughout the reporting period. Of the 452 meetings, PAS supported patients at their CPA's, mental health tribunals and parole boards, either by attending with them fully (140), attending the full meeting and the patient attending part of the meeting (42) or on their behalf (78). PAS was present at 96% of all meetings, an increase of 6%. This equates to 100% of meetings patient's requested our attendance at. Those who declined gave reasons such as them not feeling as if there was any need to attend as they knew where they were at in their progress or feeling they were sufficiently able to advocate for themselves.

One notable change which will be evident in the next report is around the use of care plans. Due to the change of the CPA format, care plans will be sent to PAS should the patient wish, in advance of their CPA allowing them time to process and discuss the care plan and any information they wish to include making it a more person centred process.

4.9.1 Care Programme Approach Outcomes

The following table highlights the patient and hospital outcomes relating to care programme approach (CPA) meetings with further insight into the volume of work included pre and post CPA and which CPA's patients decline independent advocacy to attend. As can be seen, transfer CPA's over this reporting period were requested 100% of the time and only 1 admission CPA declined, highlighting both the beginning and end of a patients' journey in TSH are crucial times for the support of independent advocacy.

Action	Patient Outcome	Hospital Outcome	Total
Pre-discussion to CPA	Patient supported to understand the process of a CPA, what is involved, who will attend, support to formulate questions and informed of their options regarding attendance.	Patients' rights to independent support upheld. Patients fully informed of the procedure of a CPA saving staff the time of discussing this information.	289
Reflective Discussion separate to CPA	Supported to fully understand contents of the CPA, the actions to be taken and plans for the next 6 months.	Ensuring patient understanding of the CPA, reaffirming of actions to be taken saving staff time disseminating this information.	133
Attendance at admission CPA	Patients fully aware of what is discussed at the CPA by attending in person or by having advocacy representation on their behalf.	Patient involvement in the CPA process, ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	30
Declined advocacy support at admission CPA	Having the choice to decline advocacy support following discussion of the admission CPA.	Patients right to independent support upheld and autonomy in decision-making.	1
Attendance at Annual or Intermediate CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	76 Annual 72 Intermediate
Declined advocacy support at Annual or Intermediate CPA	Patient approached and discussed the CPA process ensuring their right to independent support. Making the choice to decline advocacy support at the meeting.	Patient rights to independent support upheld and autonomy in decision making.	7 Annual 7 Intermediate
Attendance at Transfer/Discharge CPA	Patient and/or advocacy attendance at the CPA. Ensuring the patient voice is heard and questions answered.	Patient involvement in the CPA process ensuring patient centred care and accessing their rights to independent support in line with the Mental Health Act.	28
Declined Advocacy Attendance at Transfer/Discharge CPA	Patient able to self-advocate and make an autonomous choice to decline support.	Patients right to independent support upheld and autonomy in decision making.	0

4.9.2 Mental Health Tribunal Outcomes

The following table shows the outcomes relating to Mental Health Tribunals alongside the pre and post discussions which take place to ensure the patient understands their rights and potential outcomes.

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Pre-discussion to Mental Health Tribunal	Patients provided with verbal and written information ensuring they understand their legal rights and the process of the Mental Health Tribunal. Supported to actively write a statement if they wish.	Patients informed and supported with their legal rights i.e. their right to a solicitor and support from Advocacy in line with the Mental Health Act.	113
Attendance at Mental Health Tribunal	Patients supported to attend the mental health tribunal or have their voice heard through advocacy attendance in their absence.	Patients' legal rights to independent support met. Patient involvement in their care.	50
Reflective discussion after the Mental Health Tribunal	Patients supported to understand the outcomes of a tribunal and their legal rights following.	Patient supported to understand their rights and the outcomes saving staff time sharing this information.	30
Declined advocacy support at a Mental Health Tribunal	Able to make an autonomous decision and attend with their solicitor or had no challenges and declined all attendance.	Patient supported to understand their rights and make a choice.	3

4.9.3 Other Legal Outcomes

This final table highlights the outcomes relating to other legal matter such as Adult Support and Protection (ASP), Parole Boards and attending meetings with solicitors.

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
New Admissions	Patient is informed of the role of Advocacy, their legal rights and how we can support them through their care and treatment.	Legal obligation to provide Advocacy is met as per the Mental Health Act.	32
Supported during a meeting	Patient supported by Advocacy to attend meeting and express their views.	Patients supported as per their right to have Advocacy support as per the Mental Health Act.	81 – Staff, Independent Dr's, MHO's etc. 60 - Solicitors
Parole Board	Patients provided information regarding their legal rights	Patients informed and supported with their legal rights i.e. their right to	13 Pre-Discussions

	and the process of the Parole Board Hearing. Ongoing discussion with patients to ascertain levels of understanding and support accordingly. Statement written and submitted in advance if desired.	a solicitor and support from Advocacy.	1 Reflective Discussions 4 Attended 1 Declined
Adult Support and Protection	ASP referral made when patient feels or is deemed at risk. Advocacy support to attend the meeting.	Hospital fulfilling legal obligation to support patients through ASP process.	29 Discussions 13 Attended 0 Declined 2 Submitted

4.10 Advance Statement Outcomes

The table below shows the outcomes for both the patient and hospital of this input from PAS.

Action	*Patient Outcome*	*Hospital Outcome*	*Total*
Advance Statement Completed	Patient's wishes expressed regarding future care and treatment giving a guarantee the clinical team will take these into account.	Fulfilling legal obligation, providing knowledge of Advance Statements and support to complete these. Advance Statements are person centred, considering patient's wishes. Accurately recording and storing Advance Statements with medical records.	24 Completed Advance Statements 14 Updated Advance Statement 271 Discussions

5 Progress to Actions of the Last Report

Action	**Outcome**
Organisational:	
Continue to recruit Board Members.	Ongoing. The advert remains live on Volunteer Scotland where we respond to requests. 1 new board member recruited over the period.
Updating patient rep recruitment and training materials.	Achieved, 2 new board reps approached and in the process of joining the board.
Host an away day for the board to identify priorities and organisational change to progress the service	Achieved, away day hosted in December 2024.

Service:	
Become more aware of positive ways of working such as with supported decision making.	Achieved, a variety of communication methods are in place to support patients to share their views. PAS are in the process of commissioning talking mats for TSH patients relating to legal rights and CPA's and we look forward to highlighting the impact in the next report.
Address issues regarding patients in seclusion or in very restricted positions.	We continue to meet with patients in seclusion/very restricted positions on a schedule which works best for them. We will add the numbers of discussions we have with individuals in this position in the next report.
Responding to consultations and attend short life working groups as appropriate, to champion the voice of our patients in their unique position.	Achieved, all requests for input over the reporting period were met.
Work towards more easy read and ID friendly documents such as advance statements.	Partially achieved, the advance statement template was updated to be friendlier. Work on further documents will take place when we have the talking mats operational.
Work with social work on a patients' rights week to highlight the variety of rights patients have whilst in TSH.	Partially achieved, we have plans in place to host a Patients' Rights Day in November 2025.

6 Areas of Good Practice

We continue to maintain good practice and meet requirements of the Service Level Agreement by:

- Review of Policies and Procedures
- Monthly support sessions with all staff
- Ongoing staff growth, professional development and training
- Approachable, unbiased, and visible service
- Positive and professional relationships with stakeholders and other professionals relevant to patients and independent advocacy
- A variety of expertise within PAS team providing knowledge and experience in a unique setting

- Flexibility to adapt and meet the needs of TSH and patient group as required
- Annual feedback on the service from patients with patient involvement on the development of the Patient Questionnaire such as including the reinstatement of the Skye Centre Drop In
- Development of projects which benefit the patient group positively as they are identified
- Concerns raised on behalf of patients to ensure policy and practice is followed appropriately and issues are raised in the right forum

"Thank you for explaining the excessive security appeal so well and clearly."

Named Person

7 Patient Stories

7.1 CCTV and Complaints

When CCTV was introduced in communal areas at The State Hospital, patients quickly began to see it as a way to ensure fairness and transparency. One patient on an admissions ward submitted a complaint after being restrained, feeling the intervention was unnecessary. They requested the CCTV footage to support their case.

Although the footage lacked audio, something patients often raise as a concern, it provided a clear, factual account of what happened. After being reviewed by TSH, the patient agreed that the situation had been managed appropriately and withdrew the complaint. Instead, the issue was resolved through an alternative route, ensuring the patient's voice was heard and their rights respected.

This story reflects a wider trend: most requests to review CCTV come from admissions wards and are linked to complaints. In several cases, complaints have been withdrawn after footage review, reducing unnecessary escalation and promoting constructive resolution. While the absence of audio remains a drawback, the presence of CCTV has strengthened trust by moving away from reliance solely on staff accounts and toward objective evidence.

Impact:

- Patients feel empowered to challenge decisions and exercise their right to complain.
- Complaints are resolved more effectively, often through alternative routes.
- Transparency and accountability have improved, fostering confidence in the process.

"I choose to submit complaints through PAS as I trust you to keep on top of it for me."

Patient

7.2 Supporting Mental Health During Transfer

As patients approach the end of their admission and prepare to transfer from The State Hospital, the process can be challenging. For one patient, a sudden deterioration in mental health occurred just days before their planned move. This raised concerns about whether the transfer should proceed.

Independent advocacy stepped in to ensure the patient's voice was heard. The patient felt unable to attend a Mental Health Tribunal. At their request, independent advocacy attended on their behalf, relaying their views and later discussing the outcome with them. Independent advocacy also provided clear information about their rights, including options to challenge decisions or submit a complaint if they disagreed with the proposed plan.

Ultimately, the clinical team decided to postpone the transfer, moving the patient back to a Treatment and Recovery ward for additional support. Independent advocacy continued to work alongside the patient, ensuring they understood the reasons for the decision and what steps they could take next.

Impact:

- The patient's views were represented at key meetings despite their inability to attend.
- Independent advocacy ensured the patient understood their rights and options, reducing anxiety and promoting informed decision-making.
- The process upheld the patient's right to participate in decisions about their care, even during a period of mental health instability.

"Advocacy are good for providing [legal] information. When I ask my doctor he just says he doesn't know."

Patient

7.3 Building Trust During Admission

When a patient is admitted to The State Hospital, the first few weeks can be overwhelming. For one individual recently admitted to Arran 1 for a short-term assessment, uncertainty about their legal status and missing property created significant anxiety. Independent Advocacy visited weekly, providing consistent support and clear information about their rights, detention, and options for challenging decisions. For property based queries the prison was contacted, the relevant property lists obtained and financial claims submitted as necessary.

Through these regular visits, the patient built trust with the advocacy team and felt confident to raise concerns about medication and communicate with their solicitor regarding an ongoing court case. Although their stay lasted only six weeks, the patient reported that having independent advocacy present helped them feel heard and informed during a critical period.

Impact:

- Weekly visits strengthened engagement, even for short-term admissions.
- Patients understood their rights and options, reducing stress and confusion.
- Positive early experiences with advocacy increased awareness of support available in prison or future settings.

"I appreciate you coming to see me every week, it really helps."

Patient

8 Future Areas of Work and Service Development

8.1 Organisational

PAS remains committed to providing the highest quality independent advocacy service to TSH patients. We continue to develop the service to meet the needs of an evolving patient group and changing environment we work in. As an organisation we aim to develop in the following areas:

- Recruiting Board Members to increase the numbers and diversify experiences
- Hosting an AGM with the inclusion of meaningful presentations
- Host an away day for the board and staff to identify key priorities for the organisation

8.2 Service

As a service, we continue to look at ways to improve in the following areas:

- Implementation of PAS specific talking mats for legal matters and CPA's
- Responding to consultations and attend short life working groups as appropriate, to champion the voice of our patients in their unique position
- Complete the annual questionnaire and take forward the views of patients on the PAS service
- Work towards more easy read and ID friendly documents such as advance statements
- Expansion of the TSH3030 project across the services 'Voices for Rights'
- Host a Patients' Rights Day with social work colleagues with a themed focus each year
- Expansion of the organisation to include the new Female Service whilst ensuring fair and equitable service is offered and no patients are negatively impacted by the increase in required provision
- Exploring staff wellbeing and the inclusion of reflective practice for the staff team

"It has been good having advocacy. I found when I first came to the hospital I wasn't well, I would get excited when you would come and see me as I felt safe to talk to you and knew you would listen to me. I think it is really good we are able to trust our conversations are confidential."

Patient

9 Financial Report

Income and Expenditure Report

For the period from 1 April 2024 to 31 March 2025

	£
Gross Income	151,827
Gross Expenditure	138,196
Incoming Resources	
Government Funding	151,381
Bank Interest	446
Cost of Charitable Activities	
Employment Costs	130,037
Insurance	1,962
Print, Post, Stationery	196
Subscriptions	435
Training	130
Computer Costs	9,139
Trustees/Meeting Expenses	890
Sundries	661
Advertising	414
	143,864
Governance Costs	
Accountancy Fees	2,932
Professional Fees	3,856
	6,888

Total Resources Expended as per Account	**150,752**
Cash & Bank Accounts	**62,368**
Liabilities payable in one Year	2,162

10 Next Review Date

The Patients' Advocacy Service Annual Report will be available to The State Hospital Board from November 2026.

11 Reference List

Equalities Act (2010), [Online], Available at https://www.legislation.gov.uk/ukpga/2010/15/contents

Scottish Independent Advocacy Alliance (2019), Independent Advocacy, Principles, Standards & Code of Best Practice. [Online], Available at https://www.siaa.org.uk/wp-content/uploads/2019/10/SIAA_Principles_Standards_Best_Practice_report_2019.pdf

The Patients Rights (Scotland) Act (2011), [Online], Available at https://www2.gov.scot/Topics/Health/Policy/Patients-Rights

The Mental Health (Care and Treatment)(Scotland) Act (2003), [Online], Available at http://www.legislation.gov.uk/asp/2003/13/contents

12 Glossary

PAS - Patients' Advocacy Service
TSH - The State Hospital
SLA - Service Level Agreement
GDPR - General Data Protection Regulation
SIAA - Scottish Independent Advocacy Alliance
AGM - Annual General Meeting
PPG - Patient Partnership Group
CPA - Care Programme Approach
MHT - Mental Health Tribunals
PCI - Person Centred Improvement
PCIL – Person Centred Improvement Lead
PCIT – Person Centred Improvement Team
SLWG - Short Life Working Group
ASP - Adult Support and Protection
AWI – Adults with Incapacity

Paper No. 25/108

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 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.

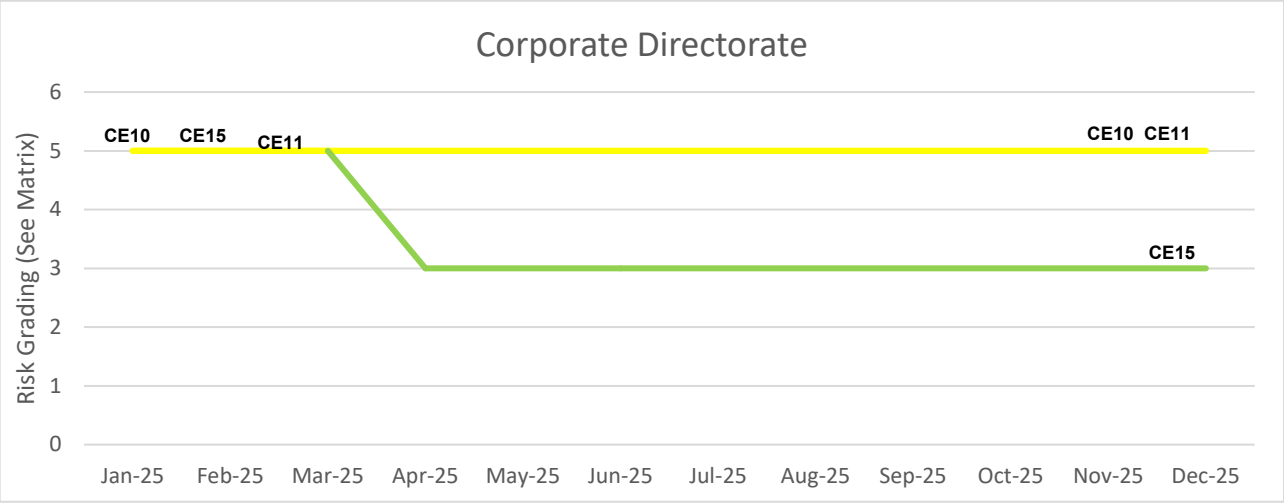
Risk Matrix

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

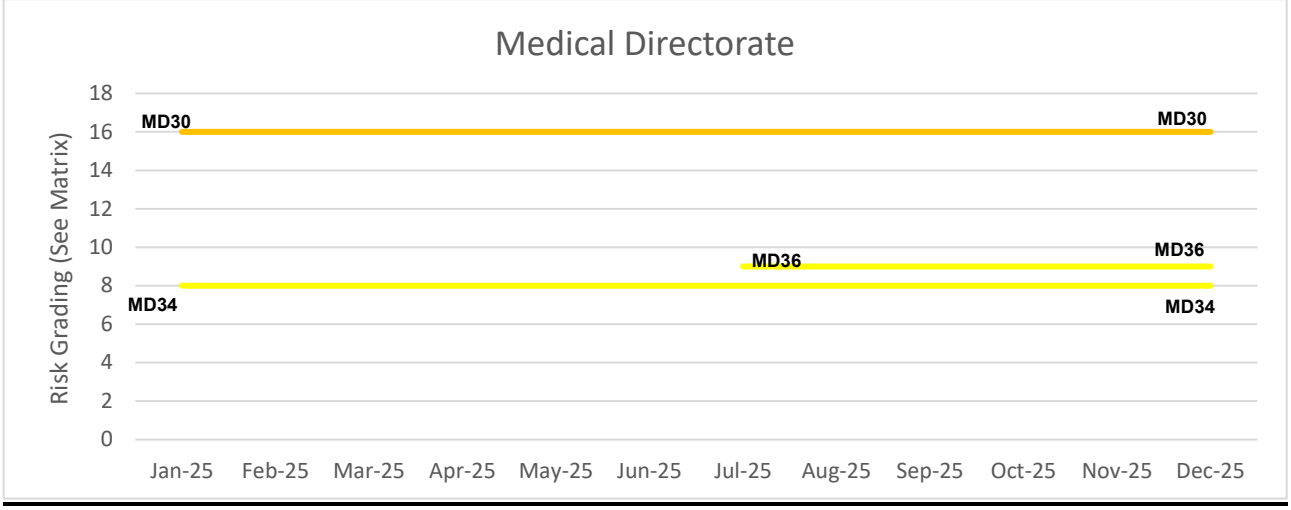
Corporate

There are no changes to the risk gradings withing the Directorate.



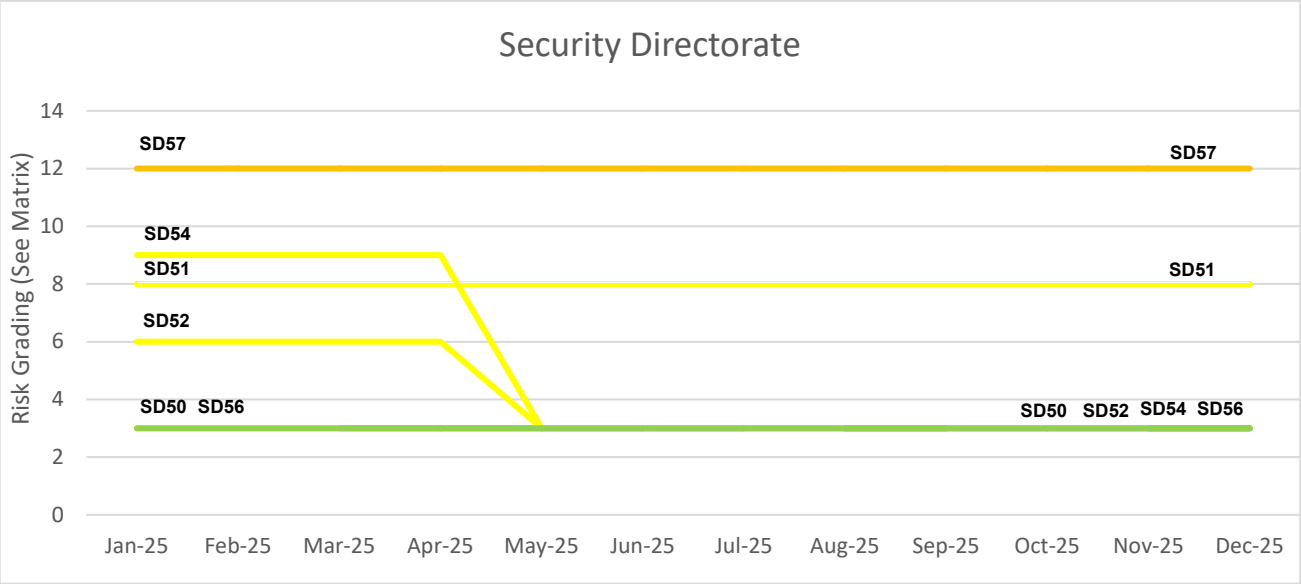
Medical

There are no changes to the risk gradings withing the Directorate.



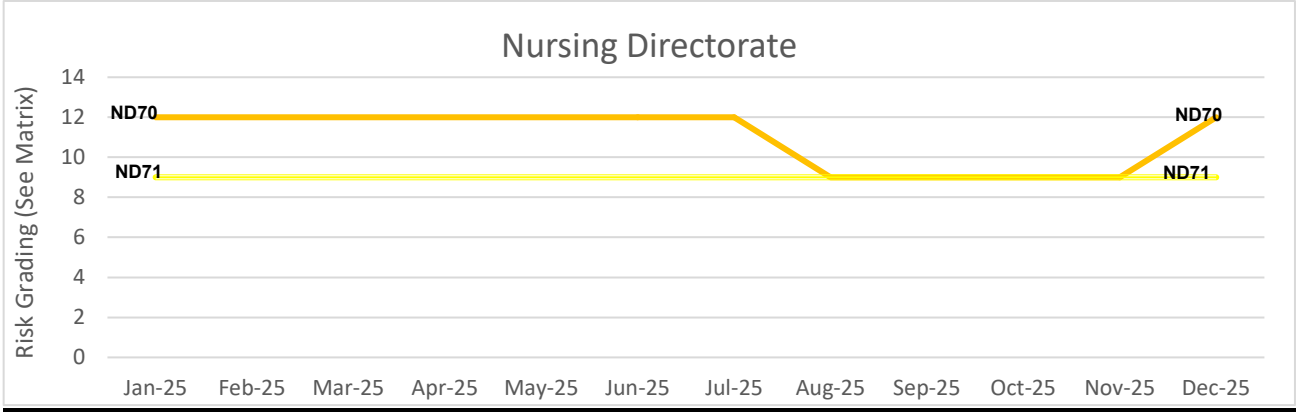
Security

There are no changes to the risk gradings withing the Directorate.



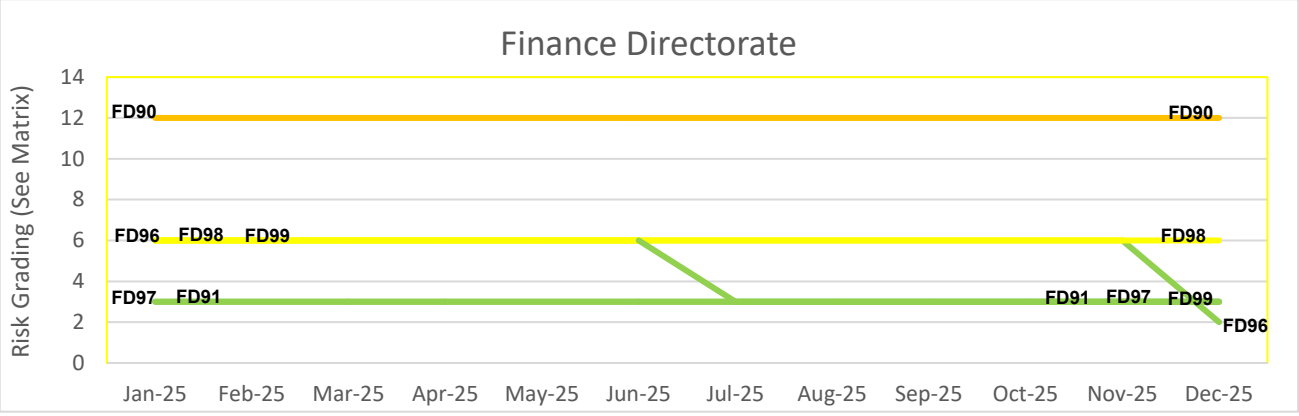
Nursing

ND70 Failure to utilise our resources to optimise excellent patient care and experience has been increased to 'Moderate x Likely' increasing the overall grading to 'High'. Details in Section 3.5.



Finance

FD96 Cyber Security Breach has been reclassified from **'Medium'** to **'Low'.** Over the past 12 months, any breaches or attempted breaches have been assessed as negligible, with all incidents effectively managed.

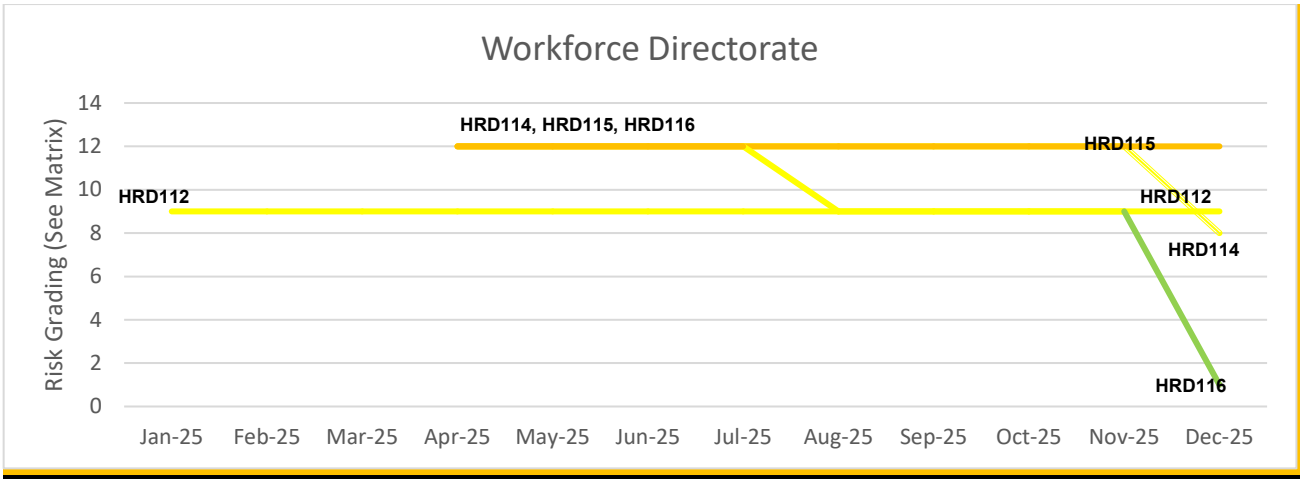


Workforce

HRD115 Sickness absence levels increase above acceptable levels remains at **'High',** details in Section 3.5.

HRD114 Reduced Working Week has been lowered to **'Medium'** from **'High'**. All departments have submitted their reduced working week plans, which have now been sent to the Scottish Government.

HRD116 Delay in completion of PVG checks from Disclosure Scotland has been further downgraded to **'Low'** from **'Medium'**. Data has demonstrated that both the impact and likelihood of the original risk have been effectively mitigated.



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

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 no "Very High" rated risks but has 5 'High' graded risks, updates on the progress to reduce from High are outlined below:

Medical Director:

MD30- Failure to prevent/mitigate obesity.

The risk and its oversight method (BMI) have been debated and revised, with agreement that BMI is ineffective for monitoring physical health. The KPI will be reviewed with the risk assessment, and any grading changes will be reported to The Board.

Security Director:

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

SD57 was elevated to 'High' in October 2024 due to non-compliance with national event review timelines. No impact data since change in process is available yet; risk grading will be updated once data is available.

Finance Director:

FD90: Failure to implement a sustainable long-term model

FD90 reflects ongoing national financial challenges and expected budget constraints from the Scottish Government for 2024/2025. Quarterly meetings with the Scottish Government and monthly internal reviews are in place. While the organisation is currently at break-even, recurring funding for the women's service remains at risk, so the overall risk level is still high. The Reduced Working Week (HRD 114) may also impact on the organisation's position in 26/27. The risk rating remains **'High'.**

Workforce Director:

HRD115 – Sickness Absence

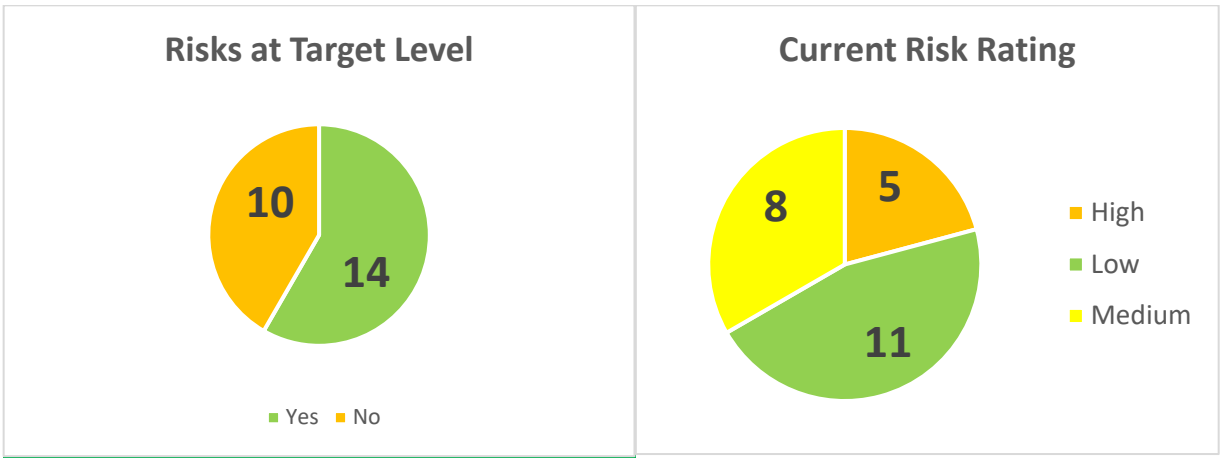
HRD115 Sickness absence levels increase above acceptable levels remains at **'High'.** Progress on absence is positive and showing significant improvement since December 24. Absence figures remain above the 5% target as of October 25.

Nursing Director:

ND70 Failure to utilise our resources to optimise excellent patient care and experience. Following analysis of recent data and staffing challenges this risk has been elevated to "High" to reflect the current staffing challenges faced by the organisation.

The primary factors contributing to this situation include the routine operation of the female service above its funded establishment and the increased resource demands required to manage periods of heightened clinical acuity and risk in male wards. Consequently, the operating model continues to fluctuate above the funded establishment due to clinical acuity and has remained over the funded establishment since Aug. Ongoing vacancies further exacerbate these challenges. Recruitment efforts are ongoing, with approval granted to over-recruit nursing staff by up to 5% of whole time equivalent. Additionally, initiatives are in progress to address broader issues related to gender and risk management.

3.6 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 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, ND70	MD30, HRD115,	
Possible	FD91		ND71, HRD112, , MD36	FD90	
Unlikely	FD96		FD98,	MD34, SD51, HRD114	
Rare	HRD116		FD97, SD56, FD99, SD50, SD54, CE15, SD52		CE10, CE11

Review Periods:

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

3.7 CRR Development

Implementation of the new Incident Management software (InPhase) is on track, with full rollout expected by March 2026; it will be used for incident and risk register recording at both Local and Corporate levels starting then.

3.8 Local Risk Register

Department/Local Risk Registers track risks that can be managed within individual departments by heads of service and senior charge nurses. Any risks that require escalation will be discussed at OMT before escalation to CMT for oversight.
Risks may be added from:

- Local risk assessment reviews
- Impacts of local incidents
- Specialist advisors (e.g. Health & Safety)
- Performance management escalation

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	Jan 26	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	Jan 26	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	Jan 26	Security, Risk and Resilience Oversight Group	Not at Target	-
Workforce HRD115	Workforce	Sickness absence levels increase above acceptable levels	Major X Possible	Major x Possible	Moderate x Possible	Director of Workforce	Head of HR	Jan 26	Workforce Governance 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 Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Jan 26	Clinical Governance Committee	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	Mar 26	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	Moderate x unlikely	Moderate x Unlikely	Chief Executive	Head of Risk and Resilience	Mar 26	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	Mar 26	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	Feb 26	Clinical Governance Committee	Not at Target	-

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 SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	Mar 26	Security, Risk and Resilience Oversight Group	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	Mar 26	Clinical Governance Committee	Not 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	Mar 26	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	Mar 26	Clinical Governance Group	Not at Target	-
Workforce HRD114	Workforce	Impact of reduced working week	Major X Possible	Major x Unlikely	Moderate x Unlikely	Director of Workforce	Head of HR	Jan 26	Workforce Governance Group	Not 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	Apr 26	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 26	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	Mar 26	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	Mar 26	Security, Risk and Resilience Oversight Group	At Target	-

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 SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Feb 26	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	Apr -26	Finance and Performance Group	At Target	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Negligible x Unlikely	Negligible x Unlikely	Finance and Performance Director	Head of eHealth	Jun 26	Information Governance Committee	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 26	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	Apr 26	Information Governance Committee	At Target	-
Workforce HRD116	Workforce	Delay in completion of PVG checks from Disclosure Scotland	Major X Possible	Negligible x Rare	Negligible x Rare	Director of Workforce	Head of HR	Mar 26	Workforce Governance Group	At Target	↓

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	18 December 2025
Agenda Reference:	Item No: 10
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Senior Management Accountant
Title of Report:	Finance Report – to 30 November 2025
Purpose of Report:	For Noting

1 SITUATION

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

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

2 BACKGROUND

The approved annual operating plan for 2025/26 was submitted to SG and signed off, with a projected breakeven forecast. Regular meetings between TSH and SG monitor progress against targets – the most recent being 6 November 2025.

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 third quarter of 2025, with ongoing staffing costs required for escorting contracting staff.

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 £55,687, in addition £1,278m has been assumed in the budget for the new capital charges (enhanced security project).

The State Hospital Annual Budget	£'000
Total Budget	56,965

Outstanding allocation – Excellence in Care £36k

The year-to-date position is £340k underspent, a slight reduction from last month – in part driven by the high level of vacancies across the hospital. In addition, there has been a reduction in nursing overtime with no costs to date associated with patient boarding out, resulting in a reduced spend within nursing. In previous years the higher overspend within nursing masked the underspend resulting from the high level of vacancies.

3.2 2025/26 Budget

The 3-year plan required by SG includes savings requirements of £1.9m (approx.3.8%) to ensure the forecasted breakeven position. It is anticipated that full savings plans will be achieved.

The formula Capital budget for 2025/26 has been set at £282k, with an additional £560k non-recurring capital allocated for the patient wander path, Skye centre animal shed repair and Islay roof repair. A further allocation of £220k has recently been awarded to cover the necessary update of LED lighting across the site.

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	4,508	2,630	2,631	(2)	0.00		Capital charges have increased as a result of new assets being added to the register. Capital charges will be fully funded by the Scottish Government.
Central Reserves	2,648	0	0	(0)	0.00	0.00	Unallocated RRL has been phased to period 12 and will be released or returned as required. This includes unallocated budget for women's services and AFC reform costs that have not been implemented yet.
Chief Exec	2,729	1,610	1,585	25	26.87	25.59	Vacancies within departments are resulting in a small underspend overall.
Finance	2,886	1,758	1,762	(4)	33.18	31.18	Pressure is resulting from service contracts within Ehealth, this is offset against vacancies in finance and procurement. Annual cost pressure of £185k to cover M365 has been funded non recurringly from reserves.
Human Resources Directorate	1,244	727	697	30	16.03	16.31	Underspend in training and vacancies across the directorate. £16k pressure within HR as a result of additional PVG certificates.
Medical	3,849	2,277	2,220	58	20.68	20.83	A consultant vacancy in earlier months has created a year-to-date underspend. Prescribing drugs currently report a small underspend it is anticipated drugs costs will increase in future months. Invoiced SLA costs are currently in dispute and could result in this underspend diminishing.
Misc Income	(120)	(79)	(87)	9	0.00		YTD income benefit from the previous ECP patient. No further benefit anticipated at this point.
Nursing And Ahp's	29,935	17,178	17,102	76	440.28	442.74	see below for detailed narrative from nursing directorate
Security And Facilities	9,287	5,418	5,271	147	124.29	120.06	Vacancies across the directorate are contributing to underspend, utilities pressures have been funded from reserves.
	56,965	**31,521**	**31,181**	**340**	**661.33**	**656.71**	

Nursing & AHPs (as provided from Nursing Directorate)

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 previous updates, pro-active recruitment campaigns to manage the Band 5 vacancy gap continue with the most recent round of interviews taking place in December 2025. These interviews resulted in 17 individuals being offered Band 5 posts on completion of their nurse training.. Recruitment is ongoing up to and including onboarding into January 2026.

As also detailed in previous reports the hospital now has one additional ward established to care for female patients. This service was formally stood up at the end of July 2025. Recruitment to support the opening of this service, whilst successful, did impact on Band 5 vacancy figures for the existing male services, and work remains ongoing to balance deficits across the site with regular reporting to Board Directors.

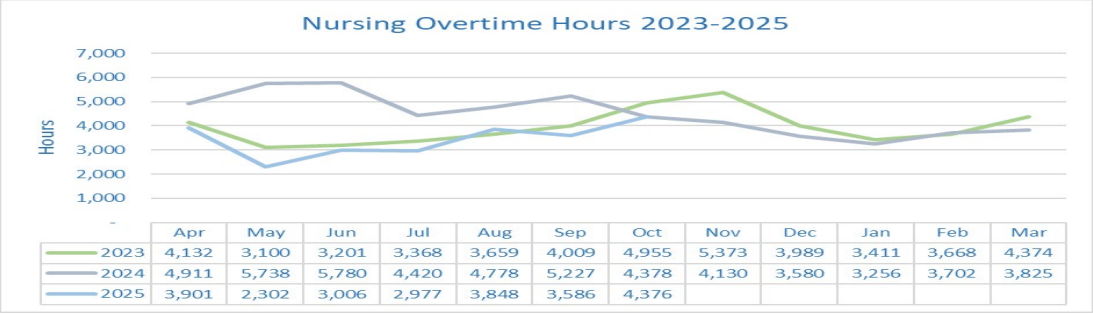
Robust attendance management processes and regular reviews of employee relation cases remain in place as do the monthly finance meetings with Senior Charge Nurse (SCN). These meetings enable supportive discussions with around effective roster management, effective use of allocated funding, and robust 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	2,302	3,006	2,977	3,848	3,586	4,376					

- A significant reduction in overtime was recorded between May and July ’25. Following the additional ward for female services being rolled out, the vacancy levels increased across the site. This has resulted in an increase in overtime to backfill these vacancies. It is anticipated that as we continue to fill the nursing vacancies the overtime costs should decrease again.

M365

- M365 remains a pressure to The State Hospital, the pressure has been offset against non-recurring reserves.

Energy and Inflation Increases

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

AFC Reform

- A recurring budget of £1.4m was allocated from The Scottish Government to manage AFC reform that was instructed to be implemented by April 2026. This funding is intended to cover:
  - Reduction of AFC staff working week from 37.5 hours to 36 hours.
  - Band 5 – band 6 regrading costs approved for nursing staff.
  - Protected Learning Time

  Work is underway to agree how the recurring budget should be allocated to next year’s budget.

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, closely monitored and reported to the oversight board. The budget allocated was intended to cover the full financial year and as

the service was not introduced until July '25 it is anticipated there may be non-recurring budget carried forward. While the allocation is for phase 1, further funding has yet to be confirmed, and discussions with Scottish Government will be taken forward through the quarterly finance meetings and the sponsorship review process.

- Additionally, due to the level of recent clinical activity within the women's service, this will now require detailed analysis and forecast in order to assess correctly the demands for 2026/27 and to set the necessary budget and allocate appropriate resources therefrom.

3.5 Benefits:

ECP Patient Income

- There is a year-to-date benefit of £9k as a result of the phasing of the income achieved from the Exceptional Circumstances Patient from NHS Fife. The patient has now been discharged, and not further ECP income is anticipated at this point.
- Discussions have taken place with Scottish and Northern Ireland Governments regarding the Scottish Government's requirement for charges to be raised for Northern Ireland patients – which is expected to be in place for 2026/27 (with billing taking place for Northern Ireland patients from 1 April).

Travel & Training

- Reduced spend has continued, with most meetings and many aspects of training now online.

Vacancies

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

4 ASSESSMENT – SAVINGS

Savings targets of £1,920k have now been identified, the savings targets are currently being fully achieved as demonstrated in the table below:

Directorate	Annual Target £k	YTD Target £k	Savings Achieved £k	Suplus/ (Shortfall) £k
Chief Exec	70	40	44	4
Finance	128	75	75	0
Human Resources Directorate	37	21	23	2
Medical	113	66	67	1
Nursing And Ahp's	872	509	499	(10)
Security And Facilities	700	409	412	3
	1,920	**1,120**	**1,120**	**0**

It should be noted that of the Hospital's budget 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

Capital priorities are planned and agreed through the Capital Group, allocations and currents plans are set out on the table below:

Capital CRL 2025/2026	Annual Plan £k	YTD Spend £k
Capital		
Anti Barricade and Observation Panels	55	5
E-health equipment	54	26
Kitchen Equipment/Doors	41	
Defib & Vital Signs Machines	41	
Hi Voltage Switch Room Door	25	
Key Safes	20	14
TV protection Cabinets	20	
Laundry Equipment	18	18
Records Office Upgrade	8	8
Thomson Gray		
Over Commitment		
Capital CRL Allocation	**282**	**71**
BCP Funding		
Islay Repair	160	
Patient Wander Path	250	
Animal Shed Replacement	70	
Fire Alarm Replacement	80	
BCP Allocation	**560**	**0**
Additional Capital		
LED Lighting Replacement	220	
Additional Capital Allocation	**220**	**0**
Total CRL	**1,062**	**71**

6 RECOMMENDATION

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

Revenue

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

Capital

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

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	Monitoring of financial position
Corporate Objectives	**3. Better Value** – a) Meet the key finance targets set for the organisation and in line with Standard Financial Instructions. c) Deliver all Scottish Government financial budget and resource reporting and monitoring requirements for NHSScotland national matters, through Board Chief Executive, Director of Finance and Human Resource Director groups.
Workforce Implications	No workforce implications – for information only
Financial Implications	Reporting on financial outturn and budgetary compliance
Route to Board Which groups were involved in contributing to the paper and recommendations.	Senior Management Accountant Partnership Forum CMT
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:	18 December 2025
Agenda Reference:	Item No: 11
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Director of Nursing and Operations/ Director of Workforce
Title of Report:	Nursing Resource Strategy 2026/27
Purpose of Report:	For Noting

1 SITUATION

The purpose of this report is to provide the Board with an overview on the direction of the Nursing Resource Strategy for 2026/27 in response to a number of internal and external influences.

2 BACKGROUND

There have been a number of influencing factors which will have an impact on the nursing workforce particularly over the next 6 months. The Director of Nursing and Operations felt it was important to provide the Board with a strategic overview.

The main influencing factors are as follows :-

- The e-Rostering system (Optima)
- The Reduce Working Week
- Band 5/6 review and Protected learning time
- Clinical acuity
- Gender Balance
- The Women's Service
- Attendance Management

A timeline for these has been provided in Appendix 1

3 ASSESSMENT

e-Rostering

A key element for Nursing Resource over the coming year is to progressively step towards full utilisation of Optima (eRostering). This follows on from successful testing of the roll out in Mull Hub which was also part of the agreed process to decentralise resourcing and empower the SCNs to manage their own wards. The continued roll out has been supported by both CMT and Partnership at their December meetings and will continue into early 2026.

The Reduced Working Week

The timetable for the implementation of the reduced working week as part of the Agenda for Change pay deal was determined by the Scottish Government.

In February 2025, the Cabinet Secretary for Health and Social Care wrote to all boards advising that the final reduction of 1hour to a 36 hour by 1 April 2026. All Boards were to have an agreed plan by 1 October 2025, both of which should be agreed by Partnership.

In response, we have taken the opportunity to fully review the shift arrangements for nursing staff. Through staff engagement we want to understand what is important to people, as well as ensure that service provision is optimised. This will also allow a greater focus on health and wellbeing, work life balance and compliance with working time regulations, along with minimising the resources required to support safe staffing.

From this engagement options were developed in partnership, which are being presented to staff throughout December. There are also planned engagement sessions to provide further information and answer any questions staff may have. An indicative Joint Staff Side ballot for union members and a Microsoft form survey for all Nursing staff will run concurrently from Wednesday, 3 December 2025 to Wednesday, 17 December 2025.

Once the outcome of this is known the agreed roster pattern will be communicated to staff and implemented in time for the April deadline.

Band 5/6 review and Protected Learning

There is currently a review of the Band5/6s whilst there has not been a huge uptake locally there is the potential that any changes made nationally will have an impact at the State Hospital. Senior leaders are involved in all relevant forums and will continue to reflect on this as part of the workforce governance groups workplan, to provide opportunities for proactive planning in response to any changes.

The impact of the introduction of protected learning time will be fed through the Workforce Governance Group.

Clinical Acuity

Clinical acuity has been a factor noted to contribute to nursing resourcing challenges. Whilst our longitudinal data does not see a shift in presentation, there is a recognition of the impact of the peaks in acuity. We continue to monitor the impact and once staffing has returned to the agreed over recruited position, we will determine if this provides the necessary buffer to ensure that these spikes in acuity can be absorbed without any detriment elsewhere on site.

Women's Service

The Board were advised of the impact of the introduction of the Women's Service on the nursing resource and this has taken considerable effort and time to recover. Since opening, the Women's Service, it has been operating above its funded establishment due to the complexity and acuity of these patients. This has had an impact on the rest of the site. The women's service project board are reviewing the staffing requirements and will factor this into the communication with Scottish Government regarding ongoing funding required.

Gender Balance

The gender balance within the hospital is also a consideration to ensure we have the agreed requirements across the site and can respond to any additional patient needs. There is ongoing monitoring of the gender and skill mix of the workforce through the workforce governance group. Nationally there is a reduction in not only number of nursing students but also of males, there are plans in place to address this locally, the workforce governance group will monitor progress and identify any additional actions required.

Absence Management

The persistently high sickness absence rate is also a clear impact on nurse resourcing. Through the Workforce Governance structure, there are a number of measures in place continuing to work towards a reduction in the sickness absence rate to within the 5% target. There continue to be regular oversight meetings with the Chief Executive, Director of Workforce and the Director of Nursing and Operations.

Recruitment

There are also plans in place to continue with the proactive approach to recruitment in recognition of not only the usual predicted turnover of staff but also to recruit to the resulting loss of WTEs given the reduction in the working week of nursing staff. This will begin in January with a view to staff onboarding in time for April 2026 when this will come into effect. CMT approved over recruitment of the base establishment to 105%.

4 RECOMMENDATION

The above report provides an overview of the multiple factors influencing nursing resourcing over the next six months and the resulting strategy sets a clear direction and a comprehensive approach to the governance required.

The Board is asked to note the contents of this report.

Appendix 1

Timeline for the Nursing Resource Strategy

	Dec	Jan	Feb	March	April	May	June	July
E rostering								
Absence Management								
RWW Shift Ballot								
Band 5/6 Review								
Women's Service								
Gender balance								
Recruitment								

How does the proposal support current Policy / Strategy /ADP	Supports the delivery against the Workforce strategy/ ADP and compliance with the HCSA.
Corporate Objectives Please note which objective is linked to this paper	**Better Care** a) Implement the Annual Delivery Plan and the Medium-Term Plan, aligning the organisational aims and direction to the health priorities set out in Scottish Government Policy, aligning to NHS Reform across NHSScotland. c) Eliminate the use of Day Time Confinement to all but very exceptional circumstances. d) Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk. e) Ensure the principles of rehabilitative care are applied optimising opportunities for meaningful patient activities, educational development and occupational development across all service areas. f) Develop and implement an interim women's service model, in line with the project initiation. In the context of the State Hospital's Clinical Care Model, this will be an admissions ward, with equivalence of service provision to that of male patients in the existing admissions service. g) Develop and implement an outreach service model for women from high security to medium security providers and the Scottish Prison Service. The aim of the outreach service is to work in partnership with service teams in the management of patients who may require admission, or who are displaying behaviours that could necessitate a high security referral. i) Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. 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. **2. Better Health** b) Continued improvement of the physical health opportunities for patients. c) Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient. d) Address the overall social wellbeing issues for patients undergoing treatment.

	3. Better Value a) Meet the key finance targets set for the organisation and in line with Standard Financial Instructions. **4. Better Workforce** a) Development and delivery of the three-year Workforce Plan 2025/28 within the context of the planning framework and guidance from Scottish Government. b) Continue to support and build partnership working so that this is embedded across the organisation. c) Deliver and monitor staff resourcing aligning to the Health and Care (Staffing) (Scotland) Bill (2019) across the State Hospital, and in conjunction with the local delivery of the national e-rostering programme, through the Workforce Governance Group. d) Maximise workforce sustainability through delivery of the State Hospital's Recruitment and Retention Strategy, through modern, inclusive recruitment practice and continued development of a supplementary workforce. e) Promote and deliver a framework of wellbeing within the framework of a Staff and Volunteer Wellbeing Strategy i) Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation. 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	Noted in paper
Financial Implications	No Additional finance implications at this time. It is anticipated that funding will be provided centrally to offset the gap created by the reduced working week.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Details work overseen through Clinical Governance and Staff Governance
Risk Assessment (Outline any significant risks and associated mitigation)	none
Assessment of Impact on Stakeholder Experience	Staff engagement underway

Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 2025
Agenda Reference:	Item No: 12
Sponsoring Director:	Director of Nursing and Operations
Author(s):	DTC Oversight Group
Title of Report:	DTC Report
Purpose of Report:	For Noting

1 SITUATION

The purpose of this report is to provide an update regarding the levels of DTC, to inform the Board of the progress made regarding the areas identified for improvement enabling DTC to return to a never event and thereafter be managed under business continuity measures.

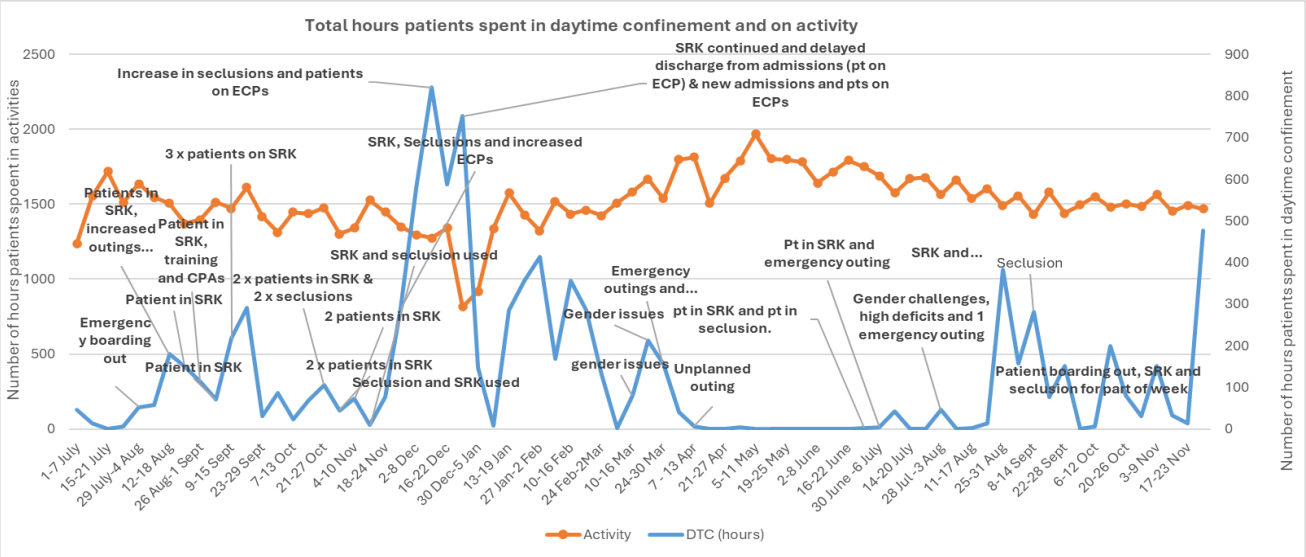
The data presented in the report covers the period up to and including the 30 November 2025.

2 BACKGROUND

The Board remains firm in its commitment to eliminate Day Time Confinement. Work has concluded identifying the root causes and the measures required to address this. The data demonstrates that these working assumptions have been correct. However, the ask to introduce a new women's service has hampered progress due to the resulting loss of staff. It is taking some time to recover the staffing numbers there has been good progress made.

3 ASSESSMENT

Chart 1



Hospital wide run chart (Chart 1)

November has seen an increase in DTC from 318.1 hours to 673.3 hours. The number of activities being provided to our patients stayed relatively consistent with the lowest week having 1453.6 hours (week beginning 10 November) and 1565 hours (week beginning 3 November). This is quite a bit less than we were seeing in May and June when we were averaging 1750 hours (this is all planned and drop-in activity). A seasonal reduction in grounds access hours and the inclement weather we have experienced during November has contributed to this. There were also 3 emergency outings in November which is the same number as October.

<u>Operational Management</u>

Meeting Structure and Progress – Oversight meetings continue to evolve. There is still work streamlining the process and ensuring the membership is right at all forums. There are plans to undertake a process mapping exercise to look at these meetings in more detail and ensure process is efficient and effective. There is also a need to further develop the recording of these meetings and the rationale behind the decisions that they make.

There is now a central Teams Channel which will hold all relevant information pertaining to DTC.

Recruitment

Mull temporary wte uplift

The Board approved the over recruitment of 10WTE band 3 staff on a fixed term basis. 9.6wte have been used to increase the staffing complement in Mull 1 and 2 led by available data which indicated that this would have a significant reduction in DTC within the area. This working assumption was shown to be correct. Therefore, a full paper will be submitted via Partnership and the Workforce Governance Group for the funded establishment to be rebased and this increase in Mull hub staffing to become permanent.

Clinical Acuity

During this reporting period there has been an increase in clinical acuity which has required up to 19 extra shifts per day over our funded establishment, this is due to two of patients requiring seclusion, a patient requiring SRKs, periods of outboarding and 3 female patients currently being nursed separately. The clinical teams continue to review all patients on enhanced levels of care to ensure they are necessary and proportionate to level of need. We are reviewing the data regarding the

impact of the fluctuations in acuity to consider how we can more easily absorb the fluctuations in demand.

DTC Incident command

The DTC oversight group developed a bespoke DTC incident command process to ensure a proportionate but robust process of decision making and recording following the escalation of DTC. There was a series of development sessions with key personnel who would be involved in the decision-making process facilitated by the Risk Department. Following feedback from these sessions it was agreed that the current Gold Command (major incidents) process would not be required particularly as the DTC can often be for short duration and does not require the same breadth of expertise that can often be involved in Gold Command situations.

There was also a need to ensure that the process was accurately recorded and that there was a consistent approach regardless of whether the escalation occurred in or out of hours. It was agreed that the DTC incident command would be held on Teams and this would be recorded and transcribed. There has been a template developed which the relevant director would use as an agenda to ensure consistent approach to decision making and recording. Their PA would then check the transcription and transfer to the agreed template, once approved by the Director this would be uploaded to a dedicated file in the DTC Teams Channel.

It has been agreed that the escalation of DTC will come to either the Director of Nursing (DoN) or the Associate Director of Nursing (ADN) in hours, out of hours it would be the Duty Director. In the unlikely event that neither the DoN nor the ADN are available in hour it would be escalated to the duty Director.

The Operational Support Plan (business continuity) that is linked to staff resource and escalation has been reviewed as part of the rolling work of the DTC oversight with only minor amendments required to specifically refer to DTC escalation process.

This process and the DTC Incident Command Template was approved by CMT on 3 December 25.

4 RECOMMENDATION

The Board is asked to note the contents of the above report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Working towards a full understanding of DTC and its elimination.
Corporate Objectives Please note which objective is linked to this paper	Better Care, Better Health
Workforce Implications	eHealth support required to build a Tableau dashboard
Financial Implications	As above, eHealth time however no further costs.
Route to Board Which groups were involved in contributing to the paper and recommendations.	The DTC Oversight Group reports direct to CGG and then CGC. With escalation routes to OMT & CMT for Operational issues.
Risk Assessment (Outline any significant risks and associated mitigation)	Change in how staff shortages are recorded and reported. However, the detail remains the same.
Assessment of Impact on Stakeholder Experience	• Reduced workload in recording of shortages for multiple layers of staff. • Consistent application and review of DTC • Improved framework to support on call directors that may be less familiar with nursing resource challenges
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:	18 December 2025
Agenda Reference:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Head of Clinical Quality Corporate Planning, 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 updates the Board on developments in quality assurance and improvement since the last Board meeting. It demonstrates their alignment with the hospitals strategic planning and organisational learning processes, supporting the commitment to embedding quality in care and service delivery .

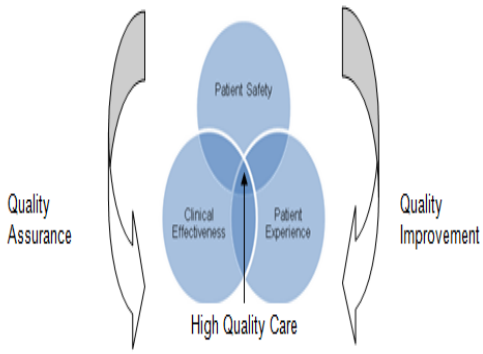
2. BACKGROUND

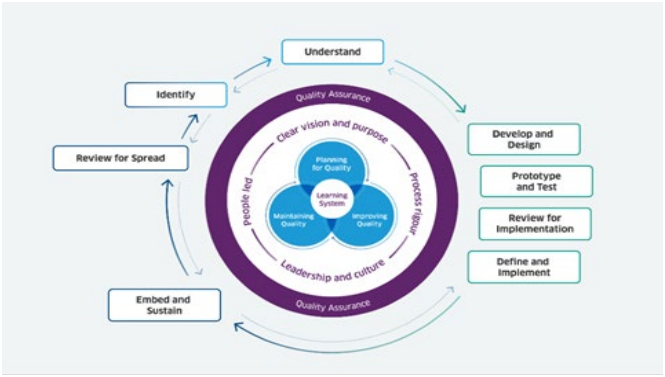
Quality assurance and improvement at the State Hospital align with the Clinical Quality Strategy 2024–2029, approved by the Board in August 2024. This strategy outlines the direction and goals for enhancing clinical care, aiming to improve patient experiences through person-centred, safe, high-quality support. The State Hospital (TSH) Quality Strategy also aligns with the newly launched Scottish Approach to Change, outlined in figure 1 below. Key aims to provide focus for the organisation quality vision include to:

- Deliver safe, effective and person-centred care based on available evidence and best practice.
- Improve patients outcomes and experience.
- Demonstrate meaningful involvement of patients, carers, volunteers and all other stakeholders in quality assurance and improvement activities.
- Assure the Scottish Government and stakeholders of safe systems, ongoing quality improvement, and efforts to reduce health inequalities in patient care.
- Develop a culture of ongoing learning and 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.

Figure 1





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 clinical audits.
- An update on quality improvement capacity building within the State Hospital.
- 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 supports 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. The audits provide feedback and assurance that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure quality improvement and action plans are discussed at the commissioning group.

Within this reporting period, there have been four local audits completed by the Clinical Quality Department and actioned through the Commissioning Groups. Three of the audits gave moderate assurance to the organisation as pockets of good practice were found and improvement plans have been agreed. One audit, the Audit of the Clinical Care Policy gave limited assurance due to the number of areas of non-compliance with the implementation of the policy. It should be noted that this is the first annual cycle of this audit for a policy that includes significant changes in practice (moving us from observation to intervention). A robust improvement plan is being agreed with the Associate Nursing Director.

- Audit of Clinical Care Policy
- PMVA Post Physical Intervention Audit
- Psychotropic PRN Audit
- Nutritional Screen Tool Audit

The Master Audit table (table 1) provides a summary of recent local audit outcomes for each ward. Compliance is indicated by a colour code: green for excellent adherence or minimal improvement, amber for areas requiring action, and red for significant improvements required.

Table 1: Master Audits

	Arran 1	Lewis 1	Arran 2	Arran 3	Lewis 2	Lewis 3	Mull 1	Mull 2	Mull 3	Iona 2	Iona 3
Medication Trolley Audit											
Medicine Fridge Audit											
HEPMA Audit											
PMVA Post Physical audit			n/a				n/a	n/a			
Unvalidated progress notes											
Nurse progress note on each shift											
Controlled Drugs Audit						n/a					
RMO contact with patients											
Observations of Care											
PMVA Seclusion Audit				n/a		n/a	n/a	n/a			
Oxygen cyclinder checklist											
Epilepsy Audit		n/a			n/a	n/a	n/a				
Clinical Care Policy Audit							n/a	n/a			
PRN Audit						n/a	n/a		n/a		
Nutritional Screening Tool Audit											

Service Leadership Teams are advised of the master audit adherence to enable overview of audit adherence within their wards. A report on the master audit adherence will be presented at Clinical Governance Group in February 2026, and 6 monthly thereafter, to provide oversight.

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

The monthly variance analysis data (covering November 2025) revealed improvements with professions attending the patient's CPA reviews (although key worker attendance decreased) and reports being available for the CPA review. An issue was identified within the Transitions Service where the new CPA process for generating patient-specific medical reports was not followed, resulting in these reports not being incorporated into the final CPA documentation. This will be highlighted to the appropriate staff.

2. QUALITY IMPROVEMENT

2.1 QI Forum

The QI Forum continues to play a pivotal role in driving a culture of continuous improvement, ensuring alignment with our organisational priorities for patient safety, operational efficiency, and clinical excellence.

- **Current Portfolio:** Ten active QI projects are underway, led by multidisciplinary teams across clinical, operational, and patient groups. These initiatives are designed to deliver measurable improvements in care quality and patient experience.
- **Recent Achievements:** Two projects have been successfully completed since the last report, contributing to enhanced processes and outcomes within the hospital.
- **TSH3030:** Following the success of TSH3030, 2025. Two posters have been accepted at conferences.
    - ❖ TSH3030: A 30-day quality improvement sprint- outcomes and lessons learned, has been accepted for presentation at the Internation Forum on Quality and Safety in Healthcare scheduled for March 2026
    - ❖ The "Mind the Gap" project presented a poster (Appendix 1) at the Forensic Network Research Conference 2025. This project has been valuable for the Psychology Transitions Service, formalising previous informal discussions with medium secure psychology teams and promoting collaborative problem-solving. It has also encouraged conversations about multidisciplinary involvement in referrals and was well received by both teams.

These initiatives collectively support our commitment to delivering safe, person-centred care and operational excellence. The Forum will continue to monitor progress, evaluate outcomes, and prioritise projects that deliver the greatest value to patients and the organisation.

Planning will commence in January for TSH3030 2026 cycle.

2.3 QI Capacity Building

2.3.1 – Scottish Improvement Leaders Programme (ScIL)

Cohort 53 – Three staff members applications were supported by NES to commence cohort 53 of the ScIL Programme which commenced in November 2025

2.3.2 -QI Essential Training

The QI Essential Training programme, delivered internally and facilitated by staff trained through the Scottish Improvement Leaders (ScIL) Programme, aims to enhance staff capability in quality improvement methodologies.

Cohort four successfully concluded in November 2025, with five participants (three clinical and two non-clinical staff) completing the course. These staff members are now engaged in small-scale quality improvement projects, which are scheduled for presentation to course facilitators in January 2026.

Cohort five is set to commence in December 2025, with five staff members registered to participate.

2.4 Realistic Medicine

2.4.1 - Team Based Quality Reviews

Team Based Quality Reviews (TBQR) are a structured approach to continuous quality improvement, enabling multidisciplinary teams to reflect on practice and identify actions for enhancement. This collaborative process strengthens team accountability, promotes shared learning, and contributes to safe, person-centered care

ID Service - The Team Based Quality Review panel has met and the first TBQR (Reboot & Rethink) meeting for the service was held in November 2025.

The Admission and Assessment Service first Panel meeting took place in October 2025 and the first TBQR meeting for the service has been arranged for December 2025.

3. EVIDENCE FOR QUALITY

3.1 National and local evidence-based guidelines and standards

The State Hospital has a robust process for reviewing all incoming guidance to determine its relevance to the State Hospital. Pertinent documents are evaluated by multidisciplinary teams using an evaluation matrix to ensure compliance. During the period 1 October to 30 November 2025, 30 guidance documents have been reviewed: 21 documents were considered either not relevant or were overridden by Scottish guidance and 9 were shared for information. There were no guidance requiring an evaluation matrix to be completed during this period

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required
HIS	1	1	0
MWC	9	8	0
National Institute for Health & Care Excellence (NICE)	20	0	0

There are currently two additional evaluation matrices which have been outstanding for a prolonged period. The review process for the HIS Gender Identity Healthcare Standards Gender ID Healthcare gap analysis has now been completed and will be tabled and Person Centered Improvement Steering Group (PCISG) in December and then Physical Health Steering Group (PHSG) for final sign off at the end of January.

The NICE guideline regarding Obesity is tabled to continue being reviewed within Supporting Healthy Choices in December. The process is delayed due to the high number of recommendations to review and scheduling conflicts within the group.

Table 4: Evaluation Matrix Summary

Body	Title	Steering Group	Current Situation	Publication Date	Projected Completion Date
HIS	Gender identity healthcare: Adults and young people	PHSG	Gender ID Healthcare gap analysis completed Final sign off by PHSG at the end of January	September 2024	January 2025
NICE	Overweight and obesity management	PHSG	To be progressed in absence of current Scottish guidance (publication anticipated March 2027). Evaluation matrix created and being reviewed by SHC group in December.	January 2025	February 2026

Appendix 1

Mind the Gap: Enhancing the Psychology Transitions Pathway from High to Medium Secure Services

Liam Hopkins (Assistant Psychologist, The State Hospital), Dr. Clare Neil (Consultant Clinical Psychologist, The State Hospital)

clare.neil@nhs.scot

1. Aim

Patient transitions between high and medium secure services involve changes in environment, clinical team and risk.

Quality improvement project aimed to explore and enhance the referral and transfer process between high and medium secure psychological care.

2. Methods

Process-mapping exercise of current referral and transfer process – including identifying potential gaps and questions to explore with medium-secure services.

Semi-structured consultations with seven psychologists in medium-secure services to seek their views on the referral and transfer process.

Thematic analysis principles to analyse consultation data and identify key themes.

Force-field analysis to highlight driving and restraining forces impacting the referral and transfer process.

3. Findings

Themes	Driving Forces	Restraining Forces
Collaboration	Proactive outreach and pre-referral discussion	Inconsistent involvement of psychology in assessments
Treatment Needs	Psychological work and identifying unmet needs	Patient to articulate work; link between formulation and therapy
Insight	Patient insight into new environment; Robust formulation around insight	Patient required to articulate insight during assessment.
Continuity	Written summaries and handovers of psychological work	Patient views about psychology; Differing service views on risk.

4. Recommendations

Strengthen collaboration → Establish regular formal/informal discussions throughout process and encourage full multidisciplinary team involvement in decision making.

Formulation-driven care → Consider reviewing TSH treatment delivery to ensure interventions are formulation-driven; and risk assessments are updated in line with therapeutic progress.

Support consolidation → Help patients consider how they will apply skills and knowledge learned from psychological work in medium-secure services.

Bridging the gap → Standardise handover of psychological care; prepare patients for ongoing psychological work - including benefits of this within new environment and at stages of transition.

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE **CGC(M)25/03**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 14 August 2025.

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

Chair:	
Non-Executive Director	Cathy Fallon
Present:	
Non-Executive Director	Stuart Currie
Non-Executive Director	David McConnell
Board Chair	Brian Moore
In Attendance:	
Associate Medical Director	Dr Duncan Alcock [Item 9]
Corporate Business Manager	Anne Donnelly
Head of OD and Learning	Sandra Dunlop [Item 8]
Head of Psychology	Dr Liz Flynn
Personal Assistant	Vicky Gregg [Minutes]
Acting Director of Estates and Resilience	Allan Hardy
Consultant Forensic Psychiatrist	Dr Sheila Howitt [Item 19]
Chief Executive	Gary Jenkins
Senior Nurse for Infection Control	Jonathan Lee [Item 12]
Lead Allied Health Professional	Lindsey MacGregor [Item 7]
Director of Nursing and Operations	Karen McCaffrey
Clinical Quality Facilitator	Julie McGee [Item 6]
Patient Learning Manager	Julie McHugh [Item 8]
Director of Finance & eHealth	Robin McNaught
Research and Development Manager	Jamie Pitcairn [Items 5a and 5b]
Head of Corporate Governance	Margaret Smith
Medical Director	Professor Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon opened the meeting and noted apologies from Ms Shalinay Raghavan, Non-Executive Director, Ms Monica Merson, Head of Corporate Planning, Performance and Quality, Dr Gordon Skilling, Consultant Forensic Psychiatrist, and Ms Sheila Smith, Head of Clinical Quality.

Ms Fallon commented on the pack of papers presented for the meeting, saying that the papers were in the main too long and also concentrated unduly on staff rather than patient care aspects. She thought that it would be helpful for papers to align more closely to the proposed draft clinical governance standards and linking these to the patients' perspectives. She added that there was too much content focussed on data and detailed background rather than key themes. She put forward the view that she would like to see a different approach to the papers submitted to the Committee in the future.

Mr Moore welcomed these comments, and added his agreement to them, saying that this should be viewed from a governance perspective in terms of assurance. Papers should be focused on patient outcomes, but also meet the needs of the Committee in terms of its governance duty and responsibilities.

Professor Thomson noted the discussion, and confirmed that efforts would be made to take this into account going forward, especially to ensure that patients were at the centre of reporting. Mr Jenkins agreed with this, and referred to the organisational development session scheduled to take place, which would have a focus on governance matters as well as a more streamlined operational approach.

There was agreement around the table to this refreshed focus.

The Committee:

1. Endorsed a refresh in approach to Committee business.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF PREVIOUS MEETING

The Committee approved the minute of the previous meeting held on 8 May 2025.

The Committee:

2. Approved the minute of the meeting held on 8 May 2025.

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

The Committee:

1. Noted the updates from the Rolling Action List.

5 RESEARCH COMMITTEE

a) ANNUAL REPORT 2024/25
b) RESEARCH STRATEGY

The Committee received the State Hospital (TSH) Research Committee Annual Report 2024/25. Mr Pitcairn highlighted a number of areas of key work including ongoing and completed studies, publications, and work taken forward to involve patients in the development of research-related tools. Mr Pitcairn also highlighted the important contribution of the Research Fellow in providing support to individuals who did not have dedicated time within their roles to engage in research activities.

Mr McConnell thanked Mr Pitcairn for his report and asked about the status of the Research Fellow post. Mr Pitcairn replied that the fellowship period had ended at the end of 2024/25 and that the Research Committee was considering appointing a new Research Fellow or establishing an alternative role.

Mr Moore thanked Mr Pitcairn for his report and noted that it would be useful for future reports to include examples of research evidence that had been implemented into practice. Mr Moore also

noted that it would be beneficial to showcase research at TSH to a broader audience and suggested that posters could be presented at the NHS Scotland Annual Research Conference.

Mr Pitcairn informed Mr Moore that the Forensic Network hosted an annual Research Conference featuring poster and presentation submissions. The next conference was scheduled in October, and he would encourage presenters to consider submitting their work to the NHS Scotland Research Conference next year.

Ms Fallon highlighted that there were no research studies from the Social Work Department and that this should be given further consideration.

The Committee received TSH Research Strategy for 2025-2029. A staff engagement exercise was undertaken to inform the Strategy, and Mr Pitcairn provided an overview of the feedback that was received. The key areas of focus moving forward included promotion of research and the resources available, research study dissemination, and meaningful involvement of patients and others with lived experience in all aspects of the research process where possible.

Mr Pitcairn proposed that the Strategy Action Plan would come to the Committee on a regular basis to monitor progress against the actions identified, and Committee members were content with this proposal.

In response to Mr McConnell's question regarding how the structural changes that may be introduced by the new Forensic Mental Health Board might affect research, Mr Pitcairn expressed his view that this would be a valuable opportunity to foster collaborative working across the newly established Board.

There was discussion around the importance of linking data and research to meaningful outcomes and Mr Jenkins noted that the Research Strategy should clearly demonstrate how research had positively impacted the organisation.

Ms Fallon noted member's agreement to approve TSH Research Strategy.

<u>The Committee:</u>

1. Noted the Research Committee Annual Report.
2. Endorsed TSH Research Strategy.

6 MENTAL HEALTH PRACTICE STEERING GROUP 12M REPORT

Committee members received the Mental Health Practice Steering Group 12 Month Report presented by Ms McGee, who provided an update on the key pieces of work over the last year which included roll-out of the new Care Programme Approach (CPA) process, the Clinical Outcomes Pilot, and work on trauma-informed care.

Mr Jenkins thanked Ms McGee for the report and for her helpful presentation on the new CPA process at the Board Development Day last week. Mr Jenkins asked Ms McGee if consideration had been given as to how patient outcome measures would be embedded into clinical practice, and she advised that the appropriate steering group would operationalise these measures across the hospital. Mr Jenkins noted that it would be beneficial to capture the outcome of this piece of work without it dissipating across too many groups.

Professor Thomson commented that plans and timescales were in place for development of the suite of outcome measures. Once developed, the measures would be taken to a workshop for agreement by clinicians.

Mr Moore noted the increased uptake of trauma-informed care training and noted that it would be useful for the Committee to receive future reports on the extent of the uptake. Mr Moore also noted that it would be useful to receive feedback on the implementation of the Relational Approaches to Care online module to help determine whether the balance between face-to-face training and the use of online modules was appropriate.

Mr Jenkins advised that following the Board Development Day last week he had a discussion with Dr Flynn regarding the opportunity to embed trauma-informed care within the Women's Service as an initial starting point. He had advised Dr Flynn that he would welcome a proposal on this model to see if it led to significantly different outcomes in areas such as staff wellbeing and motivation.

Ms Fallon thanked Ms McGee for the report and requested that the peer review panel details, patient care feedback, and family intervention work was included in the next report to the Committee. Ms Fallon noted that a re-audit of grounds access was scheduled in December and requested that an update on this was provided to the Committee at its meeting in February 2026.

Action: Ms McGee

The Committee:

1. Noted the Mental Health Practice Steering Group 12 Month Report.
2. Requested an update report to return in the February meeting.
3. Requested an update on the Ground Access Re-audit to the February 2026 meeting.

7 REHABILITATION THERAPIES 12M REPORT

The Committee received the Rehabilitation Therapies 12 Month Report presented by Ms MacGregor who provided an overview and highlighted the key areas for the benefit of Committee members.

Mr McConnell thanked Ms MacGregor for the report and asked if the introduction of the Women's Service and reconfiguration of services would have benefits across the broader service in the hospital. Ms MacGregor replied that the Allied Health Professions assessment and treatment pathways were still in development and emphasised that collaborative working across professional teams would be essential in shaping and delivering the Women's Service.

Mr Jenkins noted the report highlighted that staffing stability had a direct impact on service delivery and asked if there was an alternative plan if staffing did not reach full complement by the end of the year, as anticipated. Ms MacGregor advised that significant work had been undertaken in relation to recruitment, including role promotion internally and externally, and strengthening links with Higher Education providers. She expressed her view that these efforts were reflected in the positive response to recruitment.

Mr Moore thanked Ms MacGregor for her report and commended the increase in the number of Intellectual Disability patients accessing sessions at the Skye Centre, as well as the amount of hub and weekend activity. He asked if the matter concerning the use of the Assessment of Motor and Process Skills (AMPS) tool was resolved. Ms MacGregor replied that she had been informed another business may be assuming responsibility for the AMPS tool, and should this transition occur, its use could potentially be reinstated.

Ms Fallon thanked Ms MacGregor for the comprehensive report and welcomed the introduction of the Self-Assessment Tool. Ms Fallon noted that it would be useful for future reporting to the Committee to include an assessment on the impact of the tool.

Actions:

1. The content of future reports should be focussed around the rehabilitation of the patients

rather than the department and staffing.
2. Whilst the current staffing position is very good, it was recognised that this was likely to be a recurrent problem and a back-up plan should be developed.
3. The Skye Centre plays a significant part in rehabilitation and an activity improvement plan should be developed.

The Committee:

1. Noted the Rehabilitation Therapies 12 Month report.
2. Requested future reporting on the Self-Assessment Tool.

8 PATIENT LEARNING

Committee members received the Patient Learning 12 Month Report and Ms Dunlop and Ms McHugh joined the meeting. Ms Dunlop presented a summary of the key achievements for the period January-December 2024. Ms Dunlop highlighted that the Patient Digital Inclusion Project was unable to progress in 2024 due to concerns raised by the Security Department.

Mr Currie commended the innovative strategy used to engage hard-to-reach learners and asked Ms Dunlop how the success of this strategy would be measured. Ms Dunlop explained that learners are screened at the start of their programme to determine their baseline core skill levels. Based on this assessment, their learning is structured to improve these skills, with the aim of accreditation through formal qualifications.

Mr Moore thanked Ms Dunlop for the report. Regarding the Digital Inclusion Project, Mr Moore asked that the Committee be kept appraised on any significant developments. He asked if there was any update on recruitment of volunteers and Ms Dunlop advised that there were some challenges recruiting volunteers, with only one currently, who supported the Patient Learning Centre. Ms McHugh added that one candidate had noted their interest presently.

The Committee:

1. Noted the Patient Learning 12 Month Report.

9 DUTY OF CANDOUR ANNUAL REPORT 2024/25

The Committee received the Duty of Candour (DoC) Annual Report from Dr Alcock, who provided an overview of DoC activity in 2024/25. He highlighted that while there was no specific timeframe for issuing a written apology for a DoC incident, the Lead Reviewer was required to meet with anyone identified as having experienced a DoC incident within 10 days. During this meeting, a verbal apology would be provided, followed by a written apology at a later stage.

Dr Alcock noted that the DoC Policy was due for review at the end of this month. New national guidance had been issued, and this would be incorporated into the revised policy.

Mr McConnell thanked Dr Alcock for the report and asked for clarity around the data for DoC incidents considered by the DoC Group. He noted a significant decrease in the number of incidents considered by the group in 2023/24 compared to the previous year, followed by an increase in 2024/25. Dr Alcock responded that in his opinion, this was random variation. Given that the data spanned three years and involved small numbers, he noted that it would be difficult to identify a trend.

Professor Thomson commented that if the number of DoC incidents was considered in the context of incidents throughout the hospital as a whole, it may appear proportionate. She suggested that Dr Alcock explore the data further for future reporting to the Committee.

Professor Thomson noted that, of the four DoC incidents investigated, one had been subject to an external review and this concluded that the issue in question was not a contributing factor. This has still to be considered by the DoC Committee. She further noted that the Scottish Government had provided guidance that DoC did not constitute an admission of wrongdoing and therefore it did not automatically imply that financial recompense would be required from the Board.

Mr Jenkins thanked Dr Alcock for his stewardship, highlighting the volume of work carried out in the background to review the 170 DoC incidents that had been reported.

Ms Fallon echoed Mr Jenkins commendation for the work carried out and thanked Dr Alcock for the report provided.

The Committee:

1. Noted the Duty of Candour Annual Report 2024/25.

10 PATIENT SAFETY PROGRAMME 12M REPORT

Members received the Patient Safety Programme 12 Month Report presented by Ms McCaffrey, who provided an overview and summarised the core activities of the Patient Safety Forum in the last 12 months.

Mr Jenkins welcomed the report and thanked Ms McCaffrey for the level of detail it covered. In relation to the Quality of Care Reviews, Mr Jenkins asked if data were collated and reported nationally. Ms McCaffrey explained that each NHS Board currently submits its own “Excellence in Care” data to Public Health Scotland. However, initial discussions had taken place with the Scottish Executive Nurse Directors (SEND) to establish if there was an appetite to consolidate this data across all NHS Boards. Once a clear position was established, Ms McCaffrey would provide an update to the Committee.

Mr Moore commented that he found the structure of the report helpful and asked if Ms McCaffrey could provide some context around the five outstanding recommendations in relation to the previous “Rights, Risks, and Limits to Freedom” document published by the Mental Welfare Commission for Scotland. Ms McCaffrey explained that the recommendations related to revision of the Mechanical Restraint Policy and that work was ongoing to conclude this piece of work. Ms Fallon requested that this was added to the Rolling Actions List to provide feedback to the Committee at its next meeting.

Action: Secretariat

Ms Fallon welcomed the report and asked Ms McCaffrey whether it might be premature to consider the debrief guidance as good practice, given that a standalone debrief guidance document was in development. Ms McCaffrey replied that she would like it to be fully embedded in practice first as it had only been tested in identified wards. Ms Fallon also requested that an update on peer reviews was included in the next report to the Committee.

Action: Ms McCaffrey

The Committee:

1. Noted the Patient Safety 12 Month Report.
2. Mechanical Restraint Policy update to be added to the rolling action list for feedback at the next committee.
3. Requested an update on peer reviews in future reporting to the Committee.

11 DAYTIME CONFINEMENT

The Committee received the Daytime Confinement (DTC) report, presented by Ms McCaffrey who highlighted the significant reduction in the use of DTC. She attributed this change primarily to a shift in staff mind-set, where DTC is no longer seen as the default response during periods of service pressure. Ms McCaffrey also emphasised the importance of effective operational management and ongoing evaluation in maintaining the reduced levels of DTC.

Ms McCaffrey noted that there may be a slight increase in DTC once staff in the Women's Service who were currently redeployed across the hospital returned to their posts. However, a recent recruitment campaign had been successful and newly appointed Band 5 nursing staff were due to on-board between September and October.

Mr Jenkins thanked Ms McCaffrey and all who had contributed to the work in eradicating DTC.

Ms Fallon echoed Mr Jenkins commendations for the work in relation to DTC and thanked Ms McCaffrey for her report.

The Committee:

1. Noted the Daytime Confinement Report.

12 INFECTION PREVENTION AND CONTROL REPORT

The Committee received the Infection and Prevention Control (IPC) Report and Mr Lee joined the meeting. Mr Lee summarised the key points in the report for the benefit of members.

Mr Lee noted that the new IPC audit and inspection programme was now fully underway. The IPC Team was pleased with the ongoing findings and results and was using this data to refine the audit and inspection process. Mr Lee also informed members that TSH IPC guidance continued to be reviewed and updated with a more proactive move to national guidance.

Ms Fallon thanked Mr Lee for his comprehensive report and commented that she appreciated the links to the Health Improvement Scotland IPC Standards.

Mr Jenkins expressed his appreciation for the work carried out by Mr Lee since he had taken up post, noting in particular the positive impact he had made in practical leadership of infection prevention and control across the hospital.

The Committee:

1. Noted the Infection Prevention and Control Report.

13 BED CAPACITY REPORT AND APPENDIX 1

Members received the Bed Capacity Report presented by Professor Thomson who provided an overview and noted that although bed capacity was tight, it was manageable.

Professor Thomson highlighted that TSH was currently operating at a rate of 89.2% bed occupancy, with beds full in Treatment and Recovery and Transitions. She reported that the time between admission and referral for admissions within the reporting period was within 6 weeks, except for one case where there was a disagreement as to the level of security, and this progressed to Stage 1 of the Forensic Network Conflict Resolution Process.

Ms Fallon 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 for the benefit of the Committee. Mr Hardy highlighted that an additional Corporate Risk had been added in relation to the impact on patients within the Women's Service if the long term model was not implemented. The current rating for this risk was medium and it would continue to be monitored.

Mr McConnell thanked Mr Hardy for the update and asked why there was not a risk related to the Interim Women's Service. Mr Hardy replied that now the Interim Service was operational, its risk of being unable to deliver the care required was comparable to that of other services across the hospital. He explained that as the service became operational, any identified risk areas would be managed appropriately, and a new risk created if necessary.

Mr Currie highlighted the usefulness of including the timing of upcoming reviews and the monitoring frequency in Appendix 1 of the report. He referenced Mr McConnell's comment in relation to the risk for the interim Women's Service, noting that the Women's Service Project Oversight Board had an ongoing role in reviewing any emerging risks to determine whether escalation to the wider governance structure was required.

The Committee:

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

15 SPECIFIED PERSONS REPORT 2024/25

Committee members received the Specified Person's Report 2024/25 and Mr Hardy noted that this Report was previously submitted to the Board for approval, however it had been agreed that it would be more appropriate to remit this item from the Board to this Committee.

Mr Hardy outlined they key points in the Report for the benefit of members, noting that reporting as set out was a requirement by Scottish Government. There was discussion around whether further information should be added in respect to the use of CCTV, and Mr Jenkins confirmed that he would liaise directly with Mr Hardy on this point, prior to submission of reporting.

Action: Mr Jenkins / Mr Hardy

Professor Thomson asked in terms of governance of the process, if a more detailed account should be provided to the Scottish Government in the Report, such as including feedback on any restrictions applied. Mr Hardy advised that the Scottish Government do not request this level of detail, however this information was available if required. Professor Thomson added that detailed data on restrictions were included in the Incidents and Patient Restrictions Report to the Committee, and members were content to agree that this provided assurance for governance purposes.

The Committee:

1. Endorsed the Specified Persons Annual Report for submission to the Scottish Government, subject to any refinements made in relation to CCTV Surveillance.

16 INCIDENTS AND PATIENT RESTRICTIONS Q1

Committee members received the Incident and Patient Restrictions Quarter 1 Report and Mr Hardy provided a brief overview of incident and patient restriction activity as detailed within reporting.

Mr Moore made reference to the ligature incident recorded in the report and asked if there was a risk of serious harm, had the patient not alerted staff i.e. whether there was anything within the patient's room that would have posed a ligature risk, and if so, whether steps could be taken to remove it. Mr Hardy confirmed that no additional ligature points were found in the room beyond those present in all patient bedrooms. On this point, Professor Thomson advised that while significant care and attention was given to managing the risk of self-harm within the hospital, it was impossible to eliminate the risk entirely. Proportionality had to be maintained, as even in a completely stripped-down room, patients may still find unexpected ways to harm themselves.

Mr Jenkins agreed with Professor Thomson's point and advised that he had a discussion with the Health and Safety Advisor regarding the ligature-risk process within all wards and departments and had assurance that risk-assessment processes were in place to identify all risks surrounding patients and their environment, and that staff act in accordance with these assessments.

Mr Jenkins also requested that in relation to presentation of the report going forward, in 'Table 1: Patient Restrictions Trend Analysis', the percentages recorded for urinalysis in previous quarters were marked as not applicable, as reporting 0% would be inaccurate, given that urinalysis was not in use at the time.

Action: Mr Hardy

Professor Thomson further noted that the layout of the report would be reviewed by the Serious Adverse Event Review (SAER) Group to ensure the report provided clear assurance.

Ms Fallon thanked Mr Hardy for his report.

The Committee:

1. Noted the Incidents and Patient Restrictions Q1 Report.

17 LEARNING FROM ADVERSE EVENTS

Members received the Learning from Adverse Events Report relating to Serious Adverse Events Reviews (SAERs) and Mr Hardy highlighted that only one live investigation was ongoing and that this was a DoC Incident. Mr Hardy noted that many of the actions in the report had been reviewed at last week's Organisational Management Team (OMT) meeting.

There was discussion about the content of the paper, and the level of assurance provided to the Committee. Mr Jenkins noted the importance for this Committee to get this assurance, in terms of the appropriateness of the risk management approach within the hospital, and the delivery of the SAERs process. Further, that learning was being taken to mitigate risks going forward. He thought that this report should be refreshed to reflect this to ensure that future reports would provide succinct, meaningful information, and would clearly articulate learning.

Mr Moore and Mr Currie supported Mr Jenkins' view that the report was essential for this Committee, as well as his proposal to review the report content. Mr Moore highlighted that the Scottish Government had clear expectations in terms of timescales for completion of SAERs, and he also noted the importance of the Board being alerted to any learning issues. Mr Currie added that reporting should not be focused on operational management, and should be meaningful in terms of the learning taken from SAERs.

There was agreement around the table to this position, and Ms Fallon thanked Mr Hardy for his report and for the useful discussion this had generated.

Action: Mr Hardy

The Committee:

1. Noted the updates in the Learning from Adverse Events Report.
2. Agreed on revision of the report as discussed.

18 LEARNING FROM COMPLAINTS AND FEEDBACK Q1

Members received the Learning from Complaints and Feedback Report Quarter 1 Report presented by Ms Smith who noted that there had been an increase in complaints received in the last quarter. Most were closed at Stage 1, and there had been a positive improvement in timescales for resolving Stage 2 complaints, with most being resolved within 20 working days.

In terms of the outcomes of complaints, these was a balance in complaints upheld, partially upheld, and not upheld, and Ms Smith felt that this demonstrated a thorough investigation process and consideration of the patients' perspective.

Ms Smith noted that of complaints raised in relation to staff attitude/behaviour/conduct, most were not upheld, however two were partially upheld. She believed that this showed good reflection at ward level in acknowledging that immediate management of the situation may not have been as effective as it could have been. Ms Smith noted the positive feedback received from patients in relation to the TSH3030 project as well as the changes that had been implemented within the Shop in relation to the display of pricing.

In response to Mr Currie's question regarding the 22 complaints supported by the Patient's Advocacy Service (PAS), Ms Smith clarified that PAS had supported 22 patients in submitting complaints, and she agreed to adjust the wording in future reports to make this clear.

Action: M Smith

Mr Currie asked whether any learning from complaints regarding staff attitude and behaviour could be incorporated into the induction process for new staff, potentially through the use of case studies to explore how they might respond in similar situations**.** Ms Smith outlined the links in place with the staff induction process, through the presentation on NHS Values and Behaviours, and noted that she would consider the use of case studies. She also explained that feedback on complaints is sent to Charge Nurses and Senior Charge Nurses so that they can address any issues locally.

Dr Flynn commented that progressing the trauma-informed agenda more widely may feed into attitudes and behaviours from staff.

Ms McCaffrey noted that work was ongoing on development of Senior Charge Nurses and Charge Nurses in how they use feedback from complaints to steer staff practice. She added that she was cited on the work of the Patient Centred Improvement Group and any themes from feedback and complaints were addressed. Lastly, Professor Thomson commented on the way that the main issues raised were grouped within reporting, noting that it may be helpful to re-frame these to give additional clarity on how many complaints overall related to staff attitude and behaviour.

The Committee:

1. Noted the Learning from Complaints and Feedback Q1 Report.

19 DISCUSSION ITEM: CLINICAL CARE OF WOMEN'S SERVICE

Dr Howitt joined the meeting and presented an overview of the challenges faced in setting up the Interim Women's Service, and the progress made to date. She outlined future plans for development of the service and highlighted the risks that may be encountered as the service evolves.

Mr Jenkins thanked Dr Howitt for her presentation and commended all involved in developing the service. He noted that he was reassured that the risks identified were consistent with those which had already been highlighted and extended his support to Dr Howitt as the service developed further.

Mr Currie conveyed his thanks to all involved in development of the service. He recognised that, while the implementation of the service may present certain risks and challenges as it evolved, these experiences would be valuable in shaping and refining the strategic direction for Phase 2.

Professor Thomson added her thanks to Dr Howitt and the wider team involved in development of the service. She highlighted the importance of staff development sessions so that staff in the service have dedicated time and a structure to develop their skills.

Professor Thomson also highlighted that the Outreach Service would be engaged going forward with Medium Secure settings. Dr Howitt explained that this was a pilot of the Outreach Service and differed from the formal model that would be implemented in the future. Dr Flynn commented that the Outreach Service would be psychology-led and that there was a meeting with stakeholders scheduled next week to discuss expectations for the service.

Ms Fallon thanked Dr Howitt for her presentation and commended the significant work that had been undertaken in a short space of time. She welcomed future updates to the Committee to share learning and development.

The Committee:

1. Noted and discussed the content of the presentation.

20 AREAS OF GOOD PRACTICE / CONCERN

Ms Fallon highlighted that the involvement of patients in the development of the Participant Information Sheet Template outlined in the Research Committee Annual Report was an area of good practice. She added that the Committee should remain mindful of the debrief guidance, as this may constitute an area of good practice in the future.

No areas of concern were noted by the Committee.

21 COMMITTEE WORKPLAN 2025

The Committee reviewed and agreed the work plan for 2025. Ms Fallon noted that the Clinical Model Research Findings, Grounds Access Re-audit, and Patient Learning Digital Inclusion should be added to the work plan for the February 2026 meeting.

Action: Secretariat

Professor Thomson noted that reporting arrangements for Women's Service should be added to the work plan.

22 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Ms Fallon noted that the Soft Restraint Kit Audit would be available for discussion once this had been reviewed by the Audit and Risk Committee. She added that she would share the research study on staff experience from a clinical student to newly qualified practitioner with Ms Radage, as this would be relevant to the Staff Governance Committee.

23 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

Professor Thomson suggested a presentation on the Intellectual Disability Service, and this was agreed by the Committee.

Action: Secretariat

24 ANY OTHER BUSINESS

There was no other business raised at the meeting.

23 DATE OF NEXT MEETING

The next meeting would be held on Thursday 13 November 2025 at 9.30am.

The meeting concluded at 1.15pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 2025
Agenda Reference:	Item No: 14ii
Author(s):	Corporate Business Manager
Title of Report:	Clinical Governance Committee – Summary Report
Purpose of Report:	For Noting

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

1	Intellectual Disability Service (IDS)	The Clinical Lead for the Intellectual Disability Service provided a comprehensive presentation which highlighted its unique patient group with complex needs. The Positive Behavioural Support program had reduced incidents of violence, restraint, and self-harm. Challenges included bed capacity, patient mix and delayed discharges. Future priorities focused on improving grounds access, extending garden areas and creating sensory rooms. Referral pathways, financial pressures, and delayed discharges with plans for a capital proposal in 2026 were also discussed.
2	Daytime Confinement (DTC)	Reporting highlighted staffing pressures heightened by the launch of the Women's Service. Incident command training had been delivered, and feedback would be reviewed to strengthen operational management. Recruitment strategies and ongoing commitment to eradicate DTC were also discussed.
3	Learning Points from SAERS	Reporting outlined changes in the governance of SAERS to align with national reporting standards. The committee reviewed the oversight of SAERS across the governance framework committees and agreed for further discussion at the next Board Development Session.
4	Learning from Feedback and Complaints Report Q2	Reporting outlined performance indicators in the management of complaints as well as the main issues which had been raised and the learning taken and the large number resolved early resolution. The committee noted a low awareness of completing the "What Matters to Me Plan" collaboratively with patients and asked for this to addressed.
5	Bed Capacity Report	The report provided data across patient admissions and transfers, patient flow within services in TSH as well as across the wider forensic estate.

6	Clinical Care Policy Internal Audit Report and Review	Reporting noted the review and recommendations focused on improving practice and governance, with actions being monitored by the Patient Safety Group. The Committee welcomed the substantial assurance achieved by the audit.
7	Corporate Risk Register Incidents and Patient Restrictions Report Q2	The Committee reviewed the Corporate Risk Register – Clinical Risks and agreed that reporting represented an accurate statement of risk. Detailed reporting was received on all aspects of Incidents and Patient Restrictions. The Committee welcomed the revised reporting format and noted the high number of patients with grounds access and assurance provided, particularly Clinical Governance Group oversight, of operational issues.
8	Annual and Interim Reports: • Unscheduled Care 6M Report • Pre Transfer CPA/MAPPA 12M Report • CAP Forum 12M Report • PCIT 12 M Report • SHC 12M Report • PHSG 12M Report	The Committee received assurance reporting in the form of annual (12 Month) or interim 6 Month reporting as listed and there was detailed discussion around key factors in reporting. Members noted the approval of the Flow Navigation Centre pilot. 100% completion rate for transfer/discharge CPAs and an increase in carer attendance at CPAs. The raised profile of the person-centered agenda across the hospital and requested patient feedback incorporated into future reporting. Improved care planning and physical activity compliance, challenges with flu and COVID vaccine uptake and next year's priorities which included obesity prevention, audit implementation, and out-of-hours care review. Progress on the patient shop, though some restrictions remained, and plans for an EPOS system with an updated requested in 6 months.
9	Areas of good practice/concerns	The Committee noted good practice in terms of the high rate of ground access, transfers CPA completion rate and the patient Annual Physical Health Screening program.

RECOMMENDATION

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM **CF(M)25/04**

Minutes of the meeting of the Clinical Forum held on Monday 25 August 2025.

This meeting took place by way of MS Teams and commenced at 11:30am.

Chair:

Consultant Clinical Psychologist	Dr Joe Judge

Present:

Consultant Nurse	Dr Hamish Fulford
Dietitian	Diane Mullen
Acting Senior Charge Nurse	Craig Smith
Pharmacist	Ashleigh Wallace

In Attendance:

Consultant Forensic Psychiatrist	Dr Leanne Duthie (Item 5)
Personal Assistant	Vicky Gregg (Minutes)
Consultant Forensic Psychiatrist	Dr Shiela Howitt (Item 5)
Head of Corporate Governance	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Dr Judge opened the meeting and welcomed Mr Craig Smith, Acting Senior Charge Nurse representing the Skye Centre. Apologies were noted from Dr Stuart Doig, Consultant Forensic Psychiatrist representing the Medical Advisory Committee.

2 ELECTION OF VICE CHAIR

Ms Wallace expressed her interest in the role of Vice Chair. Dr Judge nominated Ms Wallace and there was agreement around the table to elect Ms Wallace as Vice Chair.

3 MINUTES OF THE PREVIOUS MEETING

The Forum approved the minutes of the previous meeting held on 11 June 2025.

4 MATTERS ARISING AND ROLLING ACTION LIST

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

In relation to Action No. 2, draft Terms of Reference (ToR) for the Nursing Advisory Group Ms Smith advised that work was ongoing with the Associate Nurse Director to develop the ToR and an update would come to the Forum in November.

The progress on Action No. 4, Forum ToR was discussed, with Ms Smith advising that experience in other NHS Boards was that it was clinical practice that defined membership, rather than direct patient contact. Ms Smith proposed that Mr Smith provide representation for other staff groups within the Skye Centre such as activities and support staff, and Mr Smith agreed to this proposal.

5 DISCUSSION ITEM: WOMEN'S SERVICE

Dr Howitt and Dr Duthie joined the meeting and Dr Howitt and presented a wide-ranging overview of the progress of the Women's Service to date. She highlighted that the Interim Service was originally intended to provide care to pre-trial and pre-sentencing female patients however its remit had been extended to encompass all female patients requiring high secure care. She added that capital funding would be required from Scottish Government for Phase 2 of the service and highlighted the potential risk if funding was not made available.

Dr Howitt noted that a patient had now been admitted to the service and that challenges had arisen around activity provision at the Skye Centre and attendance to the Multi-Faith Centre. She was exploring solutions around these issues and acknowledged that further challenges would likely arise as the service evolved.

Ms Wallace highlighted the importance of facilitating activities for female patients to prevent them from becoming isolated and she noted that in other secure services such activities were typically managed based on individual risk assessments.

Dr Judge echoed Ms Wallace's remarks and noted that it was important to ensure that female patients were treated equitably. He asked Dr Howitt if recruitment of internal staff to the Women's Service had affected the wider organisation, and Dr Howitt responded by saying that this had impacted staffing levels across the site overall, however newly appointed nursing staff were due to onboard in October.

He noted that implementation of Phase 2 of the service would result in the displacement of staff in the existing site. Dr Howitt advised that the options appraisal conducted encompassed looking at different configurations across the site, and that this would form part of any future business case in this respect.

Dr Howitt outlined future plans for the service and it was agreed around the table that she would return to the Forum in six months to provide an update.

Action – Secretariat

Dr Judge thanked Dr Howitt for her presentation and welcomed future updates to the Forum.

6 REVIEW /UPDATES FROM EACH GROUP/PROFESSION

(a) Medical Advisory Committee

Forum members received and noted the Medical Advisory Committee Meeting minutes from 9 June 2025.

(b) Psychology Professional Practice Group

Members received and noted the Psychology Professional Practice Group Meeting minutes from 14 August 2025. Dr Judge highlighted issues regarding recruitment and retention of psychology staff at a national level, and he also highlighted that Daytime Confinement continued to present challenges for psychology staff as they were frequently required to work in the wards or to take the emergency responder, due to staffing challenges within nursing.

Dr Judge queried if the Vice Chair of the Psychology Professional Practice Group, Dr Campell, would be expected to attend the Forum in his absence and Ms Smith clarified that while Dr Campbell could attend as a psychology representative, he would not be expected to chair the meeting, as that responsibility would fall to Ms Wallace in her role as Vice Chair.

(c) Nursing

Forum members received the Nursing Advisory Committee draft ToR. Dr Fulford advised that he

was content with the ToR and he would provide feedback as they continued to be developed. He was mindful of the role he had in the hospital within psychology, and that he was not in a position to represent the views of the entire Nursing Directorate at Forum meetings, pending further development of the Nursing Advisory Group.

(d) Allied Health Professionals

Ms Mullen informed members that the AHP Group had been continuing to develop their ToR and these were almost finalised. The group met last week, and Ms Mullen advised that discussions at the meeting had focused on Daytime Confinement and the resulting pressure on AHP staff. She noted that this was having an impact on their individual workloads, and that this was being monitored locally.

In relation to recruitment, Ms Mullen advised that a new Occupational Therapist (OT) had commenced post and would be working across the Transitions Service and Iona 2. She further advised that two additional OTs and an OT Support Worker were due to start in September.

Ms Mullen noted that the AHP Team had completed a wellbeing project for TSH3030 and were keen to continue this initiative. To support team morale, the group had agreed to meet informally once a month in addition to formal bi-monthly meetings.

(e) Pharmacy

Members received and noted the Pharmacy Group Update presented by Ms Wallace who highlighted the key aspects for the benefit of members. She noted that the Pharmacy Team had completed a TSH3030 project to encourage participation in a daily team walk, and even although the project had concluded, efforts were still being made to continue this practice to promote team morale.

She informed members that the Pharmacy Team recently had a productive Team Development Session where they had identified areas for improvement as a team, and defined their core team values as quality, dependable, respectable, approachable, and ambitious. She noted that a Reflective Practice session was planned to conclude their development work.

(f) Health Centre: Dentistry and Optometric

There was no representative from Dentistry or Optometric in attendance at this meeting and it was noted that efforts continued to be made to identify a representative.

Skye Centre

Mr Smith advised that the patient activity timetable had recently been adjusted to better accommodate staffing. He noted that four additional activity staff had been recruited, and he hoped to review the timetable early next year with a view to increasing patient activity sessions.

7 MINISTERIAL ANNUAL REVIEW

Ms Smith informed members that each year, the Board is held to account by Scottish Government for its performance against Key Performance Indicators. She explained that as part of this process, the Minister for Social Care, Mental Wellbeing and Sport would meet with the Board. This year the Minister was scheduled to visit in-person on 24 November 2025, and as part of that visit he would meet with the Clinical Forum.

Ms Smith informed members that a briefing outlining the activities of the Clinical Forum would be prepared for the Minister in advance, and that she would support the Forum with preparing the briefing. Dr Judge proposed that a meeting of the Forum was scheduled to prepare for the visit and that a Microsoft Teams channel was created to facilitate sharing of information amongst members. There was agreement around the table to this proposal.

Action: Secretariat

Dr Fulford noted that senior leadership within the hospital had regular communication with Scottish Government, and other individuals in non-leadership roles may not be aware of these interactions. He highlighted that this may indicate a disconnect in communication across the organisation and suggested the Forum could act as a mechanism to bridge this gap. In response to Dr Fulford's remarks, Ms Smith expressed her willingness to support efforts to enhance communication throughout the organisation.

Dr Judge noted to members that there was a national Area Clinical Forum Chairs Group and he had reached out to the Chair of this so that he could join this group, on behalf of the State Hospital. He also confirmed that he would seek engagement with the State Hospitals Board Chair to discuss the Forum's strategic alignment and relationship with the Board, and there was agreement around the table that this was a positive way forward.

8 ANY OTHER BUSINESS

There was no other business raised at this meeting.

9 NEXT MEETING DATE

The next meeting will be held on 27 November 2025 at 9:00am via Microsoft Teams.

The meeting ended at 12:35pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 2025
Agenda Reference:	Item No: 16
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 30 November 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

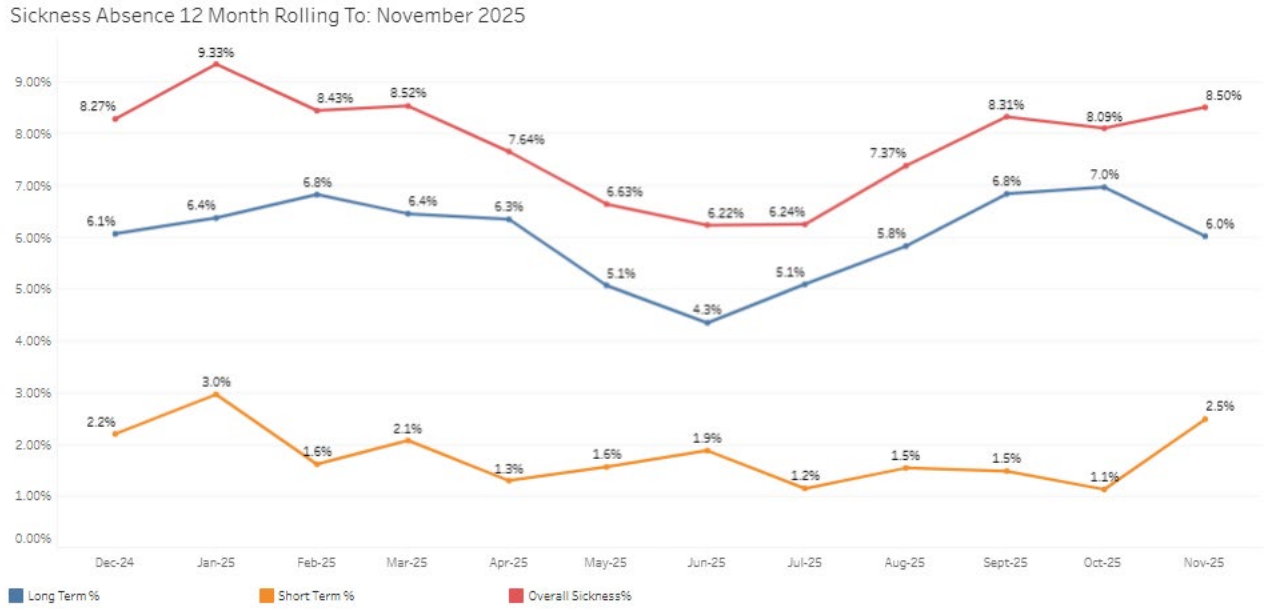
TSH Sickness Absence (Dec 24 to Nov 25)

Despite seeing a sustained improvement during the summer months, sickness absence remains a significant challenge for TSH as sickness absence begins to creep upwards towards winter.

From the June position of 6.22%, the lowest monthly absence figure since May 2022, there has been a steady increase in overall absence. However, in the month of November, Long Term absence decreased by 1% and short term more seasonal reasons impacted the slight increase in November.

The fall from the start of the year, a peak of 9.33% in January 25, to the low in June, and the subsequent increase, is illustrated in Graph 1 below:

GRAPH 1 – all staff



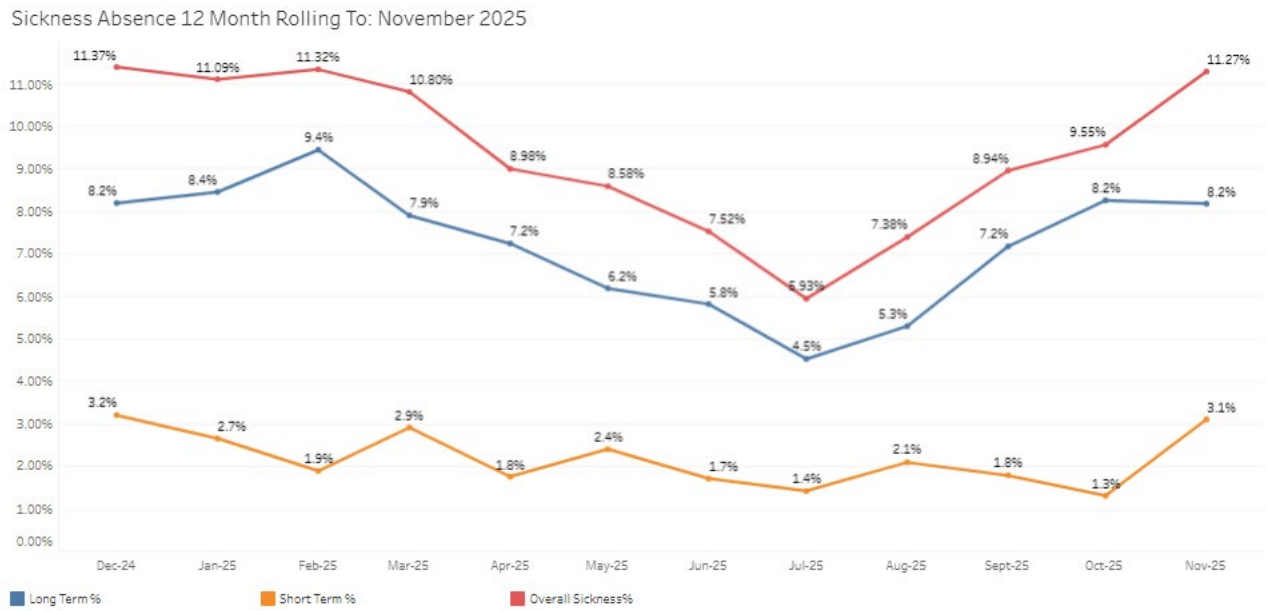
The main contributing factors to the increased absence figure is:

- Increase in Nursing (further illustrated in graph below)
- Seasonal trend (Cold, Cough and Flu – Gastro related absence)
- Increase in short term

Nursing Sickness Absence (Dec 24 to Nov 25)

The increase in absence is reflected in Nursing (from 6.93% in June to 11.27% in November) and ultimately this area remains the major challenge for TSH

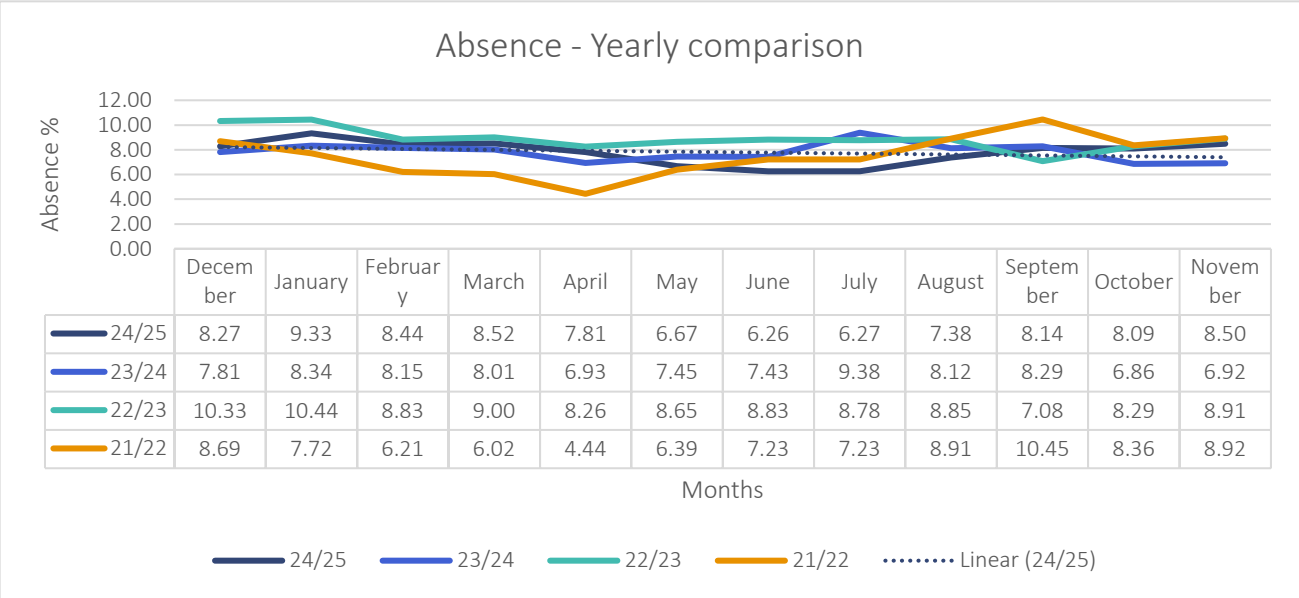
GRAPH 2 – nursing hubs



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.

Despite the recent increase, the current trend for this year, and actual position, leaves grounds for optimism in trying to set a lower benchmark (or starting point) from which we recognise that we need to manage and mitigate seasonal trends (including winter).



	December	January	February	March	April	May	June	July	August	September	October	November
24/25	8.27	9.33	8.44	8.52	7.81	6.67	6.26	6.27	7.38	8.14	8.09	8.50
23/24	7.81	8.34	8.15	8.01	6.93	7.45	7.43	9.38	8.12	8.29	6.86	6.92
22/23	10.33	10.44	8.83	9.00	8.26	8.65	8.83	8.78	8.85	7.08	8.29	8.91
21/22	8.69	7.72	6.21	6.02	4.44	6.39	7.23	7.23	8.91	10.45	8.36	8.92

ATTENDANCE MANAGEMENT OBSERVATIONS

Patterns/Trends for TSH:	The increase in absence is mainly related to Short Term with Long Term absence falling for the time in 4 months, This increase in short term absence accounts Cold,Cough and Flu and Injury/Fracture which can be related to the time of year.	
Identified Departments of Concern:	Lewis 3 Mull 1 Lewis 2	27.46% 20.84% 15.06%
Identified Departments of Improvement in November:	Arran 1 Iona 3 Psychology	19.89% to 14.39% 8.47% to 6.46% 6.41% to 3.01%
Reasons:	**Key reasons for long-term absence:** Anxiety/Stress/depression/other psychiatric illnesses, injury fracture, other known causes not otherwise classified, Gastro-intestinal Problems **Key reasons for short-term absence:** Cold, Cough Flu-Influenza, injury fracture Anxiety/Stress/depression/other psychiatric illnesses	
Activity:	At the time of reporting, for the month of November, 13 members of staff attended a Stage 1 meeting, and 2 members of staff attended a Stage 2 meeting.	

	Occupational Health issued 55 appointments in November 2025. Of all appointments issued, 37 were attended (67%), 12 were cancelled and 6 were DNA. Continued focus will remain on improving the attendance rate

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 earlier in this paper.

Sickness Absence Statistics by NHS Board

1st October 2024 - 30th September 2025

	Absence Rate		
	Total	Long Term[1]	Short Term[2]
Scotland	**6.37**	**4.04**	**2.33**
NHS Ayrshire & Arran	6.19	4.11	2.09
NHS Borders	5.60	3.17	2.43
NHS National Services Scotland	4.89	3.32	1.57
NHS 24	9.22	5.75	3.47
NHS Education For Scotland	2.39	1.58	0.81
Healthcare Improvement Scotland	4.16	2.64	1.52
Public Health Scotland	3.21	1.82	1.40
Scottish Ambulance Service	9.32	6.69	2.64
The State Hospital	7.47	5.56	1.91
National Waiting Times Centre	5.97	3.67	2.30
NHS Fife	6.85	4.59	2.26
NHS Greater Glasgow & Clyde	6.66	4.35	2.31
NHS Highland	6.11	3.68	2.43
NHS Lanarkshire	7.12	4.95	2.17
NHS Grampian	5.19	2.82	2.37
NHS Orkney	5.93	3.73	2.21
NHS Lothian	5.99	3.50	2.49
NHS Tayside	6.50	3.99	2.51
NHS Forth Valley	7.87	5.27	2.60
NHS Western Isles	6.19	3.78	2.40
NHS Dumfries & Galloway	5.76	3.39	2.37
NHS Shetland	4.66	2.47	2.19

The key challenge remains trying to get as close to 5% absence target, but also ensuring that lowest baseline Is set prior to the peaks of winter.

In order to support this, the regular planned activity will continue as we 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

Bespoke wellbeing provision has also increased to support the increase in Mental Health/Stress absence and will continue to focus on these areas through our dedicated pathways.

(b) RECRUITMENT / SUPERNUMARY STAFFING

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

TIME TO HIRE	TBC	Information unavailable at time of report production. Will be confirmed verbally
VACANCIES ADVERTISED	6 posts totalling 6 vacancies were progressed during September.	
NURSING RECRUITMENT	3 Band 5 Registered Nurses and 6 Band 3 HCSWs joined on 1 Dec; 2 more HCSWs start in Jan. 7 Band 5 Nurses and both the SCN and Charge Nurse posts are in pre-employment checks, with January starts planned.	
EMPLOYABLITY:	As part of our Workforce Plan and Anchor Strategy, we aim to increase the number of Modern Apprenticeships in the next 3 years. We encourage managers to consider whether their teams could accommodate a Modern Apprentice before roles are formally advertised.	

Since April 2025 there has been an ongoing increase in the reliance on additional hours. This is related to the recruiting for the Women's service, and the associated shortfall in establishment for existing posts.

OT & EXCESS	52.64 WTE (increasing from 39.13 WTE in April yearly low)
NURSING	37.12 WTE (increasing from 23.24 WTE in April yearly low)
SSR	9.69 WTE (Drop in October to 8.11 WTE but rose again)

(c) EMPLOYEE RELATIONS - LIVE CASES

The table below provides a summary of live ER Casework: -

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	2	0	0	3
Bullying & Harassment – formal	0	0	2	0	2
Grievance – formal	0	0	0	1	1
Whistleblowing	0	0	0	0	0

(d) LEAVERS

- There were 7 leavers in November 2025. 3 were from within the Nursing and AHP Directorate, 3 from Security Directorate and 1 from Finance & Performance Management Directorate.
- This totals 31 leavers YTD, turnover of 4.78% financial year to date.
- Of the 31 leavers this financial year, 13 had less than three years of service, 11 of these from nursing roles.
- Exit interview compliance within the current financial year is 41.93% with 13 out of 31 leavers completing this.

(e) JOB EVALUATION

Progress & Status – November 2025

Progress & Status

- One new job description received during November
- There was one panel held during November
- Three posts progressed to Quality Checking panel, three outcomes were given

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 a number of workforce 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

STAFF GOVERNANCE COMMITTEE **SGC(M)25/03**

Minutes of the meeting of the Staff Governance Committee held on Thursday 21 August 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
Non-Executive Director	Cathy Fallon
Board Chair	Brian Moore
Non-Executive Director	Shalinay Raghavan
In attendance:	
Joint Head of Organisational Development and Learning	Graeme Anderson
POA Representative	Alan Blackwood
Associate Director of Nursing	Josie Clark
Personal Assistant	Vicky Gregg [Minutes]
Chief Executive	Gary Jenkins
Clinical Services Manager, NHS Dumfries and Galloway	Leanne Keenan [Item 8.5]
Unison Representative	Anthony McFarlane
Head of Corporate Planning, Performance and Quality	Monica Merson
RCN Representative	Richard Nelson
Head of Human Resources	Laura Nisbet
Head of Corporate Governance	Margaret Smith
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone and noted that there were no apologies for the meeting.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The minute of the previous meeting held on 15 May 2025 was noted to be an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 15 May 2025.

4 MATTERS ARISING AND ROLLING ACTIONS LIST

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

Ms Fallon noted that e-rostering had been discussed at the last meeting and requested an update on progress. Mr Wallace advised that the system difficulties in terms of interfacing with payroll remained, and that he had met with the company responsible for working on the interface who were currently testing it for the staff bank within NHS Lothian and NHS Lanarkshire. He noted that the testing had gone well, although it was less complex than managing the substantive payroll. He added that it was anticipated a programme would be rolled out towards the end of the year and he had indicated that the State Hospital (TSH) would be happy to be one of the earliest Boards to trial this.

Ms Radage asked for a more formal update in relation to Action No. 4, succession planning, and Mr Wallace replied that work in relation to succession planning was ongoing and an update on the Continuous Improvement Plan was scheduled for the Board at its meeting in October. Mr Anderson noted that work on the Leadership Framework was also in progress and would be integrated as part of wider management and leadership commitments.

The Committee:

1. Noted the updates from the Rolling Actions List.

5 DISCUSSION ITEM: OD STRATEGY

Mr Anderson provided a brief overview of the Organisation Development (OD) Strategy. He noted that the key areas of focus over the next three years would be wellbeing, working environment, direction, and leadership and management, and consideration was being given to which of these priorities would be addressed first.

Mr Jenkins welcomed the progress made on the (OD) Strategy. He noted that the feedback received from staff and teams was more detailed and would enable a targeted focus on areas where a meaningful impact could be achieved.

Mr Currie thanked Mr Anderson for his report and work on the strategy. He asked how the data was tracked for assurance, and how the data was linked to decision making within the organisation. Mr Anderson explained that the data followed the five stages of the OD cycle, progressing from entry to conclusion, and this process would serve as a mechanism to continuously evaluate the strategy. Mr Jenkins added that collecting excessive data could lead to over-analysis and that key metrics should be prioritised.

Ms Radage asked what the next steps were in relation to the strategy, and Mr Anderson advised that structured development programmes at local, regional, and national levels would be arranged for leaders and managers, and they would be offered ongoing support. He further advised that a cultural assessment was being developed in collaboration with a third-party supplier.

Ms Fallon asked about how staff would be shown that their feedback was being acted upon, and Mr Anderson explained that this would be achieved by engaging with staff directly and involving them in developing solutions. He noted that it was essential to tackle management and leadership as they shape organisational culture and drive change.

Ms Radage thanked Mr Anderson for his overview and noted that that six-monthly updates would come to the Committee to monitor the progress of the strategy.

The Committee:

1. Noted the overview of the OD Strategy.

6 a) WORKFORCE PLAN SBAR
b) WORKFORCE PLAN 2025-2028

Committee members received the final draft of the Workforce Plan 2025-2028 presented by Mr Wallace who noted that relaxation of timescales from Scottish Government had afforded time for further engagement and consideration of the final draft of the plan. He highlighted that the plan aligned with the Board's medium-term plan and outlined the key actions planned over the next three years.

Mr Currie thanked Mr Wallace for the plan and was pleased to see the focus on demographics and age profile. He noted that the Workforce Plan had been in development for some time and asked if feedback would be provided on Workforce Plans from other NHS Boards as this would offer insight into staff movement across NHS Scotland.

Mr Wallace explained that Scottish Government did not require 3-year plans currently due to the level of change within the organisation, and offered assurance that this had not prevented work on Year 1 of the plan. He added that in terms of the Annual Delivery Plan, the majority of work had progressed and had been completed. In relation to feedback on Workforce Plans from other NHS Boards, Mr Wallace noted that the Workforce Plan briefly referenced collaboration with other NHS Boards, however its main emphasis was on the actions that could be undertaken locally.

Ms Fallon expressed her appreciation for the plan and welcomed the concept of identifying a Unique Selling Point for TSH, along with the focus on creating career development opportunities. She noted that there were currently no validated tools for assessing workforce or workload and asked if this was something NHS Education for Scotland (NES) was working on. Mr Wallace confirmed that NES was developing a workload tool and was working towards its release in October.

Mr Moore also welcomed the Workforce Plan and emerging action plan to address the key issues. He proposed that a self-assessment against the Scottish Nursing and Midwifery Taskforce Report was conducted as part of the Workforce Plan, to acknowledge that the Board had considered this report. He further proposed that the plan should proactively address potential challenges arising from the broader Workforce Reform Agenda that could impact the workforce moving forward.

Mr Jenkins agreed with Mr Moore and emphasised the need to be clear about the Public Service Reform Strategy in the plan. Regarding gender-mix, he noted that this should be linked to risk-assessments and the plan should be clear that the position on gender-mix would remain unchanged until significant work had been completed in this area. Mr Jenkins also highlighted the push to more regionalised and national working and suggested that a caveat should be included in the plan to reflect the workforce projections around this.

There was agreement around the table to endorse the content of the final draft of the Workforce Plan and Mr Wallace would refine the report based on discussions that had been held in this meeting.

<u>The Committee:</u>

1. Noted the Workforce Plan SBAR.
2. Endorsed the content of the final draft Workforce Plan 2025-2028.

7.1 a) WORKFORCE REPORT
b) EXIT INTERVIEW FINDINGS 2024-25

Committee members received the Workforce Report and Exit Interview Findings, presented by Ms Nisbet who provided an overview of the key aspects for the benefit of Committee members. She noted that there had been an increase in the reliance on supplementary staffing compared to previous reporting to the Committee in June which was directly linked to the number of registered

nurse vacancies currently, and it was anticipated that this would reduce again when newly appointed nursing staff on-board in October.

In relation to Employee Relation cases, Ms Nisbet noted that seven had been concluded since the last Committee. There were three cases currently, all within the six month target for conclusion. It was noted that there were further changes required to the data, in terms of the omission of a further cases and directorate breakdown of staff leavers, and confirmed that this would be amended.

Ms Nisbet had included a summary of annual feedback from exit interviews in her report and noted that work had been undertaken with national colleagues to compare response rates. The findings showed that TSH was in keeping with the smaller territorial and other special NHS Boards with a response rate between 20 to 30%, whereas larger territorial NHS Boards reported rates of less than 10%.

Mr Connor highlighted that five Charge Nurses who had been promoted internally were expected to take up their new posts in the coming weeks and queried if this would mean that Band 5 deficits would rise from 4.5 WTE to 9.5 WTE. Ms Clarke responded to Mr Connor's question, confirming this figure was accurate, and advised that the Lead Nurses were in the process of completing the necessary paperwork for recruitment to these vacancies.

Ms Fallon thanked Ms Nisbet for her report, particularly the feedback on exit interviews, and welcomed incorporation of the feedback into both the OD and Workforce Strategies. In relation to employees leaving before completion of their ER casework, Ms Fallon questioned what actions would be taken in relation to these individuals, expressing her concern that unresolved issues might persist if they were to join another organisation. Ms Nisbet advised that that each case was handled with care and tailored to individual circumstances and clear communication was provided at the point of leaving that a note would be retained in the individuals Human Resources (HR) file and their ER case may be referenced in any future employment verification.

Mr Jenkins commented that it had been agreed at a previous Committee meeting that upon conclusion of an ER case where the investigation had taken some time, he and Mr Connor would conduct a review of the timelines to see if there were any missed opportunities. He proposed that he and Mr Connor review the seven cases that had concluded and provide a report to the next Committee.

Action: Mr Jenkins / Mr Connor

Ms Radage thanked Ms Nisbet for her report and asked if there was a higher uptake of exit interviews when they had been conducted face-to-face. Ms Nisbet agreed to review the data to explore this further.

Action: Ms Nisbet

<u>The Committee:</u>

1. Noted the Workforce Report and Exit Interview Findings 2024-25.
2. Agreed for further reporting to return as noted within the discussion.

7.2 MAXIMISING ATTENDANCE REPORT

Members received the Maximising Attendance Report presented by Mr Wallace who outlined the key areas for the benefit of members. He noted the positive position in relation to sickness absence, particularly within the nursing cohort, where the rate had reduced to 6.28%. He added that they key aim moving towards the winter months would be to maintain absence levels and ensure the baseline remained as low as possible.

Mr Wallace noted the improvement in the national position for sickness absence and highlighted that figures varied slightly in national reporting as a different attendance management system was used. He indicated that he hoped to provide the Committee with an update in November regarding the pathways available to staff to support access to work.

Mr Currie thanked Mr Wallace for the positive report and was pleased to see the downward trend in long term absences. He asked if there had been success supporting staff to return to work in alternative roles and also asked around preparations for the flu vaccine. Mr Wallace explained that there had been success in supporting staff back to work on alternative duties and that staff had also been supported with phased returns and redeployment. He noted that he and Ms Nisbet would consider how to capture this information in future reporting to the Committee. In relation to the flu vaccine, Mr Wallace acknowledged that communication around the vaccine needed to be more effective moving forward.

Mr Anderson highlighted that certain elements of the OD Strategy, such as the cultural assessment, would contribute to building a clearer understanding of sickness absence and its underlying causes, enabling more targeted interventions.

Ms Radage thanked Mr Wallace for his report and asked if there was any early feedback from managers in relation to the attendance management measures that had been implemented. Ms Nisbet noted that managers had welcomed the support that had been offered. Mr Anderson commented that Workforce Plan emphasised a move towards a business partnering approach within the workforce function and this would be key to empowering managers to take proactive steps in addressing sickness absence.

The Committee:

1. Noted the Maximising Attendance Report.

7.3 HEALTH AND CARE STAFFING REPORT

The Committee received the Health and Care Staffing Report and Ms Clark presented an update on work undertaken during Quarter 1 of 2025. She noted that Duty 121L, Training and consultation with staff, was progressing to “substantial assurance” and a small multidisciplinary team had been established to support rollout of the revised Mental Health and Learning Disability Workload Tool and SafeCare platform. SafeCare had been introduced in Mull and Lewis Hubs and the intention was to rollout to Arran and Iona Hubs by October. Ms Clark added that she and the Director of Nursing and Operations were liaising with Healthcare Improvement Scotland in relation to the Workload Tool.

Ms Clark noted that there were challenges nationally around the Medical Professional use of SafeCare due to the complexity of their terms and conditions and the Associate Medical Director was liaising with HR regarding this.

Ms Fallon thanked Ms Clark for the report and commended the progress that had been made towards “substantial assurance”. She asked for clarification on Duty 121H, Duty to ensure adequate time given to clinical leaders, and Ms Clark advised this was in relation to allowing leaders time for development.

Mr Moore thanked Ms Clark for her report and asked about the anticipated benefits of implementing the SafeCare platform. He further suggested that it would be helpful to include the expected benefits in future quarterly reports. Ms Clark responded that multiple platforms were currently used to record staffing and staff movement and that the implementation of SafeCare would reduce the administrative workload by consolidating these processes. She agreed to include an assessment of the impact of introducing SafeCare in the Health and Care Staffing Report to the Committee in November.

Action: Ms Clark

Mr Jenkins noted that whilst the Health and Care (Staffing) (Scotland) Act 2019 remained a statutory piece of legislation, it would be useful to revisit the Act to refresh understanding of its original purpose and consider its ongoing relevance and applicability.

Ms Radage Ms Clark for her report and the usefulness of the information contained within it.

The Committee:

1. Endorsed the Health and Care Staffing Report.
2. Requested updated reporting to the Committee in November.

7.4 a) WORKFORCE EQUALITIES UPDATE
b) EQUALITIES APPROACH AND PLAN

Committee members received the Workforce Equalities Update and Equalities Approach and Plan presentation. Mr Wallace highlighted that the work of the Workforce Equalities Group was mainly focused on the lived experience survey, and he had included a summary of the survey feedback in the Equalities Approach and Plan presentation. He noted that feedback was largely positive however it had highlighted concerns around the culture of the organisation and indicated that some individuals were apprehensive about speaking up.

Mr Wallace highlighted the key priorities that would shape the Equality Plan and advised that an Action Plan had been drafted. Mr Jenkins noted that the Action Plan would have to be agreed by the Corporate Management Team (CMT) and proposed that Executive Directors take some time as a group to work their way through the feedback and formulate the Action Plan before bringing it back to Committee, and there was agreement around the table to this proposal.

Ms Raghavan commended Mr Wallace, and all involved in the Workforce Equalities Group, noting that the lived experience survey offered valuable, unfiltered insights from participants.

Ms Radage asked if feedback had been provided to survey respondents and this generated a broader discussion around the table about exploring new methods for sharing feedback and learning, and Mr Jenkins suggested developing a more integrated shared intelligence report to capture wider organisational themes. Mr Wallace noted that the Workforce Equalities Group would address these matters at their next meeting

The Committee:

1. Noted the report.

8.1 WORKING ENVIRONMENT

Mr Wallace provided a brief update on the safe and continuously improving working environment workstream and proposed that regular reporting comes to the Committee for assurance. There was agreement around the table to Mr Wallace's proposal and a report would come to the Committee in November.

Action: Mr Wallace

The Committee:

1. Noted the working environment update.
2. Agreed reporting on the working environment should come to the Committee for assurance and requested a report to Committee in November.

8.2 NON-EXECUTIVE WALKROUND FEEDBACK

Members received the Non-Executive Walkround Programme paper. Ms Smith noted that the programme was re-started in December 2024 and there had been four walkrounds to date, in both clinical and non-clinical areas. She provided an overview of the feedback received, noting that staff had appeared to be keen to engage in the walkrounds, and to have an opportunity to discuss the work that they do, or highlight any areas of concern.

Ms Smith outlined the proposed next steps for further development of the programme, as detailed within reporting.

Mr Jenkins commented on the benefit of these walkrounds, and suggested a shared learning report would enable more targeted actions during walkrounds, contributing to a broader overview of themes and patterns across different areas.

Ms Fallon thanked Ms Smith for the report. She welcomed the suggestion of a feedback loop to senior leaders and that this could be discussed further at a Board Development Session. Ms Fallon also suggested that Non-Executive Directors' visibility could also be increased if walkrounds were undertaken at the weekend.

Mr Moore noted the improvement on previous walkrounds which had been clinically focused. He suggested that walkrounds were widened to other departments such as psychology and further suggested an annual report or communication to demonstrate that staff feedback was being taken seriously and to establish a feedback loop.

Mr Currie noted that prior to visiting areas or department Non-Executives members may find it helpful to receive a briefing to help them understand the issues that were likely to be raised.

Mr Blackwood added that from a staff side perspective he was pleased to see Non-Executive engagement at shop floor level, and welcomed this initiative.

Ms Smith thanked everyone for their helpful suggestions and it was agreed around the table that further consideration of this workstream this would be added to the next Board Development Session.

Action – Ms Smith

Ms Radage thanked everyone for their contributions to an interesting discussion, adding that it was good to see the amount of pride staff demonstrated.

The Committee:

1. Noted the Non-Executive Director Walkround Programme feedback.
2. Requested further consideration at the next Board Development Session.

8.3 CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

The Committee received the report on Corporate Risk Register – Clinical Risks from Mr Wallace who provided an update on the progress of the five active risks within the Register. He noted that the risk in relation to the Protecting Vulnerable Groups (PVG) Scheme was reduced to Medium in August 2025 and there were three outstanding applications to be shared, which would be followed up by HR.

Ms Fallon and Mr Jenkins commended Mr Wallace and all involved for the work done on PVG.

The Committee:

1. Endorsed the Corporate Risk Register – Staff Governance Risks as an accurate statement of risk within this remit.

8.4 NURSE PRACTICE DEVELOPMENT UPDATE

The Committee received the Nurse Practice Development presented by Ms Clark who outlined the key priorities in the coming year including a one-year evaluation of the Critical Care Policy.

Ms Fallon thanked Ms Clark for the update and commented that it was good to see that every new staff member was allocated a clinical supervisor. In relation to the training needs analysis, Ms Fallon asked whether expectations were being raised that could not be met. Ms Clark replied that she was mindful of this and was looking at how training could be incorporated into the existing Newly Qualified Nurse induction programme.

Mr Connor asked for clarification around staff choosing their own clinical supervisor and how many clinical supervision sessions took place. Ms Clark explained that in the first year a supervisor was allocated to new staff, and for subsequent years the option was to swap supervisor. In relation to clinical supervision sessions, she advised that sessions were not mandated or recorded and acknowledged the need to address this going forward.

Ms Radage thanked Ms Clark for the update.

The Committee:

1. Noted the Nurse Practice Development Update.

8.5 OCCUPATIONAL HEALTH ANNUAL REPORT AND PRESENTATION

Ms Keenan joined the meeting and presented the Occupational Health Annual Report and summarised the key achievements for the benefit of Committee members. She highlighted that the quality of referrals from line managers at TSH had improved through targeted questions which had supported timely occupational health advice and outcomes. She also highlighted the reduction in non-attendance at appointments, and the reduction in case review appointments, which she believed represented growing confidence in case managers.

Ms Keenan noted that the primary reason for absence was due to reduced psychological wellbeing, with anxiety and stress non-work related factors cited. Correspondingly, referrals to the psychological therapies service had increased significantly in the first six months of 2025. She added that three flu vaccine clinics had been set up in October.

Ms Fallon thanked Ms Keenan for the report and asked if the e-rostering system allowed flexible working going forward. Ms Nisbet responded to Ms Fallon, confirming that the system would enable flexible working and would allow managers to have diverse working arrangements embedded in the rules within the system. She noted that there would be some challenges in implementing flexible working for nursing staff and this was due to their fixed roster patterns, rather than limitations of the rostering system.

Mr Jenkins thanked Ms Keenan for the report and commended the connectivity in introducing a single system for managing referrals. He asked if there was any additional wellbeing support that could be offered by TSH, and also asked any issues specific to TSH could be identified in comparison with NHS Dumfries and Galloway. Ms Keenan highlighted the growing challenges staff face in balancing work with increasing psycho-social pressures, such as caring responsibilities and family needs, and emphasised the importance of managers having robust and positive one-to-one sessions with staff to understand their personal circumstances. She added that issues experienced

by staff at TSH were similar to those encountered in NHS Dumfries and Galloway.

In relation to the care management Key Performance Indicator (KPI) of seeing staff within 20 working days, Mr Moore asked if consideration should be given to seeing staff earlier and if this would have an impact on care management. Ms Keenan responded that, in her view, this would be beneficial and she would hope to align TSH with the NHS Dumfries and Galloway target which had been reduced to 15 days.

Mr Currie welcomed the report and commended the significant progress made in enhancing staff confidence in engaging with the Occupational Health Service.

The Committee:

1. Noted the Occupational Health Annual Report.

9.1 OD LEARNING AND WELLBEING REPORT

The Committee received the OD and Wellbeing Report and Mr Anderson outlined the key areas for the benefit of members. He noted that PDPR completion rates had remained high at over 90% for two consecutive months, and that mandatory and statutory training also showed high completion rates. He added that 50% of Healthcare Support Workers had completed their induction, highlighting the need for improvement in the onboarding process.

Mr Anderson reported an increase in requests for team development sessions and noted that requests were made not only in response to team issues but also as a proactive measure. He added that planning was underway for the 2026 Staff Excellence Awards.

Mr Jenkins welcomed the report and commended Mr Anderson and all involved in the learning and wellbeing initiatives.

Ms Fallon echoed Mr Jenkins' commendation and asked if there should be concern about core training, in particular fire safety and manual handling, and Mr Anderson replied that OD was actively working to improve compliance rates.

Ms Raghavan thanked Mr Anderson for his report and asked if uptake of Time for Talking counselling sessions had been low as it was a relatively new service. Mr Anderson highlighted ongoing efforts to increase awareness and accessibility of the service through signposting and peer support network.

The Committee:

1. Noted the OD Learning and Wellbeing report.

10.1 PARTNERSHIP FORUM APPROVED MINUTES

The Committee received the approved Partnership Forum Meeting minutes from 22 April 2025 and draft meeting minutes from 3 June 2025. Ms Radage noted that the Partnership Forum Meeting in July was cancelled, and Mr Jenkins advised that this was due to the peak holiday period and that it had been agreed going forward that no meetings would be scheduled during peak holiday times.

In relation to the Partnership Forum Meeting minutes from 3 June, on page 6, Ms Fallon asked for clarification around the Operational Subgroup Minutes and the comment on unsafe/unacceptable practice forms. Mr Connor explained that the form was a staff side document designed to give staff a structured way to raise concerns and provide senior management with a process to follow to address these issues. He added that once the form was submitted, senior management were required to complete a report, which was then reviewed at the Operational Subgroup to identify

outcomes and capture any learning.

The Committee:

1. Noted the Partnership Forum Minutes.

10.2 WORKFORCE GOVERNANCE GROUP APPROVED MINUTES

The Committee received the approved Workforce Governance Group Meeting minutes from 13 May 2025 and draft meeting minutes from 15 July 2025.

Ms Fallon noted that concerns had been raised regarding the Staff Bulletin being outdated. In response, Mr Jenkins stated that this would be discussed during the next Board Development Session, with a focus on identifying what constitutes relevant and effective communication.

The Committee:

1. Noted the Workforce Governance Group Minutes.

11.1 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

The following areas were highlighted:

Ms Nisbet noted that the Non-Executive Walkrounds demonstrated an area of good practice.

Mr Moore highlighted the positive report received from Occupational Health and Mr Currie noted it would be good practice to link the investment in Occupational Health and other wellbeing services to the impact on sickness absence figures.

Ms Radage highlighted the OD Strategy and said that it was good to see all the elements coming together cohesively.

11.2 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Ms Radage noted that formal reporting on e-rostering would come back through the Audit and Risk Committee but should continue to be monitored by this Committee. Ms Fallon referenced feedback from the Non-Executive Walkrounds in relation to bed capacity in the Treatment and Recovery Service and suggested ongoing oversight of this issue.

12 ANY OTHER BUSINESS

There was no other business raised at the meeting.

13 DATE OF NEXT MEETING

The next meeting would be held on Thursday 20 November 2025 at 9.30am.

The meeting concluded at 12.33pm

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 2025
Agenda Reference:	Item No: 17ii
Report Author:	Head of Corporate Governance
Title of Report:	Staff Governance Committee – Summary Report
Purpose of Report:	For Noting

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

1	Staff Governance Monitoring Return	The Committee was asked to consider and approve the Staff Governance Monitoring Return, noting that it had been approved by the Partnership Forum earlier in the week. The Committee approved the return subject to some agreed amendments so that it could be submitted by the due date. The return reflected the wide range of workstreams underway during the 2024/25 year.
2	Corporate Risk Register Quarterly Update	Reporting detailed corporate risks assigned to the Workforce Directorate. The Committee agreed this was an accurate statement of risk and considered how to reflect any risks which may arise throughout each quarter so that this could be reflected accurately, acknowledging the importance of doing so within the context of the wider range of risks reflected overall in the Corporate Risk Register.
3	iMatter Annual Report	The Committee received reporting which summarised the iMatter results for the State Hospital, noting that further reporting would be presented at the next Committee based on the national context. The Committee considered how best to utilize the results to enable meaningful engagement with staff, and how to link this more directly to the Organisational Development (OD) and Wellbeing Strategy.
4	OD Learning & Wellbeing Report	Reporting highlighted improvements in compliance in statutory and mandatory training and a significant rise in staff excellence award nominations. Members emphasized the need for benchmarking compliance against national standards to provide context and provide assurance and incorporating qualitative insights into PDPR reporting to reflect staff experience into future reporting.
5	OD Strategy Update	Reporting noted progress on year 1 commitments which included the Culture Change Programme and the Leadership and Management Development Framework. The Committee welcomed the initiatives and the appetite for training and formally endorsed the Leadership and Management Development Framework. The Committee discussed the importance of ensuring that all staff felt included and able to benefit from the strategy and related workstreams.

6	Workforce Report	The Committee received reporting covering a wide range of workforce metrics. There was key focus on recruitment and retention of staff and recognition of the effort being made in nursing recruitment, and the success in this regard.
7	Maximising Attendance Update	Reporting summarised the position, noting that although there had been a rise in sickness absence over the last quarter, there had been improvement on a year-on year performance basis. Ongoing efforts focused on qualitative support such as reasonable adjustments and temporary duties. An audit of stress-related absences will be undertaken to identify root causes and guide interventions. The Committee suggested a similar audit for musculoskeletal-related absences and welcomed the inclusion of an employee story demonstrating effective support.
8	Healthcare and Staffing and eRostering Update	The Committee received quarterly assurance reporting in this respect, noting the continuing progress being made to make optimal use of e-rostering.
9	Working Environment Report	The Committee received a new form of reporting relating to the provision within the Staff Governance Standards to ensure that staff are provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and wider community. This was welcomed as being a helpful addition to reporting and which could be built upon going forward.
10	Once for Scotland Policies Update	The Committee received an update on the continued roll out of this policy framework, and how this is being implemented within the State Hospital.
11	Workforce Equalities Group Update	This report provided an update on the group which had been focused on the recent staff experience survey, and how to establish feedback loops with staff. For example, managers had been asked to open discussion through team business meetings. It was noted that a further update would come to the next meeting, including the related Action Plan.
12	Nursing Update	The Committee received reporting outlining the background to a new governance group to report to the Partnership Forum: Nursing Partnership Forum. This will provide a dedicated mechanism through which any concerns raised in partnership can be addressed noting recent challenges in staff resourcing and the need for continued focus on improving staff communication, and wider workplace culture.
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 / concern	The Committee noted the progress and range of initiatives being taken forward through the OD strategy and the positive impact being made as the strategy was operationalised. Further good practice was noted in the staff stories presented on enabling staff back to work, as well as the partnering approach taken by Human Resources to support line managers and teams. The audit work on root causes of illness, especially stress related and muscular-skeletal was also welcomed. Staff resourcing challenges were noted as an area that required careful monitoring.

RECOMMENDATION

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	18 December 2025
Agenda Reference:	Item No: 18
Sponsoring Director:	Acting Director of Security, Estates and Resilience
Author(s):	Head of Estates and Facilities
Title of Report:	Annual Climate Emergency and Sustainability Report 2024/25
Purpose of Report:	For Decision

1 SITUATION

Health Boards are required to report on an annual basis against the aims of DL (2021) 38 (A Policy for NHS Scotland on the Climate Emergency and Sustainable Development).

2 BACKGROUND

Scottish Government Health and Social Care Directorates supplied an approved template requesting Health Boards to submit their annual return for 2024/25. The template contains the following sections:

- Leadership and governance
- Greenhouse gas emissions
- Climate change adaption
- Building energy
- Sustainable care
- Anaesthesia and surgery
- Respiratory medicine
- Travel and transport
- Greenspace and biodiversity
- Sustainable procurement, circular economy and waste
- Environmental stewardship
- Sustainable construction
- Sustainable communities

The purpose of the report is to focus on the environmental performance of our organisation and allows the hospital to reflect on its performance against the standards and allows any outstanding actions or forward planning to be highlighted.

Throughout the report data is requested in tabular form, or by questions around ‘what we did last year’ and ‘what are we doing this year’ for each section.

3 ASSESSMENT

Completed Annual Climate Emergency and Sustainability Report for 2024/25 is attached.

The tables below contain the current modelling report for TSH's Net Zero performance on a BAU scenario.

As a Board the emissions have decreased by 82.5% against the baseline year 1993/94, which is within the 5-year 1990 Kyoto window.

Prior to 1993/94, the site was operated and maintained by the Department of Environment (DoE) on behalf of the UK Government and Scottish Executive.

NHS State Hospital							
CO2e Emissions Targets		**1993/94**	**2024/25 Reported Figures**	**2025 Interim Target**	**2030 Interim Target**	**2035 Interim Target**	**2040 Net Zero Target**
The New % Pathways to a 2040 Net Zero Outcome	CO2e Emissions Targets	Baseline	-65.5%	-65.5%	-75%	-87.5%	-100%
Target – Our Current Usage Trend will have to follow these trajectories	Tonnes	10,678	3,684	3,684	2,670	1,335	0
Actual and Predicted CO2e Emissions from now to 2040	Tonnes	10,678	1,900	1,653	1,446	1,332	1,264
CO2e Emissions – Current Pathway based on current anticipated energy use	Based on 1993/94 usage levels	-	-82.5%	-84.5%	-86.5%	-87.5%	-88.2%
Potential Shortfall			-17.0%	-19.0%	-11.5%	0.0%	11.8%

According to the data above, TSH is already 17% ahead of its Net Zero goal based on 2024/25 figures. To achieve the target for decarbonising heat sources, TSH will need to commission a feasibility study to evaluate options like ground source or air source heat pumps, as well as any other innovative technologies suited to the location. With a deadline of 2038, this work must be carried out within the next five to six years.

Additionally, renewable electricity options such as wind turbines and solar PV will be investigated as part of the same feasibility study during this period. As Net Zero strategies are developed over the next five to six years, suitable funding sources will also need to be secured so that TSH can adopt the necessary technologies for achieving Net Zero.

This year's priorities include creating and implementing a high-level waste route map, advancing initiatives for active travel, raising awareness of biodiversity and greenspace, and fully rolling out an Environmental Management System (EMS) for The State Hospital.

4 RECOMMENDATION

The Board are asked to approve the content of the Annual Climate Emergency and Sustainability Report for 2023/24 for submission to Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	To support the Climate and Sustainability Strategy and allow measurement towards our objectives in line with Scottish Government Objectives
Corporate Objectives Please note which objective is linked to this paper	a. Deliver programme of sustainable working and progress to net zero recognising the impacts of climate change and financial constraints.
Workforce Implications	None Identified
Financial Implications	None Identified
Route to Board Which groups were involved in contributing to the paper and recommendations.	CMT to Board
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	None Identified
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. 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.

Annual Climate Emergency and Sustainability report 2024/25 – for The State Hospitals Board for Scotland

Content Page

DATE OF ISSUE – NOVEMBER 2025

1. Introduction

This annual report covers climate emergency and sustainability for The State Hospitals Board for Scotland, a specialist NHS National Board providing forensic mental health care in a high-security environment. With 140 beds, it serves patients from Scotland and Northern Ireland at its South Lanarkshire site, employs approximately 650 staff, and manages 15 buildings across 63 hectares.

2. Leadership and governance

- The Board Sustainably Champion is Cathy Fallon, Non-Executive Director.
- The Executive lead is Allan Hardy, Acting Director of Security, Estates and Resilience.
- The Climate Change and Sustainability Group oversees sustainability at The State Hospital, reporting to the Security, Resilience, Health and Safety Oversight Group via the Director of Security, Estates and Resilience. Its role is to embed sustainability in hospital strategy and coordinate environmental, social, and economic initiatives. The Group ensures robust monitoring and review processes are in place, providing assurance to the Oversight Group about effective management within the Board.
- The Corporate and Operational Management Teams handle the day-to-day delivery of services. The Climate Change and Sustainability Group addresses strategic or company-wide matters, receiving reports from CMT only when necessary.

The Group is tasked with updating the State Hospital's strategic action plan to highlight sustainability in its values, mission, vision, and principles. An independent audit by RSM reviewed TSH's progress on NHS Scotland's Global Climate Emergency and Sustainable Development Policy (DL 38). Despite resource and financial constraints, the audit found that TSH can meet all 68 DL 38 requirements by 2040. TSH has already cut emissions by 81% since 1990, built a strong governance framework, and complies with NHS Scotland's reporting standards.
Positive progress toward meeting DL 38 requirements was acknowledged. However, benchmarking within the RSM client base revealed opportunities to establish sustainable structures for ongoing improvement and oversight. The State Hospital and the Climate and Sustainability Oversight Group have considered these recommendations and intend to implement them where feasible. Notably, plans include appointing a Sustainability Coordinator and creating a sustainable action plan that could integrate recommendations from the Net Zero Route Map. This plan will outline SMART sustainability targets, set clear timelines, interim goals, key performance indicators, and identify financing options.

3. Summary of impacts

The State Hospitals Board for Scotland plans to achieve net-zero greenhouse gas emissions by 2040 for the sources listed below. The table shows the hospital's annual emissions.

Table 1: For 2024/25, The State Hospital has not set target reductions due to the focus on data accuracy for current baseline years.

Greenhouse gas emissions 2023-2024 & 2024-2025, tonnes CO2 equivalent (tCO2e)					
Source	**2023/24 emissions (tCO2e)**	**2024/25 emissions (tCO2e)**	**Percentage change – 2023/24 to 2024/25**	**2024/25 – target emissions**	**Difference between actual and target emissions – 2024/25 (percentage)**
Building energy	1569.22	1900.3	21.1% Increase	No target set	No target set
Non-medical F-gas	8.33	17.72	112.7% Increase	No target set	No target set
Medical gases	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Metered dose inhaler propellant	Not recorded	<1	Unable to calculate	Not applicable	Not applicable
NHS fleet travel	20.47	8.17	60.1% Decrease	No target set	No target set
Waste	52.72	48.98	7.1% Decrease	No target set	No target set
Water	2.67	2.84	6.4% Increase	No target set	No target set
Business travel	3.42	2.09	38.9% Decrease	No target set	No target set
Total emissions	**1657.90**	**1980.1**	**19.4% Increase**	**No target set**	**No target set**
Carbon sequestration	Not recorded	Not recorded	Not applicable	Not applicable	Not applicable
Greenhouse gas emissions minus carbon sequestration	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable

In summary reference to table 1:

- Building energy emissions increase is due to decarbonisation of the grid slowing over the past year and the increase in LPG consumption due to the biomass boiler being inoperable for a protracted period and a colder period over the reported year compared to the year before.
- Non-medical F-gas saw over 100% increase due to various repairs to air conditioning units during the period.

Table 2 below sets out how much of key resources we used over the last two years.

Source	2023/24 Use	2024/25 Use	Percentage change – 2023/24 to 2024/25
Building energy (kWh)	9,131,167	9,903,494	8.5% Increase
NHS fleet travel (km travelled)	60,542	56,189	7.2% Decrease
Waste (tonnes)	111	123	10.8% Increase
Water (cubic metres)	18,225	16,855	7.5% Decrease
Business travel (km travelled)	20,519	12,500	39.1% Decrease

In summary reference to table 2:

- Waste saw a reflective increase due to increased activity on site.
- Water saw a small reduction which is within expected parameters.
- Both fleet and business travel have seen a positive reduction during the period.

2045 Greenhouse Gas Reduction Targets

We aim to help cut greenhouse gas emissions and reach net-zero by 2045, focusing on areas where our influence is limited, like supply chain, patient travel, and staff commuting. At present, The State Hospital lacks the necessary data to provide updated estimates for these emission sources. We currently do not have systems in place to analysis patient travel and staff commuting, and the necessary technology to access supply chain information.

4. Climate change adaptation

Climate change worsens existing health risks and creates new ones, such as increased infectious diseases and more severe heatwaves and weather events, affecting public health and healthcare systems. NHS Scotland is essential in building climate-resilient health systems to address these challenges.

The changing climate is increasing risks for health and health services. More information on these risks in the UK can be found in the UK Climate Change Committee's Health and Social Care Briefing available here: www.ukclimaterisk.org/independent-assessment-ccra3/briefings/

- *What are the main risks from climate change that the Health Board has identified through its Climate Change Risk Assessment?*

The State Hospital has recognised extreme weather as a primary risk, including prolonged heatwaves, heavy rain, and cold spells. These conditions mainly impact transportation, site access, essential supply deliveries, and can cause disruptions to the electrical supply.

- *Does the Health Board have a plan to reduce those risks?*

The State Hospital, with support from NHS Assure, regularly updates its adaption plan to address equipment, buildings, and processes susceptible to severe weather over the next 10–20 years. The Hospital also maintains business continuity plans for power loss and adverse weather, with resources to manage power on-site for up to seven days if necessary.

- *What main actions has the health board taken to reduce those risks since the last report?*

Since the previous year's report, all applicable business continuity plans have undergone review, with special emphasis given to mitigating the effects of adverse weather on transportation, site accessibility, and essential supply deliveries. Remedial work was completed on our generators on-site to replace components that were end of life (control panels). The upgrade of these ensures that if there were to be any issues with these components that spares are readily available. Further work in planned to increase resilience further giving us a three tier resilience approach.

- *What main actions are going to be carried out to reduce those risks in future years?*

The State Hospital is implementing a series of measures outlined in the Climate Change Risk Assessment using the Climate Change Risk Assessment and Adaptation Planning Tool, which are being advanced under the direction of the Sustainability Group.

5. Building energy

Our goal is to transition all State Hospitals Board for Scotland buildings to renewable heat sources by 2038. The State Hospital site consists of 15 buildings, including patient accommodations, therapy areas, offices, facilities for carers, security, and estate buildings.
In 2024/25, 1900.3 tonnes of CO2 equivalent were produced by The State Hospital use of energy for buildings. This was an increase of 21.1% since the year before.

In 2024/25, The State Hospital used 9,836MWh of energy. This was an increase of 7.7% since the year before.

Table 3 and 4 below outlines our performance

Building energy emissions, 2015/16, 2023-2024 & 2024-2025, tonnes CO2 equivalent (tCO2e)				
	2015/16 energy emissions	**2023/24 energy emissions**	**2024/25 energy emissions**	**Percentage change 2015/16 to 2024/25**
Building fossil fuel emissions	832.7	997.87	1330.94	59.8% Increase
District heat networks and biomass	57.3	19.54	11.63	79.7% Decrease
Grid electricity	1425.3	551.80	557.73	60.9% Decrease
Totals	**2315.3**	**1569.21**	**1900.3**	**17.9% Decrease**

Table 4

Building energy use, 2015/16, 2023-2024 & 2024-2025, MWh				
	2015/16 energy use	2023/24 energy use	2024/25, energy use	Percentage change 2015/16 to 2024/25
Building fossil fuel use	3096	4652	6122	97.7% Increase
District heat networks and biomass	4342	1819	1027	76.3% Decrease
Grid electricity	2848	2659	2687	5.7% Decrease
Renewable electricity	0	0	0	0%
Totals	**10,288**	**9,130**	**9836**	**4.4% Decrease**

- *What did we do in 2024/25 to reduce emissions from building energy use? [DN: Answers to this question should include information about the funding invested and the types of projects undertaken]*

The Building Management System was upgraded to Ecostructure, improving heating and hot water efficiency and enabling advanced analysis across all buildings. Staff can now access the system remotely if unable to be onsite due to bad weather, ensuring continued operation. This upgrade replaces the legacy Continuim product and future-proofs our infrastructure.

- **What are we doing in 2025/26 to reduce emissions from building energy use? [DN: Answers to this should include information about the funding invested and the types of projects to be undertaken]**

During the year, we secured funding from the Scottish Government to replace lighting with LED systems in several buildings:

- Reception
- Family Centre
- Essential Services
- Harris
- Intake Substation

Additionally, this project aims to incorporate advanced LED technology, such as presence detection and daylight saving features, to further decrease energy consumption.

- *What are our long-term projects to cut emissions from building energy use?*

The State Hospital plans to install LED lighting in all clinical areas. A full business case and project plan is in place and this commences in financial year 25-26

6.1 Sustainable care

How we deliver care affects our environmental footprint and greenhouse gas emissions. NHSScotland has set three sustainability priorities: anaesthesia, surgery, and respiratory medicine.

6.2 Anaesthesia and surgery

Greenhouse gases like nitrous oxide, entonox, and volatile anaesthetics are used for pain relief and anesthesia. The NHS can lower emissions by improving anaesthetic practices and managing gas delivery systems. The State Hospital has no emissions from these gases because it does not have operating theatres or treatment rooms.

6.3 Respiratory medicine

Greenhouse gases serve as propellants in metered dose inhalers that treat asthma and COPD. The majority of emissions from these inhalers come from reliever types, specifically Short Acting Beta Agonists (SABAs). Improving condition management not only benefits patient care but also helps 77lower these emissions.
Environmentally friendly alternatives, such as dry powder inhalers, are available and can be used when clinically suitable.
Each year, the Scottish Government provides all health boards with an assessment of emissions related to medical gases and inhaler propellants. For secondary care, The State Hospital is included in the 2024/25 emission figures since prescribing for these purposes does not occur within its health board. Emissions are recorded in the table below.

Table 5

Inhaler propellant emissions, 2018/19, 2023-2024 & 2024-2025, tonnes CO2 equivalent (tCO2e)				
Source	2018/19 (baseline year)	2023/24	2024/25	Percentage change 2018/19 to 2024/25
Primary care	Not applicable	Not applicable	Not applicable	Not applicable
Secondary care	Not recorded	Not recorded	<1	Not calculated
Total	Not recorded	Not recorded	<1	Not calculated

7. Travel and transport

In 2022, domestic transport accounted for 28.3% of Scotland's greenhouse gas emissions, with cars being the largest contributor. NHSScotland supports prioritising active travel and public transport to build a healthier, more sustainable system.

- *What did we do in 2024/25 to reduce the need to travel?*

As a single site Board, there is no cross-site travel. Business travel has declined since Covid, and flexible or remote work policies further reduced commuting for staff.

- *What did we do in 2024/25 to improve active travel?*

Active Travel became a regular topic at Climate Change and Sustainability Group meetings, and the Health and Wellbeing Strategy Group now also oversees active travel as part of their ongoing agenda. The Wellbeing group focuses on specific staff benefits and new opportunities related to active travel. Both groups are still exploring ways to enhance travel arrangements, including possible hub pick up points for employees working shifts.

The hospital introduced cycle to work programs and is considering a salary sacrifice schemes for cars that staff can benefit from. Work is ongoing to finalise this piece of work. There has been an evaluation of better vehicle lease options for staff, especially for electric vehicles. An approved supplier has been established with work ongoing with our payroll to arrange the sacrifice part for staff.

- *What did we do in 2024/25 to improve public and community transport links to NHS sites and services?*

Due to the sires isolated location this area of work proves difficult for the hospital to try to advance. No specific items to report for last year, but we will explore any new opportunities that arise.

- *What are we going to do in 2025/26 to reduce the need to travel?*

The State Hospital will keep exploring ways to make travel easier for staff. Most operational meetings happen on Microsoft Teams, so people don't have to be on-site or travel between locations. We also ask our external partners to use Teams for meetings when possible. The hospital will keep encouraging this approach, along with promoting flexible work options for staff where it is feasible, so we can continue reducing the need for travel.

- *What are we going to do in 2025/26 to improve active travel?*

The State Hospital will continue to assess opportunities for enhancing active travel. Given the site's remote location, the Board will explore strategies to facilitate more sustainable travel from various local and urban areas, with the goal of reducing reliance on private vehicles by staff, visitors, and volunteers. Expanding public transport services presents challenges due to limited influence over third-party providers.

- *What are we going to do in 2025/26 to improve public and community transport links to NHS sites and services?*

The location of the hospital makes it difficult to enhance public and community transport links, as these are dependent on third party interaction. The demand in the local vicinity is low therefore to promote better transport opportunities is limited. We currently offer visitor pick up and drop off services from the local train station using a local taxi service. This is mainly to support visitors who struggle with car transport. This will be reviewed, and where possible developed, by the Climate Change and Sustainability Group.

The table below summarises the emissions recorded and percentage change between the last two reporting years.

Fleet and Business Travel

Greenhouse gas emissions, tCO2e	**2023/24**	**2024/25**	**Percentage change**
Fleet emissions,	**20.47**	**8.17**	**60.1% Decrease**
Business Travel	**3.42**	**2.09**	**38.9% Decrease**

Table 6

We are working to remove all petrol and diesel fuelled vehicles from our fleet, but we also consider, due to the type of transport requirements we have to deliver, this may be not fully possible.

The following table sets out how many renewable powered and fossil fuel vehicles were in The State Hospitals Board for Scotland's fleet at the end of March 2024 and March 2025:

Table 7

	March 2024		**March 2025**		
	Total vehicles	**% Zero tailpipe emissions vehicles**	**Total vehicles**	**% Zero tailpipe emissions vehicles**	**Difference in % zero tailpipe emissions vehicles**
Cars	0	0	0		
Light commercial vehicles	7	29%	7	57%	100% Increase
Heavy vehicles	0	0	0	0	
Specialist vehicles	5	0	5	0	No difference (see note below)

The State Hospital have the following list of specialist vehicles, that are used on site for grounds maintenance.

- 2 tractors (these were reported last year as heavy vehicles) These vehicles have been reclassified as specialist vehicles as under 3.5tonne.
- 2 sit-on grass cutting machines
- 1 quad bike

The following table sets out how many bicycles and eBikes were in The State Hospitals Board for Scotlands's fleet at the end of March 2024 and March 2025:

Table 8

	March 2024	March 2025	Percentage change
Bicycles	0	0	No difference
eBikes	0	0	No difference

The following table sets out the distance travelled by our cars, vans and heavy vehicles in 2024/25.

Table 9

Distance travelled, kms	Cars	Light commercial vehicles	Heavy vehicles	Specialist vehicles	Total
2023/24	N/A	60,542	N/A	Not recorded	60,542
2024/25	N/A	56,189	N/A	Not recorded	56,189
Percentage change	N/A	7.2% Decrease	N/A	Not recorded	7.2% Decrease

Business travel is staff travelling as part of their work in either their own vehicles or public transport. It covers travel costs which are reimbursable and doesn't cover commuting to and from work. The table below shows our emissions from business travel by transport.

Business travel emissions, tCO2e	Cars	Public transport	Flights	Total
2023/24	3.42	0	0	3.42
2024/25	2.09	0	0	2.09
Percentage change	38.9% Decrease	0%	0%	38.9% Decrease

8. Greenspace and biodiversity

Biodiversity
Biodiversity, or the wide variety of living organisms within an environment, has declined at a rapid rate in the last 50 years. Evidence demonstrates that these trends are attributed to human activities, such as land use change, habitat degradation and fragmentation, pollution, and the impacts of climate change. The State of Nature report published in 2023 has highlighted the decline of nature across Scotland, with 11% of species now classed as threatened with extinction.

Public bodies in Scotland have a duty under the Nature Conservation (Scotland) Act 2004 (Nature Conservation Scotland Act 2004) to further the conservation of biodiversity, taking care of nature all around us. Furthermore, the Wildlife and Natural Environment (Scotland) Act 2011 (Wildlife and Natural Environment Scotland Act 2011) requires every public body to summarise their activities to meet this duty, through the production of a publicly available report.

- *What steps has your organisation taken to identify, protect, and enhance biodiversity?*

TSH continue to maintain grounds both within and outwith the secure perimeter to enable and encourage local community access for walking and other outdoor activities. The external areas have been allowed to renature to create natural spaces. Allowing large areas of unused land, both within and outside the secure perimeter, to renature and leaving external grassland and existing trees undisturbed contributes positively to biodiversity. These practices create habitats for various species and support ecological processes, such as pollination and seed dispersal, which are crucial for insects, birds, and other wildlife.

What actions have been taken to contribute to the NHSScotland Estate Mapping programme, or to develop an internal mapping programme?

The State Hospital leads all NHS facilities in terms of greenspace as a percentage of total land, at 65.7%. Work to develop what can be achieved by these greenspaces still requires to be developed.

- *What actions have been taken to mainstream biodiversity across the organisation?*

At this current time the activities that are in place are not fully embedded. The Hospital will create a biodiversity action plan that will allow us to look at work that can become mainstream across the organisation and also externally into local community.

- *How have nature-based solutions been utilised to address the climate and biodiversity emergencies?*

The State Hospital has large areas of unused land both within and outwith the secure perimeter. The site includes around 32 hectares of unused grassland and existing trees, which have public access for dog walking etc and are left to renature. Also the internal land in certain areas is left to grow at certain times of the year. By permitting grasses to grow and produce flowers and seeds, the site enhances food sources and shelter for wildlife, thereby supporting local ecosystems.

- *What actions have been undertaken to raise awareness, engagement and understanding of biodiversity and nature?*

Currently, no specific initiatives have been implemented by The State Hospital to enhance awareness, engagement, or understanding of biodiversity and nature. The organisation acknowledges the importance of these areas and recognises that further work will be required to address awareness and engagement in the future. Plans to improve engagement and understanding are expected to form part of the Hospital's forthcoming biodiversity action plan, which aims to embed biodiversity considerations more fully across the organisation and within the local community.

- *Have any biodiversity surveys, monitoring, or assessment been carried out? Are there systems for long-term tracking?*

The State Hospital has not yet conducted any biodiversity surveys or monitoring. However, it is recognised as an area for future development, and plans are in place to address it in the coming years. This aligns with the obligations of public bodies in Scotland to support biodiversity conservation in their operations. At present, there are no established systems for long-term tracking, but this is expected to be implemented as part of future initiatives.

Greenspace

The design and management of the NHSScotland green estate for both human and planetary health presents an opportunity to achieve a variety of mutually advantageous outcomes. These encompass climate change mitigation and adaptation, enhancement of biodiversity, improvement of health and wellbeing for patients and staff, promotion of community resilience, and facilitation of active travel.

Currently, The State Hospital leads all NHS facilities in terms of greenspace as a percentage of total land, at 65.7%. Work to develop what can be achieved by these greenspaces still requires to be developed. This will be looked at as we progress on our sustainability journey.

All greenspace across the facility is managed and maintained across the year and kept in good state of repair. Our greenspace sits in two areas of the hospital's operation, one side being within the secure perimeter and as such must be maintained in accordance with the security standards required for the site. The other side of the greenspace sits outwith the secure perimeter and sits within areas where the public can access. The areas are used regularly by the local public. The external areas have been allowed to renature to create natural spaces. Allowing large areas of unused land, both within and outside the secure perimeter, to renature and leaving external grassland and existing trees undisturbed contributes positively to biodiversity. Also, the internal land in certain areas is left to grow at certain times of the year. These practices create habitats for various species and support ecological processes, such as pollination and seed dispersal, which are crucial for insects, birds, and other wildlife.

9. Sustainable procurement, circular economy and waste

The greenhouse gases produced in creating the goods and materials used by The State Hospitals Board for Scotland were unable to be estimated for the year 2024/25.
We aim to reduce the impact that our use of resources has on the environment through adopting circular economy principles, fostering a culture of stewardship and working with other UK health services to maximise our contribution to reducing supply chain emissions to net-zero by 2045.

- *What initiatives were implemented in 2024/25 to reduce both the environmental impact and the volume of goods and services procured? [DN: Please reference contracts that have been amended or adopted with a greater focus on sustainability]*

All regulated tenders are accompanied by a Procurement Strategy document, incorporating a sustainability assessment through the Scottish Government Sustainability Test. For non-regulated Quick Quotes, sustainability considerations are evaluated as part of the Invitation to Quote process.

- *What measures are being implemented in 2025/26 to reduce the environmental impact of procured goods and services?*

All regulated tenders require a Procurement Strategy document that incorporates a sustainability assessment based on the Scottish Government Sustainability Test. For non-regulated Quick Quotes, sustainability considerations are also evaluated as part of the Invitation to Quote process.
We want to reduce the amount of waste we produce and increase how much of it is recycled.

The table below sets out information on the waste we produce and its destination for the last four years:

Type	2021/22 (tonnes)	2022/23 (tonnes)	2023/24 (tonnes)	2024/25 (tonnes)	Percentage change – 2021/22 to 2024/25
Waste to landfill	79	90	81	82	3.8% Increase
Waste to incineration	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Recycled waste	26	28	26	30	15.4% Increase
Food waste	Not Recorded	Not Recorded	Not Recorded	Not Recorded	Not Recorded
Clinical waste	5	7	4	2	60% Decrease

The State Hospitals Board for Scotland was not included in the initial high-level waste route maps developed with the Net Zero Route Map. The State Hospital will adopt best practices from other Health Boards. After applying these learnings, we will set waste reduction targets and update the tables below with data on six key waste streams: residual, cardboard, dry mixed recycling, food waste, confidential paper, and both standard and high-grade non-infectious plastics.

In 2012/2013, The hospitals sent 191 tonnes of domestic waste to landfill, the above table highlights now how we have improved our waste management journey. This work will continue as we progress.

Targets have been established to reduce our waste, with performance details provided in the following tables:

Reduce domestic waste by a minimum of 15%, and greater where possible compared to 2012/2013 – by 2025	
Target – reduce domestic waste by	30 tonnes
Performance – domestic waste reduced by	79 tonnes
Outcome	ACHIEVED
Further reduction required	None
Ensure that no more than 5%, and less where possible, of all domestic waste is sent to landfill – by 2025	
Target – reduce waste sent to landfill by	70 tonnes
Performance – waste sent to landfill reduced by	O tonnes
Outcome	NOT ACHIEVED YET
Further reduction required	70 tonnes

As part of a national procurement process a new supplier for waste management was appointed. Moving forward we should see and be able to measure this area of operation more accurately and then look at overall performance to improve.

Reduce the food waste produced by 33% compared to 2015/16 – by 2025	
Target – reduce food waste by	Currently not recorded
Performance – food waste reduced by	Currently not recorded
Outcome	Currently not recorded
Further reduction required	Currently not recorded

Regarding food waste management, we previously relied solely on waste disposals, directing all food waste to the drain. Last year, we identified this practice as an area requiring improvement. Throughout this year, we have invested in new equipment that compacts waste and extracts water, resulting in a dry residual material. As part of our enhanced waste management initiative, we will now process all food waste in a more environmentally responsible manner and will be able to provide ongoing data to support these efforts.

Ensure that 70% of all domestic waste is recycled or composted – by 2025	
Target – recycle or compost	83 tonnes
Performance – recycled or composted	30 tonnes
Outcome	NOT ACHIEVED YET
Further increase required	53 tonnes

- *What initiatives were undertaken in 2024/25 to reduce waste?*

Efforts to promote source waste recycling continued within each department and building. Additionally, the State Hospital successfully conducted a mini-competition following the implementation of the Recyclates and General Waste Management Framework as introduced by National Procurement.

- What are our plans for reducing waste in 2025/26? *[DN: Please specify how these actions are expected to help us achieve the target, or explain why this year's efforts might not be sufficient to do so.]*

The State Hospital is committed to developing a comprehensive waste route map that directly supports national targets. By appointing new waste contractors through the National Procurement Framework, we are proactively enhancing our waste management processes and reporting capabilities to help us achieve our goals.

10. Environmental stewardship

Environmental stewardship means acting as a steward, or caretaker, of the environment and taking responsibility for the actions which affect our shared environmental quality.
This includes any activities which may adversely impact on land, air and water, either through the unsustainable use of resources or the generation of waste and pollution. Having an Environmental Management System (EMS) in place provides a framework that helps to achieve our environmental goals through consistent review, evaluation, and improvement of our environmental performance.

- *What steps did we take in 2024/25 to develop and implement our EMS?*

Throughout 2024/25, The State Hospital made ongoing efforts to incorporate key information into its Environmental Management System (EMS). The intention behind this work was to lay the groundwork for developing robust action plans aimed at enhancing environmental performance. However, the pace of progress was slow, largely due to the limited time available for these activities. As a result, the hospital was unable to report any significant outcomes from this process during the period.

- *We have fully implemented EMS to ISO14001 standard at the following sites:*

The State Hospital operates a single site within the board. Due to the factors previously outlined, including the limited availability of dedicated resources and the slow pace of progress, the hospital is continuing with the process of fully implementing its Environmental Management System (EMS). Progress remains ongoing as we work towards achieving full compliance and embedding best practices throughout the site.

- *What steps will we take in 2025/26 to further develop and implement our EMS?*

The State Hospital will look to create a dedicated resource to further develop audit and compliance and implement our Environmental Management System (EMS). By establishing this focused role, the hospital aims to strengthen its capacity for ongoing review and evaluation of environmental processes. The dedicated resource will support progress towards full EMS implementation in line with the ISO14001 standard, helping to embed best practices and ensure compliance throughout the site.

- *What did we do in 2024/25 to reduce our environmental impacts and improve environmental performance?*

During 2024/25, no specific work or projects were undertaken, nor were any required at this time, to reduce environmental impacts and improve environmental performance at The State Hospital. As such, there were no targeted initiatives or interventions implemented in this period in relation to environmental impact reduction or the enhancement of environmental performance.

- *What are we doing in 2025/26 to reduce our environmental impacts improve environmental performance?*

At present, there are no specific plans in place for The State Hospital to reduce environmental impacts or to enhance environmental performance during 2025/26. This means that, for the coming year, no targeted projects or initiatives have been scheduled to address these areas. The hospital will continue to monitor its environmental performance and remains committed to identifying and implementing improvements where feasible as part of its ongoing approach.

- *What factors have prevented implementation of EMS to ISO14001 Standard for any sites in The State Hospitals estate which have not yet reached that standard?*

The State Hospital has struggled to allocate a dedicated resource for developing audit, compliance, and EMS implementation in line with ISO14001. Although the need is recognised, a focused role has yet to be established, but the hospital is working to address this.

11. Sustainable construction

Where there is a need for new healthcare facilities, we want both the buildings and grounds to be safe, nature-rich, sustainable, resilient and accessible. The State Hospitals Board for Scotland currently have no planned or ongoing building projects.

12. Sustainable communities

The climate emergency undermines the foundations of good health and deepens inequalities for our most deprived communities.
The NHS touches every community in Scotland. We have a responsibility to use our abilities as a large employer, a major buyer, and one of the most recognised brands in the world – an 'anchor' organisation – to protect and support our communities' health in every way that we can.

- *How are we fulfilling our role as an anchor institution within our local community?*

The State Hospital, serving as an Anchor NHS Board, has developed this plan to outline its intended actions, provisional baseline metrics, and governance arrangements. The initial strategic themes include:

- Progressive Procurement – The State Hospital aims to stimulate investment in the local region through responsible procurement practices. Where feasible, preference will be given to local suppliers during procurement processes, supporting employment opportunities within the community.
- Employment – As a major employer in an area of deprivation, The State Hospital is committed to enhancing recruitment efforts according to its Workforce Strategy 2025-28. This strategy sets forth measures to encourage community members to pursue employment at The State Hospital.

- Sustainable Use of Land and Property – The Hospital carefully considers land use and sustainability practices. Currently, the State Hospital maintains land outside its perimeter fence, providing community access for activities such as dog walking, outdoor recreation, and leisure pursuits, including jogging and walking.

- *What are we doing to improve the resilience of our local community to climate change?*

At present, no specific areas needing improvement have been found. Due to its location and the type of hospital it is, connecting with the local community to build climate resilience has proven challenging.

13. Conclusion

The tables below contain the current modelling report for TSH's Net Zero performance on a BAU scenario.
As a Board the emissions have decreased by a massive 82.5% against the baseline year 1993/94, which is within the 5-year 1990 Kyoto window. Prior to 1993/94, the site was operated and maintained by the Department of Environment (DoE) on behalf of the UK Government and Scottish Executive.

NHS State Hospital							
CO2e Emissions Targets		**1993/94**	**2024/25 Reported Figures**	**2025 Interim Target**	**2030 Interim Target**	**2035 Interim Target**	**2040 Net Zero Target**
The New % Pathways to a 2040 Net Zero Outcome	CO2e Emissions Targets	Baseline	-65.5%	-65.5%	-75%	-87.5%	-100%
Target – Our Current Usage Trend will have to follow these trajectories	Tonnes	10,678	3,684	3,684	2,670	1,335	0
Actual and Predicted CO2e Emissions from now to 2040	Tonnes	10,678	1,900	1,653	1,446	1,332	1,264
CO2e Emissions – Current Pathway based on current anticipated energy use	Based on 1993/94 usage levels	-	-82.5%	-84.5%	-86.5%	-87.5%	-88.2%
Potential Shortfall			-17.0%	-19.0%	-11.5%	0.0%	11.8%

According to the data above, TSH is already 17% ahead of its Net Zero goal based on 2024/25 figures. To achieve the target for decarbonising heat sources, TSH will need to commission a feasibility study to evaluate options like ground source or air source heat pumps, as well as any other innovative technologies suited to the location. With a deadline of 2038, this work must be carried out within the next five to six years. Additionally, renewable electricity options such as wind turbines and solar PV will be investigated as part of the same feasibility study during this period. As Net Zero strategies are developed over the next five to six years, suitable funding sources will also need to be secured so that TSH can adopt the necessary technologies for achieving Net Zero.

This year's priorities include creating and implementing a high-level waste route map, advancing initiatives for active travel, raising awareness of biodiversity and greenspace, and fully rolling out an Environmental Management System (EMS) for The State Hospital.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	18 December 2025
Agenda Reference:	Item No: 19
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Corporate Governance
Title of Report:	Review of Board Workplan
Purpose of Report:	For Decision

1 SITUATION

The Board reviews its workplan annually to identify the key considerations and actions required and to provide assurance on planned areas of reporting. The draft workplan is enclosed at **Appendix A**.

2 BACKGROUND

Each component part of the workplan is allocated to meeting(s) throughout the year. The workplan is developed based on planned workstreams, and reporting will be stood up to reflect change that may occur throughout this period.

3 ASSESSMENT

The workplan sets out the Board's priorities, with a review of its Corporate Objectives for 2025/26 in February which are linked to the Medium-Term Plan as well as the Workforce Plan, and six-monthly updates are included in the plan in respect of each.

The Board will continue to receive dedicated reporting around key areas of risk and resilience, with review of the Corporate Risk Register at each meeting, and dedicated reporting on the financial position. The full range of annual reporting for the 2025/26 year is planned for the June meeting, with the preparation of standing documentation reviewed at the previous meeting in April. Bed Capacity reporting has now been remitted directly to the Clinical Governance Committee.

Reporting has been included for the April 2026 meeting to provide the Board will an update on progress and any learning from changes in systems and structures which are planned as a test of change.

Throughout the year, there will be presentations providing the views of patients and carers, giving the Board the opportunity to hear the lived experience of stakeholders. In addition, the Patients' Advocacy Service will present its annual report. An update will be provided about the implementation of the Carers Strategy, and the progress being made. The Complaints and

Feedback Annual Report will be reviewed by the Board in August, prior to is submission to Scottish Government. The Quality Improvement and Assurance Report will be submitted to each meeting, in its refreshed format. Reporting on medical education, as well as revalidation and appraisal arrangements will be brought annually.

The Board will continue to receive high level reporting on workforce reporting, with the Staff Governance Committee receiving more detailed reporting in this regard. The Annual Report on the implementation of the Health and Care (Staffing) Act will come to the Board in April, prior to submission to Scottish Government, and quarterly oversight of this will be taken through the Staff Governance Committee. Quarterly reporting will continue in respect of whistleblowing and Speak Up initiatives.

There will be annual oversight of digital workstreams through annual reporting from eHealth, as well as specific updates on Network and Information Systems audit workstream, depending on the new arrangements for this. There will also continue to be annual reporting on the information governance framework.

Whole System Infrastructure including business continuity planning is scheduled for October 2026, to enable board oversight linked to national timescales, with annual reporting on the Climate Change and Sustainability in December 2026.

To date, the Security Refresh Project has reported to each meeting, and it is suggested that this is adjusted to a regular update, representing the move to business as usual reporting. The specified persons report previously received at the Board has now been remitted to the Clinical Governance Committee.

Reporting from the Women's Service Project Oversight Board is included at each meeting, pending developments throughout the year in this regard.

Annual Reporting covering the Communication remit is scheduled for the April meeting.

The workplan incudes reporting on the Board's own Improvement Plan, as well as regular reports submitted on behalf of the Committee Chairs highlighting the range of reporting and decisions made at quarterly meetings pending receipt of the approved minutes.

The Board has also scheduled a series of Board Development Sessions throughout the year, which will be held in person, allowing an additional framework through which to consider developing workstreams as they progress toward the formal Board.

4 RECOMMENDATION

The Board is asked to:

Review the revised workplan and discuss whether this is agreed to provide a robust structure for the consideration and scrutiny of the Board's business in 2026, and to advise whether any change or addition is required

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	To strengthen reporting to and oversight by the NHS Board with planned reporting throughout year
Corporate Objectives	The Workplan represents the work agenda for the Board in the coming year and as such covers the entirety of the Corporate Objects, within the context of the detailed scrutiny which takes place through the governance committee structure.
Workforce Implications	There are no implications as a result of this report
Financial Implications	There are no impacts to consider.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Requested by the Board as part of workplan, and directed through the Corporate Management Team.
Risk Assessment (Outline any significant risks and associated mitigation)	The workplan is developed to provide assurance to the Board, and there are no additional risks to consider
Assessment of Impact on Stakeholder Experience	This is considered by the Board in setting its workplan, and by CMT in proposing way forward.
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 relevant
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: BOARD BUSINESS 2026

February 2026	April 2026	June 2026	August 2026	October 2026	December 2026
• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report •	• Board Minute and Actions • Chair's Report • CEO Report	• Board Minute and Actions • Chair's Report • CEO Report
• Governance Committee Minutes/Summary Reports • Clinical Forum Minutes/ Update	• Governance Committee Minutes/Summary Reports • Clinical Forum Minutes/ Update • Board Improvement Plan Update	• Governance Committee Minutes/Summary Reports • Clinical Forum Minutes/ Update • Governance Committee Annual Reports	• Governance Committee Minutes/Summary Reports • Clinical Forum Minutes/ Update • Annual Schedule of Board/Committee meetings	• Governance Committee Minutes/Summary Reports • Clinical Forum Minutes/ Update • Board Improvement Plan Update	• Governance Committee Minutes/Summary reports • Clinical Forum Minutes/ Update • Annual Review Feedback (2025/26) • Workplan 2027
RISK AND RESILIENCE:					
• Corporate Risk Register • Finance Report	• Corporate Risk Register • Finance Report	• Corporate Risk Register • Finance Report	• Corporate Risk Register • Finance Report	• Corporate Risk Register • Finance Report	• Corporate Risk Register • Finance Report

February 2026	April 2026	June 2026	August 2026	October 2026	December 2026
CLINICAL GOVERNANCE:					
• Quality Assurance and Improvement Report • Carers Strategy – Update • Global Citizenship - Update following Scottish Health Awards nomination	• Patient, Carer & Volunteer Stories • Quality Assurance and Improvement Report	• Quality Assurance and Improvement Report	• Patient, Carer and Volunteer Stories • Quality Assurance and Improvement Report	• Quality Assurance and Improvement Report • Medical Appraisal and Revalidation Annual Report • Medical Education Report	• Patient, Carer and Volunteer Stories • Quality Assurance and Improvement Report • Patient Independent Advocacy Annual Report
STAFF GOVERNANCE:					
• Staff Governance Report • Whistleblowing Quarter 3 Report	• Staff Governance Report • Health and Care Staffing Annual Report • Whistleblowing Annual Report	• Staff Governance Report	• Staff Governance Report • Whistleblowing Quarter 1 Report	• Staff Governance Report	• Workforce Report • Whistleblowing Quarter 2 Report

February 2026	April 2026	June 2026	August 2026	October 2026	December 2026
CORPORATE GOVERNANCE:					
• Corporate Objectives 2026/27 • Performance Report • Security Update • Women's Service Project Update	• Annual Review of Standing Documentation • Medium Term Plan Update • Workforce Plan Update • Communications Annual Report • Security Update • Women's Service Project Update • Organisational Systems and Structure – Update	• Annual Accounts Reporting • Performance Annual Report • Risk and Resilience Annual Report • Security Update • Women's Service Project Update	• Performance Report • Complaints & Feedback Annual Report • Information Governance Annual Report • Security Update • Women's Service Project Update	• eHealth Annual Report • Whole System Infrastructure/Business Continuity Report • Medium Term Plan Update • Workforce Plan Update • Security Update • Women's Service Project Update	• Performance Report • Climate Emergency and Sustainability Annual Report 2025/26 • Security Update • Women's Service Project Update

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 2025
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning, Performance and Quality Corporate Planning, Performance and Quality Project Support Manger
Title of Report:	Q2 2025/26 Corporate KPI Performance Report Q1 & Q2 2025/26 Annual Delivery Plan Update
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 2 (July 2025 to September 2025) and performance against the Annual Delivery Plan 2025/26 commitments. 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

- Quarter 2 KPI data and highlight areas for improvement through a deep dive analysis for KPIs that have missed their targets.
- Quarter 1 and 2 ADP performance highlights

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 Annual Delivery Plan sets out the TSH Board delivery commitments, these are monitored and reported to provide an overview of performance against plan. 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:**

	M -Continue to support training and development for all staff at every level across the organisation.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations.	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

1. CONTENT

1.OVERVIEW

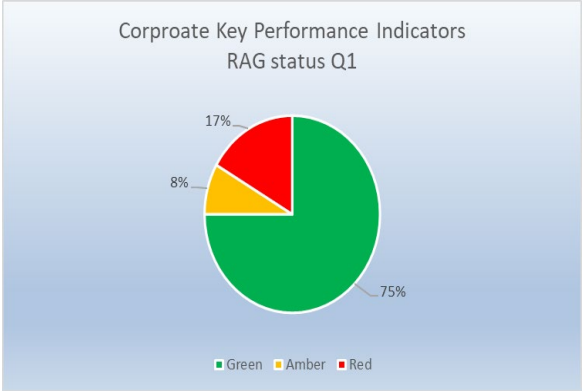
Overview	• Corporate Key Performance Indicators - This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPIs) for quarter 2 (July 2025 to September 2025). There is a total of twelve corporate KPIs. Analysis of the data using Red, Amber, and Green RAG scale reveals that 75% (9) have reached and / or exceeded their target this quarter and assessed as green, with 25% (3) KPI's off target, all with a RAG status of red. One KPI moved from amber to red this quarter. The information provided within the paper is reported by exception. The Planning, Performance, and Quality Team reviews all corporate KPIs data monthly, with areas to note highlighted in this report. All KPIs operational definitions are reviewed annually with data owners, all reviews were completed in July 2025. • Annual Delivery Plan 2025/26 - Meetings have taken place between the Corporate Planning and Performance Team and Directors to provide updates for Q1 & Q2. From the 83 Board actions identified in the Annual Delivery Plan 2025/26. 62 recommendations are being actioned, 95% of these actions have been rated as RAG scale green and are completed or on track to be completed, 5% have been rated as amber and no actions have been identified as red within the identified timescales. The remaining 21 actions identified timescales of Q3&4 2025, therefore no updates were requested at the time of meetings. All updates on the Annual Delivery Plan 2025/26 are reported to the Strategic Planning, Performance and Governance Group and externally to Scottish Government Mental Health Directorate through the quarterly sponsorship meetings. Clinical delivery is monitored locally in Services with each of the Service Leadership Team having a range of indicators which are reviewed monthly by the Clinical Quality Team. Escalation of issues, if required, is through the Board committee structure

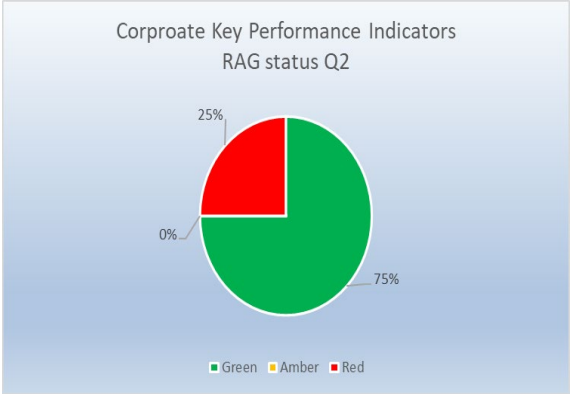
2. CORPORATE KEY PERFORMANCE INDICATORS QUARTER 2 UPDATE

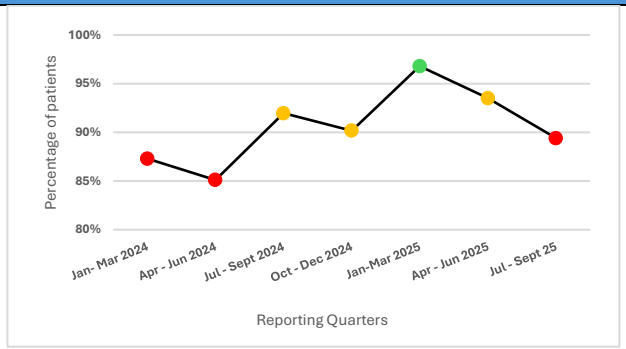
	Performance Indicator	Target	RAG Q3 24/25	RAG Q4 24/25	RAG Q1 25/26	RAG Q2 25/26	Actual Q2 25/26
1	Patients have their care and treatment plans reviewed at six monthly intervals	100%	A	G	A	R	89.4%
2	Patients will be engaged in psychological treatment	85%	G	G	G	G	87.33%
3	Patients will be engaged in off-hub activity centres *(This includes drop-in sessions which take place in hubs, grounds, and Skye Centre*	90%	G	G	G	G	96%
4	Patients will undertake an annual physical health overview by the Practice Nurse	100%	G	G	G	G	100%
5	Patients will undertake 150 minutes of moderate exercise each week.	70%	R	R	G	G	67%
6	Patients will have a healthier BMI	25%	R	R	R	R	10%
7	Sickness absence rate	5%	R	R	R	R	7.5%
8	Staff have an approved Personal Development & Planning Review	80%	G	G	G	G	90.8%
9	Patients transferred / discharged using CPA	100%	G	G	G	G	100%
10	Patients requiring primary care services will have access within 48 hours	100%	G	G	G	G	100%
11	Patients will commence psychological therapies <18 weeks from referral date	100%	G	G	G	G	97.67%
12	Patients have their clinical risk assessment reviewed annually	100%	G	G	G	G	96.40%

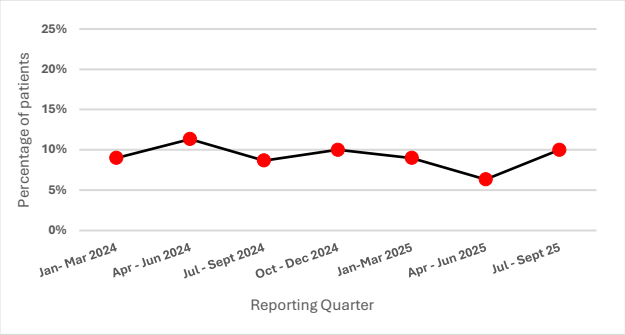
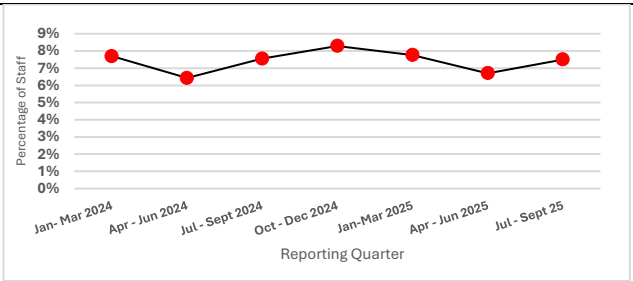
Definitions for red, amber, and green zones:

- 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.





Summary position **where an amber or red rag status has been identified**	**RAG Scale**	**Previous Reporting Data**	**Analysis of Q2**	**Actions being taken**	**Improvement Opportunities**	**Corporate Risk Register**
Patients have their care and treatment plans reviewed at six month intervals (Target 100%)	Red		There has been fluctuation in the data over Q2 with monthly variation ranging from 92.5% to 85.1%, resulting in a quarterly average of 89.4% Delays caused due to dates of meeting changing as well as documentation not be uploaded within the agreed timescales	Review of the data between health records and clinical admin continues Process Mapping document is being reviewed	Review of the data being collected to ensure that this is relevant to the target	Not associated with any corporate risk.

Patients will have a healthier BMI (Target 25%)	Red		Year to date continues to underperform. Data shows this target fluctuates although has never increased above 11.33% since Q1 2024/25	• Work ongoing with Lead Nurses, SCNs and eHealth to ensure all weights/BMI are recorded every month in keeping with guidance. • the BMI tableau dashboard has been finalised and is awaiting launch. • Service and Ward level data is provided monthly to each Service Leadership Team. • 6 patients on GLP-1s for weight loss (linking in with Pharmacological Management of Obesity guidance). • Corporate Risk Register reviewed monthly	developing winter activity timetables Supporting Healthy Choices Oversight Group met at the end of October 2025 to gain agreement to progress a new KPI measure. This is now in draft form	MD30
Sickness Absence rate (Target 5%)	Red		Year to date continues to underperform	• Regular RAG Reviews for escalated areas • Continued partnership working with focus on providing a safe working environment • Encouragement and monitoring of consistent Pathways usage & associated review of nursing reporting arrangements • Improved communication and awareness of impact of absence	OD strategy including culture assessment, bespoke wellbeing plans, line manager development and compassionate leadership will all have positive improvement	HRD116

				• Manager development • Accountability and performance management for areas which require additional support • Alternative duties and reasonable adjustments common practice to avoid absence • Dedicated case management support from HR and Occ Health for a range of individuals examples provided below, • Alignment across workforce directorate with support from wellbeing and OD colleagues where appropriate for individuals or teams • Frequent use of case reviews to meet with staff in a supported environment attended by HR, Occ Health and staff side to discuss and agree solutions. • Absence information appraised in Chief Executive Performance Reviews	on the working environment and staff experience which in turn should improve sickness absence rates. Additionally, current review of shift patterns within hub nursing (which is the most challenging area to reduce and sustain sickness absence) has a particular focus on ensuring the shifts are conducive to staff rest and well-being taking account of the working environment sickness Absence	

3. ANNUAL DELIVERY PLAN 2025/26 PERFORMANCE HIGHLIGHTS Q1& Q2

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
Mental Health	**Deliverables: 3 of 3 actions being delivered** 100% on track. Waiting on feedback in relation to the outcomes and recommendations from the Forensic Governance Advisory Group. An interim Women's Service has been established within the State Hospital and outreach work continues to be explored with medium secure service units. The State Hospital has established links with colleagues and Scottish Government to explore alignment from the wider mental health service delivery system and the Service Reform principles
Women's Service	**Deliverables: 3 of 5 actions being delivered, 2 remaining actions for Q3&4 reporting** 100% on track. Interim Women's Service was established on the 21 July 2025, clinical operational model, clinical guidance, ward modification, admission criteria and workforce model all in place. Outreach service model in the final stages of development following consultation and engagement with stakeholders. Potential for delay in Phase 2 Outline and Full Business Case identified because of national planning guidance outlined in DL 2025 (15)

Improving patient's outcomes from their clinical care experience	**Deliverables: 28 of 38 actions being delivered, 10 remaining actions for Q3&4 reporting** 73% on track. Clinical Model continues to be embedded; each service has taken forward specific activities to tailor services. A review of the risk assessments continues with a scoping exercise completed, and links established with other secure care setting. A subgroup from the Mental Health Practice Steering group has been established to carry out a review of relevant literature, domains have been identified, and testing is underway to measure outcomes for patients. Excellence in Care continue to progress with positive feedback begin received. Embedding of the new CPA process continues and the Project Board has identified the business as usual processes with normal governance routes commencing. The actions which are identified as amber are: The elimination of day-time confinement due to the impact of opening the women's service on the nursing workforce resources. Reduce weight gain within the patient group. Activities to address this continue to progress. Local targets to monitor and address weight gain continue to be developed within the admission service and more widely across the hospital through exploring new measurements.
Enhance Security, Reduce Risk and Harm	**Deliverables: 2 of 4 actions being delivered, 2 remaining actions for Q3&4 reporting** 100% on track. Development of security standards and framework have been approved by the Board and apprised by the Scottish Government. The Business Continuality plan has been submitted to the Scottish Government and funding has been aligned.
Learning from the views of patients and carers	**Deliverables: 3 of 3 actions being delivered** 100% on Track. Development of the delivery plan for the Carers Strategy has been completed with the main actions for Q1 &Q2 being the re-introduction of the careers group. Communications with carers continues through the development of induction packages for relatives. The Patient Partnership Group continue to progress with the TSH3030 project to improve communication between PPG and wards. Stakeholder awareness and skills development continue with a national group being established, exploring the difference between high, medium and low security. The Patient Centred Improvement Group has a comprehensive membership including key partner from Social Work and Advocacy who provide regular updates.
Support the State Hospital workforce	**Deliverables: 9 of 10 actions being delivered, 1 remaining action for Q3&4 reporting** 100% on track. Development of the workforce and associated action plan has been completed and submitted to the Staff Governance Group for approval. Significant engagement across organisation has taken place to promote and raise awareness of organisational health, with updates provided to Staff Governance Group. The OD Strategy has been completed, and associated action plan is being development. Work continues to maximise attendance throughout the organisation by supporting managers, with impact being seen in attendance data. A development session was delivered in September 2025 exploring the business partnering model. The Workforce Equalities Group continues to grow with a draft action plan including anti-racism plans being submitted to CMT in October 2025.

Finance and E-health/digital development	**Deliverables: 9 of 13 actions being delivered, 4 remaining actions for Q3&4 reporting** 89% on track. Finance Plan was agreed by Scottish Government with updates to the Finance Delivery Unit. Local dashboards continue to be developed linking with local delivery teams to support financial analysis. The management of digital inclusion continues to be explored, A proof of Concept test on the Made Purple equipment is being carried out in the Transition Service . The NIS audit work continues with interim submission in October 2025 on the progress again recommendations, currently waiting notification of the scope of 2026 review. National timescales are being followed in relation to making tax digital Patient digital inclusion/patients funds systems are currently under review, outcomes from this will be subject to funding. The action identified as amber was Loop - Management of annual leave for all non-nursing roasters to be fully embedded in this approach.
Climate	**Deliverables: 2 of 5 actions being delivered, 3 remaining actions for Q3&4 reporting** 100% on track. Net Zero continues to progress with the Mini tender completed and contract awarded in relation to general waste and recyclables. Food waste equipment has been purchased. Majority of the vehicles have been upgraded to electronic and the salary options for staff to purchase private electronic vehicles is being explored

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 2025
Agenda Reference:	Item No: 21
Sponsoring Director:	Chief Executive Officer
Author(s):	Programme Director
Title of Report:	Project update for the National High Secure Forensic Healthcare Services for Women in Scotland
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

TSH 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).

The proposal is 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, 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 bi-monthly. The last meeting was held on 27 November 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

The adaptations required to change two of the bedrooms to low stimulus rooms are all completed with the exception of the installation of CCTV which is due to be completed by January 2026. Work to enhance the garden area to include sensory equipment is ongoing with a view to being completed before the financial year end.

Outreach Service

The 'test of change' pilot proposal was submitted to the WPOB on 27 November and approved.

The initial pilot will focus on the following areas:

- HMP Stirling – develop enhanced mental health support to SPS and healthcare teams in managing women with high levels of mental health need who pose a risk of harm to others.
- Continuous Professional Development (CPD) – develop professional links across Medium Secure providers and SPS to improve expertise across the forensic estate.
- Training – Offer and/or facilitate training focused on aiding ability to formulate and manage risks associated in managing women with complex needs.

The CPT will continue to undertake stakeholder events with SPS and Health colleagues where there will be opportunities to reflect upon real cases and identify shared learning that can assist in determining practical and achievable objectives for the Outreach Service.

The CPT will develop an evaluation process via a 'what you said, what we did' format. An interim update on progress will be provided to the WPOB with a formal report that includes feedback provided to the meeting in May 2026.

3.3 PHASE 2 UPDATE

Strategic Assessment Process

The proposal to further develop Option 3 with Thomson Gray commenced on 29 October 2025 and a draft report expected in January 2026.

The Programme Director provided a presentation on the development of the Strategic Assessment (SA) to the Corporate Management Team on 3 December 2025. A timeline for overall submission of the SA has been developed with the aim of presenting a draft report to the TSH Board meeting in April 2026. As per DL (2025) 15, the deadline for final submission to the Capital Investment Group is March 2027.

3.4 FINANCIAL UPDATE

Phase 1
Discussion on recurring revenue are ongoing through the quarterly finance meetings and sponsorship team at Scottish Government. A re-assessment of the resource profile for the Interim Service is being undertaken by the CPT based upon current demands experienced within the service. This will inform the funding request for 2026/7. Spend to date remains within budget for both revenue and capital. The Finance Corporate Risk has been updated to reflect the position on recurring funding.

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. This allocation will be partly utilised to fund the development of Option 3 as agreed at TSH Board meeting in August 2025.

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 fortnightly 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 November 2025 the risk profile for Phase 2 was updated and approved to reflect the financial risks relative to the resources required to support the development of Phase 2 and the potential for the proposal not be supported by the Scottish Capital Investment Group. Both risks are currently graded at Medium.

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 has been established by the CPT. Recent engagement has been with the following organisations:

- HMP Stirling.
- Forensic Network.
- NHS Ayrshire and Arran – Foxgrove Development.
- NHS Assure - development support for the SA submission.
- Scottish Human Rights Commission (SHRC) – Staff members from the SHRC visited on 3 December where they had the opportunity to meet with members of the Executive team, visit the Skye Centre, Patients Advocacy Service and the Interim Womens Service in Mull 3. The feedback from the meeting was positive and there are further visits planned to meet with the Patient Partnership Group and have more detailed discussions with PAS on patients rights.

4 RECOMMENDATION

The Board is invited to **note** the status of the National High Secure Forensic Healthcare Services for Women.

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 December 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 are ongoing with Securitas regarding the remaining works required to achieve contractual completion.

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 been implemented. The Project Oversight Board continues to meet monthly and the last meeting took place on 4th December 2025. Weekly operational meetings continue.

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. 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 and are potentially subject to rapid change a full verbal update will be given to in the Board's Private Session.

b) Project Timescales

Rev 74 is awaited and will forecast an end date in January.

Works to be addressed include:

- F2K Issues previously agreed and known to the Board and to be addressed following contractual completion. These works are currently forecast for the six months following completion

- A small number of works that need to be addressed before Contractual Completion can be awarded:
    - Water ingress to cable ducts
    - Operation and Maintenance Manuals
    - Cameras affected by power fluctuations at generator tests

c) Progress

Contract Completion
Discussions with Securitas have been ongoing. Due to the commercial sensitivity and fluid nature of these discussions a verbal update will be provided in the Board's private session.

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 £1,098k. This has increased by 7k since the October 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 approximately zero.

The key project outline at 8th December 2025 is:

Project Start Date:	April 2020
Planned Completion Date (Estimate):	Jan 2026
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 08/12/25:	£9,890,426
Total costs to date (exc. VAT & retention) at 08/12/25:	£9,858,808
Total costs to end of project (Exc. VAT & retention)	£ 31,618

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 08th December 25 is:

Securitas	£ 7.299m
Thomson Gray	£ 1.329m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 1.147m
Miscellaneous	£ 0.002m
Income	-£ 0.118m
Total	**£ 9.860m**

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.