

**THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING**

**THURSDAY 16 APRIL 2026
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 26 February 2026	For Approval	TSH(M)26/01
4.	Matters Arising: Rolling Actions List: Updates	For Noting	Paper No. 26/21
5.	Chair's Report	For Noting	Verbal
6.	Chief Executive Officer's Report	For Noting	Verbal
7.	Patient Story: Women's Service Introduced by Director of Nursing and Operations	For Noting	Presentation
8.	Global Citizenship Introduced by the Medical Director	For Noting	Presentation

10.30am

RISK AND RESILIENCE

9.	Corporate Risk Register Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 26/22
10.	Finance Report – to 28 February 2026 Report by the Director of Finance & eHealth	For Noting	Paper No. 26/23

10.50am

CLINICAL GOVERNANCE

11.	Daytime Confinement (DTC) Report Report by Director of Nursing and Operations	For Noting	Paper No. 26/24
12.	Quality Assurance and Quality Improvement Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 26/25

11.10am

BREAK

11.20am

STAFF GOVERNANCE

13.	Health and Care Staffing Annual Report Report by the Director of Nursing and Operations	For Decision	Paper No. 26/26

14.	Whistleblowing: (a) Annual Report (b) Advice to Cabinet Secretary Report by the Director of Workforce	For Decision	Paper No. 26/27
15.	Staff Governance Report Report by the Director of Workforce	For Noting	Paper No. 26/28

11.50am **CORPORATE GOVERNANCE**

16.	Annual Review of Standing Documentation: (a) Standing Financial Instructions and Scheme of Delegation Report by the Director of Finance and eHealth (b) Standing Orders and Members Code of Conduct Report by the Head of Corporate Governance	For Decision	Paper No. 26/29 Paper No. 26/30
17.	Communications Annual Report 2025/26 Report by the Head of Communications	For Noting	Paper No. 26/31
18.	National High Secure Forensic Healthcare Services for Women in Scotland Report by the Programme Director		Paper No. 26/32
19.	Perimeter Security and Enhanced Internal Security Systems Project Report by the Programme Director	For Noting	Paper No. 26/33
20.	Audit and Risk Committee: Approved Minutes of meeting held 29 January 2026 Report of meeting held 19 March 2026	For Noting	ARC(M) 26/01 Paper No. 26/34
21.	Any Other Business		Verbal
22.	Date of next meeting: 12.30pm on 18 June 2026		Verbal
23.	Close of Session		Verbal

Estimated end at 12.30pm



THE STATE HOSPITALS BOARD FOR SCOTLAND

TSH (M) 26/01

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 26 February 2026

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

Chair:

Brian Moore

Present:

Employee Director
Non- Executive Director
Non- Executive Director
Chief Executive Officer
Director of Nursing and Operations
Vice Chair
Finance and eHealth Director
Non- Executive Director
Non-Executive Director
Medical Director

Allan Connor
Stuart Currie
Cathy Fallon
Gary Jenkins
Karen McCaffrey
David McConnell
Robin McNaught
Pam Radage
Shalinay Raghavan
Lindsay Thomson

In attendance:

Corporate Business Manager
Social Work Mental Health Manager
Acting Director of Security, Estates & Resilience
Clinical Forum Chair
Head of Communications
Head of Planning, Performance and Quality
Head of Corporate Governance/Board Secretary
Programme Director
Director of Workforce

Anne Donnelly
David Hamilton
Allan Hardy
Joe Judge
Caroline McCarron
Monica Merson
Margaret Smith [Minute]
David Walker [Items 21 & 22]
Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

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 18 December 2025 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minutes of the meeting held on 18 December 2025.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board noted that the listed action points as reported had progressed or were on the agenda for today's meeting. Ms Fallon asked for clarification about the clinical audit matrix reported through Quality Improvement and Quality Assurance reporting, and Ms Merson noted that it would be reported in whole to the Clinical Governance Group. Any issues would then be escalated to the Clinical Governance Committee. There had not been any matters for escalation for the last meeting.

In answer to a query on available funding for the Protected Learning Time part of the previous Agenda for Change (AfC) pay deal, Mr Wallace advised that there had been no indication of specific funding in this respect but that this was not expected to be impactful for the State Hospital at present.

The Board:

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

5 CHAIR'S REPORT

Mr Moore advised that the NHS Board Chairs Group had met with focus on the implications of the three-year spending review and Scottish Government draft budget settlement. This had also been a key focus in the Board Development Session that had taken place on 22 January alongside presentations on the State Hospital Medical Directorate and the Nursing and Midwifery Task Force underlining the importance of the workforce both in the short term and the longer term.

NHS Chairs met with the Cabinet Secretary for Health and Social Care on 17 February, and this meeting had provided assurance on the Reduced Working Week implementation linked to redesign and innovation. The significance of whistleblowing as a critical safeguard and as fundamental to strong governance was also discussed, as well as the key priorities of Public Service Delivery Scotland including workforce, digital data, and shared services. There had been a further NHS Board Chairs meeting this week, and one of the key presentations was on the Public Health Scotland 10-year Strategy which was relevant to the State Hospital's own approach to reducing health inequalities.

Finally, Mr Moore spoke of a recent walkround visit that he had undertaken with Mr McConnell to the Women's Service meeting with staff and members of the wider multidisciplinary team. He thanked them for their engagement and their objective account of the current issues being experienced. He also reflected that the visit had given a sense of the level of staff commitment and positivity about the service. Mr McConnell agreed with this sentiment, and commented on the pride that staff felt about what had been achieved despite the existing challenges.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided his report covering his activities since the date of the last Board meeting, and commencing with national updates including meetings of the Board Chief Executive Group. This had reviewed a broad range of matters within the Operational Delivery Plan including planned and unscheduled care and the Reduced Working Week, and priorities for 2026–27. He also advised that attention had been given to planning around mental health, neurodiversity, and learning disabilities. Digital developments and business systems, as well as the public health agenda were also discussed. Board Chief Executives had their regular quarterly meeting with the First Minister highlighting progress in planned care, whole system flow issues, and ongoing sub-national planning work.

He also confirmed that the latest quarterly sponsorship meeting had taken place on 23 February

with Scottish Government, with discussions addressing the Women's Service, Northern Ireland charging, and branding for the State Hospital. Mr Jenkins outlined the position in terms of sub-national meetings which continued across the East and West regions, with briefs covering orthopaedics, business systems, and the digital front door, all working towards draft plans due by the end of March. He also confirmed that a planned mental health development day for Board Chief Executives at the State Hospital had to be re-scheduled, but was now planned for April 2026, and would include speakers from the State Hospital.

In terms of the National Executive Lead Collaborative for healthcare in custody which Mr Jenkins chaired, he noted that there had been review of thematic reports on substance misuse within the Scottish Prison Service, as well as an upcoming report from the Committee for the Prevention of Torture following a visit to Scotland.

Mr Jenkins then outlined some internal activity including a digital innovation workshop which had taken place on 26 January. There had been an on-site visit from Full Time Officers from the RCN and the POA, and this had been an opportunity to explore issues of culture and connection. He thanked colleagues for their contributions and underlined the importance of partnership working.

He confirmed that the Strategic Planning and Performance Group had met and that outputs from this were included in report on today's agenda. There had been further progress made through engagement with staff groups on organisational restructure, with planning to implement this in April. He noted that there was one key issue remaining in terms of the Security Project with reporting on that today; and that today's agenda also included review of the Corporate Objectives, as well as a new Physical Health Strategy. He also acknowledged the work progressed by Ms Merson in relation to the Annual Delivery Plan (ADP) for the coming year, with a final draft almost completed. Lastly, he highlighted that the Staff Excellence Awards would take place on 4 March.

Mr Currie said that it was important to keep focused on the key intention of the Reduced Working Week, which was aimed at staff wellbeing. He also spoke to the positives to be taken from the way in which the Women's Service had been stood up within the prescribed timescale, and the positive contributions from staff. He commented that this may provide wider system learning that could be show cased, for example at the NHS Scotland annual event. Mr Jenkins emphasised the evident dedication of the team in this respect.

Mr Moore spoke to the timescales for sub-national planning committees; with confirmation that the Sub National Plan for 2026/27 was due to be submitted to Scottish Government by 31 March 2026.

The Board:

1. Noted the update from the Chief Executive.

7 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 26/02) from the Acting Director of Security, Resilience and Estates in respect of the Corporate Risk Register. Mr Hardy provided a summary overview of the report, confirming that five risks remained rated as High, and outlined the background to each of these risks. He also provided an update on the migration of risk data to the InPhase system which was scheduled to take place in the next week with good progress being made.

Mr Currie noted the need to ensure that risks were aligned to the relevant standing committees so that clear assurance could be taken at this level, as an important governance tool, and it was agreed that this should be reviewed going forward. Following discussion, it was agreed that this should be included in the next risk update to the Board Development Session in March, which would encompass the wider risk management framework.

Action – Mr Hardy

Ms Radage noted the consistency of the five risks rated as being High over time, acknowledging these as being complex and multi-faceted areas, and asked for consideration as to whether these could be reframed whilst not diluting them. Mr Hardy said that each of these had been reviewed in

detail over the course of the last 18 months, noting the movement across the register as a whole.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk
2. Agreed to further work to develop the register would come to the next Board Development Session.

8 FINANCE REPORT

The Board received a paper (Paper No. 26/03) from the Director of Finance and eHealth, presenting the financial position to 31 January 2026 (Month 10).

Mr McNaught provided an overview of the report which recorded a small favourable variance and anticipated a break-even position at year end. He also confirmed good progress with each directorate in respect of savings planning for the coming year, with most already identified. Mr McNaught also noted the continuing pressures within the nursing budget, and confirmed that further background information had been provided to the Scottish Government with regard to resourcing of the Women's Service, and that a response was currently awaited.

He advised that the Scottish Government was content with the current forecast and savings trajectory. Further, that in relation to the capital demands for the current year, these were nearing completion from the available budget allocation including recent additional allocations for estate maintenance, and work was progressing on the capital plan for 2026/27.

Mr McConnell referred to funding of the Women's Service, and asked about the way in which the underspend recorded related to the positive position for year end, and how the costs of the service were captured given the movement of staff from other services. He asked for clarification on the consequential costs for other services. Mr McNaught confirmed that the timing of the Women's Service being stood up mid-year had meant that an underspend had been recorded, with consideration to be given to what might be required in terms of provisioning at year end to make sure that was appropriately addressed. In terms of staff costs in the context of movement across services, detailed attention was given to recording this accurately. There may be some instances of overtime arranged at short notice not being included, but this would not have a significant change to the overall position.

Mr Currie thought it was important to underline the need to re-base the budget for the Women's Service as this would stabilise resourcing overall and ensure that there was greater flexibility in service delivery. He referred to the positive benefit the increased use of LED lighting would bring, and asked about preparedness in terms of other small capital projects being in a position to be taken forward should additional funding be made available at short notice, as could be the case towards year end. Mr McNaught answered in the positive on this last point, and cited the example of procurement of laptops within the eHealth budget. It was the case that some elements of this type of funding could be targeted to specific areas. The capital plan did include potential future areas of work, which could be progressed dependent on funding. Mr Hardy confirmed that this was the case within Estates, with a proactive approach being taken.

In respect of the Women's Service, Mr Jenkins agreed with the point made, in terms of core funding and the impact this would have on service delivery across the whole hospital. The work being progressed currently was aimed at showing tangibly the difference between normal baseline running of service, distinguishing the uplift required to resource the Women's Service.

In response to a query from Ms Fallon on the savings identified from existing vacancies and what the position would be if the organisation were fully staffed, Mr McNaught said that this was related to natural

turnover of staff which could be expected to exist during the normal course of business. Mr Jenkins added assurance that there had been no delay in progressing recruitment, and that this did represent the expected lag related to the ongoing filling of vacancies. He also noted the need for

Careful financial planning going forward, within the existing landscape which included the aim within nursing to recruit to a position of 105%, the offset of this in a reduction in overtime costs, as well as the additional pressure of the Reduced Working Week.

Mr Moore summarised the discussion, highlighting that although the Board was in a good position presently, there were a number of challenges arising most particularly the balance between financial management and ensuring that the right workforce was in place to support patient care.

The Board:

1. Noted the content of the report.

9 PHYSICAL HEALTH STRATEGY

The Board received a paper from the Medical Director (Paper No. 26/04) which presented the new Physical Health Strategy for the State Hospital. Professor Thomson outlined the key aspects of the strategy for the Board. She noted that it had been developed in response to internal audit recommendations and was aimed at addressing the high levels of premature mortality and physical morbidity among patients. The strategy highlighted the strong existing foundations such as screening and vaccination programmes, while emphasising the need for enhanced staff training, improved access to patient health data, and greater focus on physical activity, weight management, and individualised engagement with patients. Professor Thomson also noted that the strategy also recognised new requirements arising from the development of the Women's Service, including additional screening and medication considerations. She emphasised that the strategy set out clear plans for implementation alongside measurable Key Performance Indicators (KPIs) covering obesity, physical activity, annual health reviews, and timely access to primary care. Finally, she noted that the strategy described the reporting framework and governance route through the Clinical Governance Committee to support Board oversight.

Ms Fallon spoke positively about the strategy, finding it to be very clear in its aims, and asked about any financial impacts. Professor Thomson confirmed that the main impact would be through the cost of anti-obesity medications and the cost of screening and vaccination programmes. She also noted the importance of enabling patient physical activity which would require adequate staff resourcing.

Ms Raghavan asked if stratification of the data existed around patient engagement with programmes, to identify any trends across patient cohorts, and also whether peer support could be a further enabler. Professor Thomson confirmed that this data was available in detail on a ward-by-ward basis, as well as identifying levels of patient access to activity, and that this was fed back to clinical teams. There were different factors across the services including mental wellbeing and stage in care journey. For example, a new initiative was underway in relation to patients with Intellectual Disability to give a tailored approach to consideration of unescorted grounds access.

Ms Radage noted that the value of peer support was evident within the Patient Partnership Group, when she had attended recently, and that catering staff had also been in attendance meaning that there had been a constructive discussion about healthy diet. Professor Thomson also noted the importance of increasing staff focus on patient physical health, across all disciplines with clinical teams recognising their role to support this as well as patients' mental wellbeing.

Mr Moore summed up the positive reception by the Board, and that the strategy was formally approved. He noted that detailed oversight of the implementation and effectiveness of the strategy would be through the Clinical Governance Committee.

The Board:

1. Endorsed the Physical Health Strategy.
2. Agreed that oversight would be through the Clinical Governance Committee.

10 CARERS STRATEGY – UPDATE

The Board received a paper from the Director of Nursing and Operations (Paper No. 26/05) which provided an update on the progress of the Carers' Strategy. This was presented by Ms McCaffrey, who noted that the strategy focused on strengthening engagement, improving communication, and enhancing the visiting experience. It was also the intention to further embed the carer voice in service improvement, recognising that the hospital formed only one part of a wider forensic patient journey.

She highlighted four priority areas - Triangle of Care, communication and information, visiting experience, and the carer pathway which had guided progress. A self-assessment of the Triangle of Care had identified areas for improvement, leading to refreshed feedback processes and better evidence of carer involvement. Work had also been undertaken to improve engagement and the visiting experience through a regional approach across the Forensic Network, which offered carers greater accessibility and anonymity. A carers' toolkit had been developed to help families navigate the complex forensic landscape, while local improvements had been made through enhanced carer involvement in the Care Programme Approach (CPA) and strengthened feedback mechanisms. The update also set out next steps, including implementing actions across a range of mechanisms.

Mr McConnell noted the points of linkages to the wider Forensic Network for carers, and asked for further background on how this occurred in practice. Ms McCaffrey said the key was in supporting the carer to develop a positive relationship with clinical teams within the State Hospital, and that it was important to recognise that once the patient moved on, the carer would also go through a transitional period with a new clinical team, and may be experiencing anxiety as a result. Practical steps would include videos or walk throughs of different care facilities, though an individualised approach would be taken in each case. She also clarified that the weight of focus was on the whole patient journey from admission onwards, maintaining carer relationships throughout.

Mr Moore thanked Ms McCaffrey for this update, which was helpful, and showed improvement and understanding of carer issues, and supporting all staff to understand the delivery of care through the carers' lens. He thought that tremendous progress had been made in this area overall. It was agreed that reporting would come back to the Board as part of its workplan.

Action – Ms Smith

The Board:

1. Noted the Carers Strategy update.
2. Requested reporting updates to be arranged to return to the Board.

11 DAYTIME CONFINEMENT (DTC) REPORT

The Board received a paper from the Director of Nursing and Operations (Paper No. 26/06) which provided an update on the progress on work undertaken to ensure that DTC would cease within the State Hospital. This was presented by Ms McCaffrey, who provided a summary overview noting that reporting covered the period up to the end of January. This showed that although a predicted spike had occurred, performance had improved substantially afterwards due to the considerable efforts of staff.

Ongoing challenges relating to resourcing and patient acuity remained relevant, but significant progress had been made, particularly through moving into an over-recruitment phase, with new staff due to start in March. She advised that further recruitment initiatives were planned, including internal and external recruitment fairs, myth-busting about high secure work, and trialling same-day interviews to accelerate hiring. The organisation had also embedded a strengthened incident command process supported by a bespoke template and clear audit trail, while the use of Microsoft Teams for recording and transcription had reduced administrative burden, allowing discussions and decisions related to DTC to be managed effectively.

Dr Judge referred to the huge efforts made in respect of recruitment of staff, and asked if there were concerns about retention levels. He also asked for further background around the evidence

available in respect of levels of clinical acuity. Ms McCaffrey responded that retention levels remained consistent with no specific concerns, and further that it was heartening to see staff who had left the organisation later opting to return. Mr Wallace added that the data in this respect for the State Hospital demonstrated a lower attrition rate than the average level for NHS Scotland. Further, it was on a downward trend. This would continue to be a key focus through the recruitment and retention strategy. Mr Jenkins added that any upward trend in staff leaving the organisation would always be of concern, but that the data did not show this to be the case. Nonetheless, it was essential to continue on the culture change programme being led with the support of Organisational Development. Ms Radage commented positively on the proactive approach being taken to recruitment, especially on the day interviews at recruitment fairs. This was discussed in terms of ensuring due process, as well as benchmarking to other NHS Boards who were also taking this approach.

In terms of clinical acuity, Ms McCaffrey confirmed that this was monitored carefully across the hospital with the longitudinal data for the male services not demonstrating a particular trend albeit with peaks being experienced. She also spoke to the different challenges that arose in the Women's Service, and how this impacted across service delivery as a whole.

Mr Moore summed up for the Board, and noted that a further update on the Women's Service would form part of the Board Development Session taking place on 5 March.

The Board:

1. Noted the Daytime Confinement Report.

12 QUALITY ASSURANCE AND QUALITY IMPROVEMENT REPORT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 26/07) which outlined key aspects of quality assurance and improvement activities. Ms Merson provided a summary of the key aspects noting that the report reported strong overall assurance in clinical audit performance, noting high compliance levels and only minor improvements required across recent local audits. It confirmed that the transition to digital CPA reporting had been completed, with improved governance expected despite some early data-entry inconsistencies.

Ms Merson advised that Quality Improvement (QI) activity remained active, with nine ongoing projects, continued staff capability building, and growing national recognition for the organisation's work. She highlighted two posters being presented at the International Forum on Quality and Safety in Healthcare in Oslo in March. Further, that TSH3030 for 2026 would be launched shortly.

Ms Merson noted that Realistic Medicine actions were progressing well, and national guidance documents had been reviewed with only a small number requiring further evaluation. Lastly, Ms Merson highlighted newly published Clinical Governance Standards from Healthcare Improvement Scotland (HIS) which would be reviewed and integrated into ongoing governance processes.

Ms Raghavan asked about the Scottish Improvement Leaders Programme (SciL) and if those projects were fed into the wider QI approach with the hospital, saying that grassroots improvements like these were important. Ms Merson agreed and provided assurance that this was the case, citing the "BRAN" questions project recently completed and which was now in active use within nursing care plans.

As Chair of the Clinical Governance Committee, Ms Fallon confirmed that the Head of Clinical Effectiveness had communicated that Clinical Governance Standards would be reviewed by the Clinical Governance Group at its March meeting, with reporting to the Committee thereafter. She also asked about the number of QI projects running presently, and Ms Merson confirmed that this represented a high level of activity, with the opportunity to initiate new projects in TSH3030 this year.

Mr Moore commented that in terms of the CPA process, it was positive to see refinements and improvements in terms of how data was captured, as well as a reduction in manual tasks.

The Board:

1. Noted the Quality Assurance and Quality Improvement Report.

13 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minutes of the meeting, which had taken place on 13 November 2025, as well as a summary report (Paper No 26/08) of the meeting which had taken place on 19 February 2026. Ms Fallon provided some further background saying the 12 monthly reports had been very positive, and that the Activity Oversight Group was being stood down.

The Board:

1. Noted the content of the approved minutes dated 13 November 2025.
2. Noted the update from the meeting held on 19 February 2025.

14 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 26/09) providing an overview of workforce performance data, and this was presented by Mr Wallace. He indicated that staff absence levels had improved, with January 2026 reducing to 7.93% from the higher winter figures seen in November and December. He said that historical data showed that this represented the lowest starting position for several years, notwithstanding distortions from COVID-related special leave, while specific areas such as Lewis 3 continued to experience high absence rates. The national comparison showed the organisation approaching parity with territorial boards, a significant improvement from previous years.

Mr Wallace also outlined recruitment activity, with further onboarding of nursing staff in March, and recruitment continued in pursuit of the 105% staffing target, supported by potential increases in hours from part-time staff. He also advised that overtime and supplementary staffing (SSR) usage had risen since December, leading to some breaches of average weekly working hours, though only at the lower threshold above 48 hours, with continued monitoring planned. Lastly, PDPR compliance, which had dipped below 90% in December due to resourcing pressures, had subsequently risen again above 90% in January.

Mr Currie was pleased to see the downward trend in absence rates, and noted the unique challenges that the State Hospital faced within NHS Scotland. He thought that there was a need to apportion resources to correlate with those mechanisms that demonstrated positive impact on absence levels. Further to use data to project into the future in terms of expected trends shown from the data. This would be essential given the reported costs of absence and the impact this was having on the organisation. Mr Wallace advised that this was planned using the SSTS system but presently this could be limited given the lag in data coming through from individual services, however, work would continue in this respect. Ms Radage noted that the Staff Governance Committee had discussed reporting on future projection, and that this would be reported to the Committee. She thought it would be helpful to have an update on benchmarking to other secure environments, and to have comparisons within reporting. This was agreed and would be part of reporting going forward.

Action – Mr Wallace

Ms Fallon referred to work-related injuries, and asked about the support in place in this respect for staff. Mr Wallace provided further background on how this was being assessed through the use of health dashboards with reporting to the next Workforce Governance Group, which would feed into the Staff Governance Committee. Ms Fallon also asked about the role of the Staff Care Specialist, and Mr Wallace outlined that this had previously been provided through a Service Level Agreement with NHS Lanarkshire but would now be in-house. This role would focus on supporting staff directly on a one-to-one basis, and also a focus on peer support and bespoke wellbeing initiatives.

Mr Moore summarised for the Board, and also noted that three wards out of eleven had sickness

absence levels of below 5% which should be recognised. It may be possible to take learning from those areas. Overall, the Board took assurance from reporting and recognised the challenges presented.

The Board:

1. Noted the Staff Governance Report.

15 WHISTLEBLOWING REPORT

The Board received a paper (Paper No. 26/10) from the Director of Workforce which provided the Quarter 3 update. Mr Wallace confirmed that there had been no new cases in this period.

The Board:

1. Noted the content of the report.

16 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 20 November 2025; as well as a summary report (Paper No 26/11) of the key areas of reporting and discussion at the meeting which had taken place on 12 February 26. Ms Radage noted the good progress made with implementation of the Organisational Development Strategy, as well as detailed discussion around e-rostering, sickness absence levels, and working environment.

Ms Fallon raised Non-Executive Walkrounds which were progressing, and how these would be communicated to staff, perhaps a bulletin from the Non-Executive cohort. Mr Jenkins also noted the current review of structure, culture change, and engagement, and that a key component was effective communication and that this may present opportunities in this respect. Mr Moore agreed it would be helpful to consider as a Board in terms of a refreshed communications approach, which could include feedback from Committees as well. There may be an opportunity to be creative, and to help to increase Board visibility in the organisation. Ms McCaffrey also emphasised the importance of asking staff for their views, and noted that she would be undertaking a planned engagement session in March.

The Board:

1. Noted the content of the approved minutes of the meeting on 20 November 2025.
2. Noted the update from the meeting held on 19 February 2026.

17 CORPORATE OBJECTIVES 2026/27

The Board received a paper (Paper No. 26/12) from the Head of Corporate Governance. Ms Smith provided a summary of the key aspects of reporting, saying that this was an annual opportunity for the Board to review and refresh its corporate objectives, linking these to existing planning mechanisms and highlighting progress made over the past year. The Corporate Objectives were presented under the four pillars of Better Care, Better Health, Best Value and Better Workforce, with proposed changes clearly marked to show movement from the previous year.

The report emphasised developments such as the implementation stages of recently agreed strategies, updates relating to the Women's Service, and the evolving national and sub-national planning context affecting the State Hospital. It also reiterated how well the objectives were embedded within the organisation's Performance Framework, and noted the importance of continuing to align these objectives with the Corporate Risk Register.

The Board discussed the importance of clearly describing its aims and this included consideration of the Women's Service especially the ongoing development of the outreach service, and the complex

landscape and interface between service providers. Further, to consider physical healthcare in terms of flow navigation to emergency and acute care when required, and that this formed part of the overall aims of the Physical Health Strategy.

Ms Fallon commented that this represented a comprehensive presentation of the key aims of the Board, and asked about two points in respect of it being helpful under Better Care to add further emphasis to continuous improvement as well as best practice research principles, and also to highlight Triangle of Care within the overall strategy for carer engagement. These points were agreed, and that the document should be amended on this basis.

Mr Currie found the linkage made to the Performance Framework, as well as the Corporate Risk Register to be constructive and helpful as it supported cohesive oversight of the overall direction of travel at a strategic level. This would enable scrutiny and give clear insight for informed decision-making.

Mr Moore added his agreement to this, and also opened discussion on the aim to eliminate daytime confinement as a key objective. It was agreed this would remain as an essential component given that the elimination was essential for positive clinical care. It was agreed that Ms Smith would amend the document and circulate the finalised version, which would also be published on the website for transparency.

Action – Ms Smith

The Board:

1. Endorsed the Corporate Objectives for 2026/27, on the bases that these would be amended in line with discussion.

18 QUARTERLY UPDATE: Q3 PERFORMANCE INDICATORS AND ANNUAL DELVIERY PLAN

The Board received a paper (Paper No. 26/14) from the Head of Planning, Performance and Quality. Ms Merson presented the key elements in respect of Quarter 3 performance across key corporate KPIs noting that eight of the twelve KPIs had met or exceeded their targets for the fourth consecutive quarter. She advised that four remained off-target with one rated amber and three red. The amber-rated KPI (six-monthly care and treatment plan reviews) had improved from red, supported by ongoing process mapping and anticipated benefits from the new real-time dashboard. The red-rated measures related to patient exercise levels, BMI, and staff absence, each reflecting longer-term seasonal or structural challenges.

Discussion on these metrics included recognition of some improvement in relation to patient obesity levels as well as confirmation that exercise equipment was available within all hubs across the hospital.

Ms Merson provided a summary overview of implementation of the Annual Delivery Plan (ADP) which had shown strong progress during Quarter 3 with 58 of the 63 actions under way (92%) rated green and only five amber. She noted that the structure of the report aligned with the organisation's critical success factors and medium-term planning framework. Ms Merson provided further background across the full range of the plan. There was discussion on the timing of audit against security standards, with the reasoning provided, confirming that this would align to follow the completion of the ongoing project work. Further there was acknowledgement of restructuring around service delivery within hubs, and that this would be embedded into future planning.

Mr Moore thanked Ms Merson for progress reporting in these key areas.

The Board:

1. Noted the content of reporting.

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

The Board received a paper (Paper No. 26/14) from the Programme Director providing the updated position in respect of this project. Mr Walker joined the meeting and led the Board through the content of the paper, noting that the Project Oversight Board had met in January and was due to meet again in April.

Mr Walker outlined the position in relation to the outreach service and the collegiate approach being taken which had been positively received by NHS and Scottish Prison Service partners, and offering a more effective consultative model. Further engagement sessions and professional development events were underway, with evaluation planned for the next Project Oversight Board meeting. He also provided a progress update on Phase 2, confirming that the draft feasibility study had been received this week, and should be finalised shortly, and this would inform the Strategic Assessment.

Mr Moore commented positively on the stakeholder work being undertaken in respect of the outreach service, and this was echoed by Professor Thomson who also noted the established clinical forum for female services and that annual patient census data had been received in the past week, and was being analysed and would be shared. Mr Walker was also able to clarify that CPD presentations were available across forensic services.

It was noted that there were some aspects of reporting relating to clinical aspects that would be reviewed within the private session held today to protect patient confidentiality given the small size of the service.

The Board:

1. Noted the update within reporting and that this was also an item for discussion in the private session of the Board today.

20 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report (Paper No. 26/15) which provided assurance that the project was nearing completion. Mr Walker noted the areas that were outstanding and confirmed that a further update would be provided within the private session of the Board today, given the commercial and security sensitivities involved.

The Board noted that systems were functioning at present, and that this was a continuing area of overspend.

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.

21 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting that took place on 2 October 2025; as well as a summary report (Paper No 26/11) of the key areas of reporting and discussion at the meeting which had taken place on 29 January 26. As Committee Chair, Mr McConnell described the main aspects of reporting for each meeting, and noted that the last meeting had included an internal audit on absence, disciplinary and suspension management processes which had achieved reasonable assurance, as well as initial planning from external auditors. Alongside the usual suite of reports, there had also been focus on the Audit Scotland report highlighting the financial challenges faced by NHS Scotland.

There was discussion on audit work on use of Soft Restraint Kits (SRKs) and the detailed internal

analysis conducted in this respect, and related reporting to the Clinical Governance Committee.
The Board:

2. Noted the content of the approved minutes of the meeting on 2 October 2025.
3. Noted the update from the meeting held on 29 January 2026.
- 4.

22 ANY OTHER BUSINESS

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

23 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 16 April 2026.

24 PROPOSAL TO MOVE TO PRIVATE SESSION

The Board then considered and approved a motion to exclude the public and press during consideration of the items listed as Part II of the Agenda in view of the confidential nature of the business to be transacted.

25 CLOSE OF MEETING

Mr Moore brought the session to a close.

The meeting ended at 12.35pm

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	February 26	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: Reporting within meeting, and confirmation that project nearing completion so action will be considered further at that point. February Update: project still ongoing and progress and action to be considered at completion. April Update: project completion is imminent and action to be completed thereafter.
2	December 2025	Patient Advisory (PAS) 12 Month Report	Provide feedback if possible on how advocacy services operate at other UK Sites	K McCaffrey	June 2026	February Update: PAS have started the process and have identified 6 key points for comparison. The next stage is to gather the necessary information and analyse the data prior to collating an overview. April Update: Work progressing as outlined.

3	December 2025	Daytime confinement	Update to return to the board including on implementation of incident command process	K McCaffrey	February 26	February Update: On Agenda (Item 13). Incident Command process outlined and reviewed a part of reporting item. CLOSED
4	December 2025	Clinical Forum minutes	To clarify point made on communication across the organisation	M Smith	February 26	February Update: Clinical Forum discussed communication within the organisation and the role of the forum especially in light of Ministerial review. In 2026, meetings will include attendance from Board Chair, Non-Execs and CEO and other Execs to CF Meetings, and this can be monitored for effectiveness. CLOSED
5	December 2025	Climate Change and sustainability	Update on data – re staff uptake of salary sacrifice schemes – cycle to work.	A Hardy	February 26	February Update: Cycle to work scheme was introduced in 2023, and 30 staff members have taken this up. Planning is in place for electric vehicles but not yet in place. CLOSED
6	February 2026	Corporate Risk Register	Alignment of each risk in terms of governance at Board and Committee level for oversight, and wider work on risk management structure – review within next BDS	A Hardy	June 26	April Update: Discussed at Board Development Session in March 26, with further areas of review outlined.
7	February 2026	Carers' Strategy	Schedule continued reporting to the Board for oversight, as part of workplan	M Smith	Immediate	April Update: scheduled annual update to Board. CLOSED

8	February 2026	Staff Governance Report	Add benchmarking to reporting – in respect of sickness absence levels at other secure environments	S Wallace	April 26	April Update: comparison to medium secure unite Included as part of reporting (Item No 16). CLOSED
9	February 2026	Corporate Objectives	Amendments to be incorporated and then circulated.	M Smith	Immediate	April Update: Amendments made and final version circulated, as well as being published on the website. CLOSED

Last updated – 13.03.26 MS

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026

Agenda Reference No: Item No: 9

Sponsoring Director: Acting Director of Security, Estates and Resilience

Author(s): Risk Management Team Leader

Title of Report: Corporate Risk Register

Purpose of Report: For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

This report provides the Board with an 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.

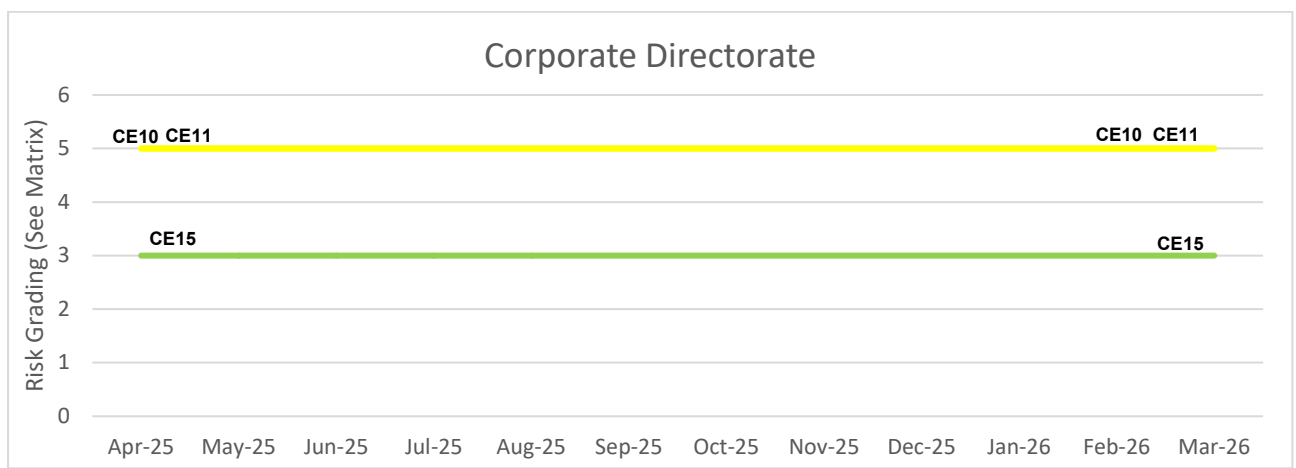
Risk Matrix

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

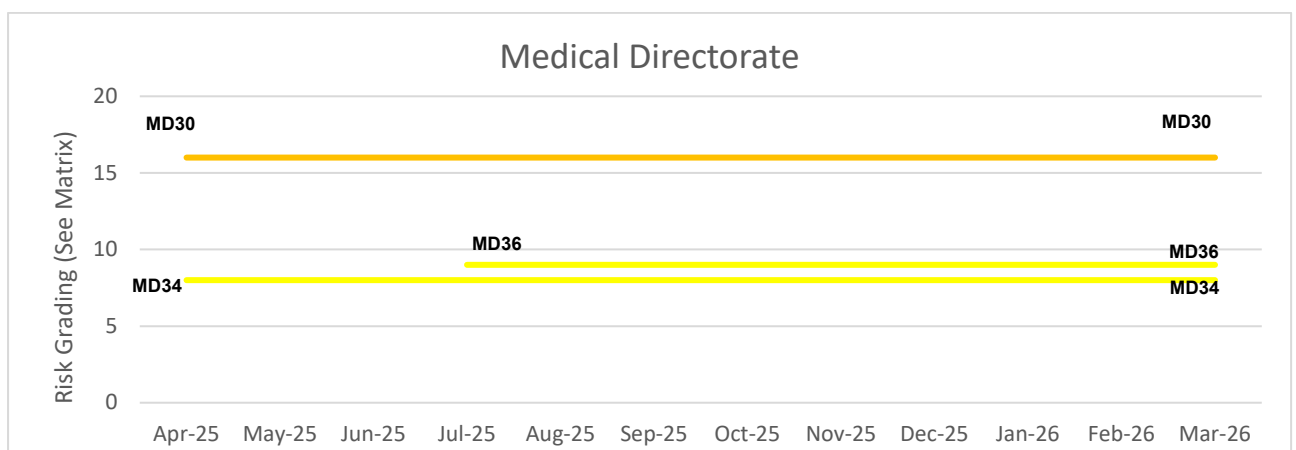
Corporate

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



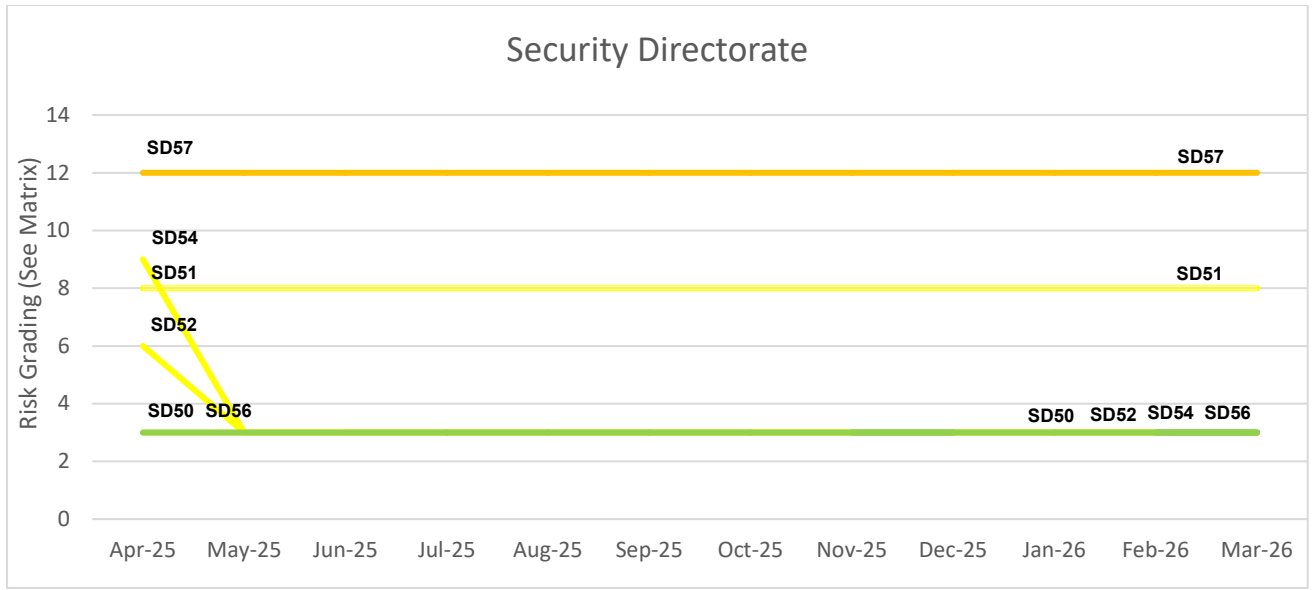
Medical

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



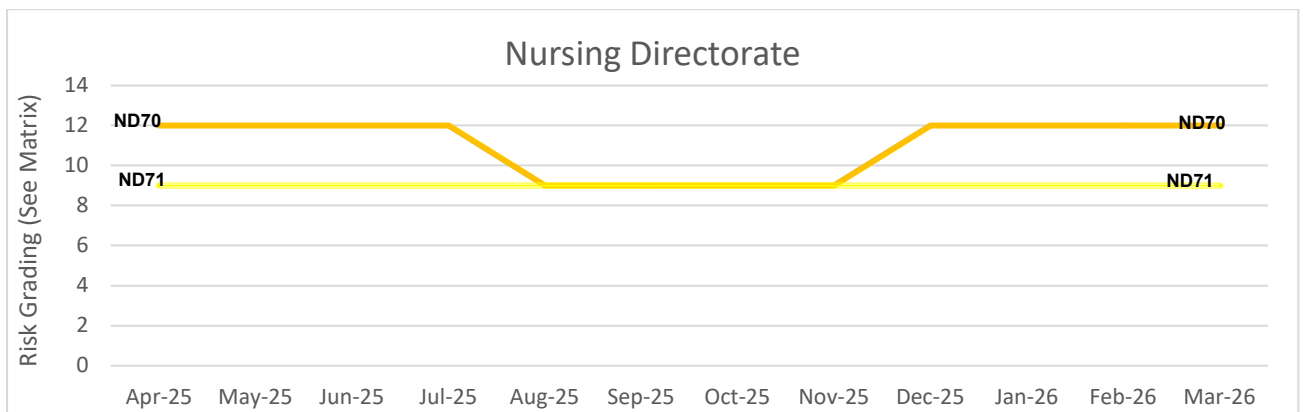
Security

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



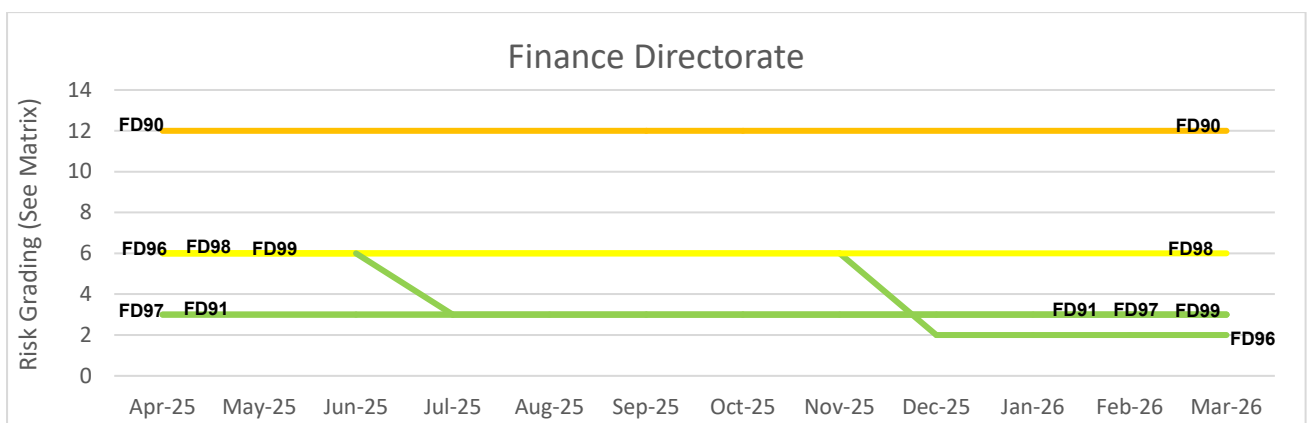
Nursing

There are no changes to the risk gradings within the Directorate



Finance

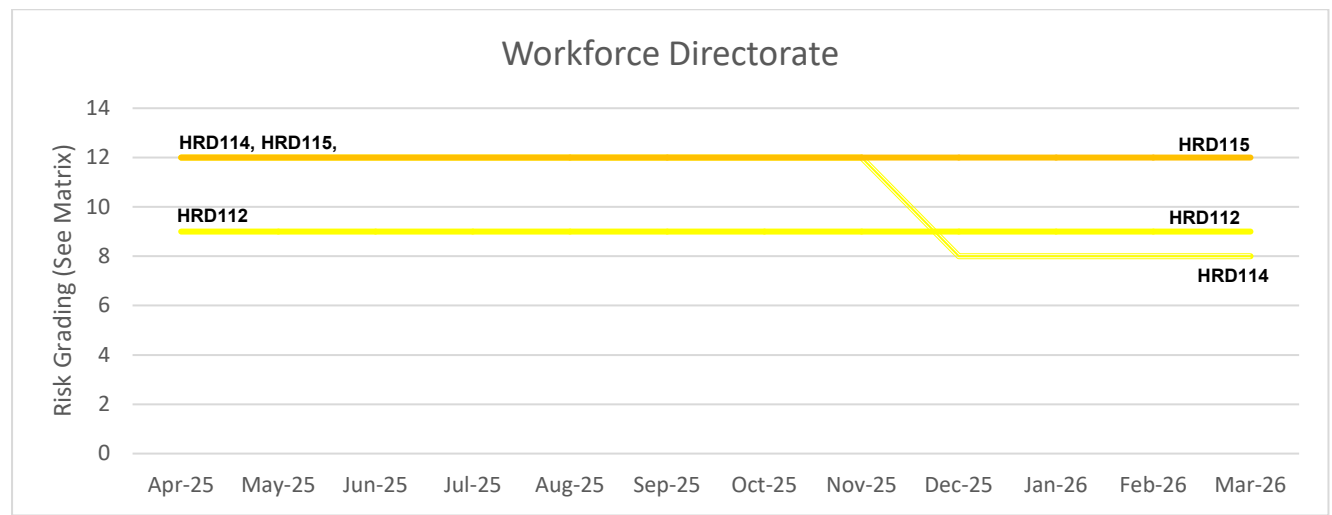
There are no changes to the gradings within the Directorate.



Workforce

There are no changes to the gradings within the Directorate.

HRD114 Impact of Reduced Working Week is currently being reviewed as the decreased in hours came into effect on 01 April 2026.



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.

Discussion and review have taken place regarding the risk and its monitoring approach (BMI), resulting in consensus that BMI is not a suitable tool for tracking physical health. The KPI has been reviewed and is scheduled to launch in April 2026, coinciding with the beginning of the new financial year. A new risk assessment has also been created and will be implemented at the same time as the KPI. As of now, the transition process is in progress.

Security Director:

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

The risk was elevated to ‘High’ in October 2024 for not meeting national event review deadlines. Although the group inherited a review that was behind schedule, they managed to approve and finalise it on time, a positive improvement in progress on previous records. Members of the SAER group report the new process to be more efficient and transparent. The Risk and Resilience Team also noted time savings and improved communication during change reviews.

The Team commissioned a Category 2 Review in December 25 which has since been upgraded to a Category 1 Review. Regular updates are being provided through the weekly meetings. Once the review is approved, the risk rating will be re-evaluated.

Finance Director:

FD90: Failure to implement a sustainable long-term model

The risk highlights ongoing financial challenges and anticipated budget constraints from the Scottish Government for 2024/2025. Regular meetings occur with the government and monthly internal reviews are held. The organisation is at break-even, but stable funding for the women's service is uncertain. The Reduced Working Week (HRD 114) may affect the organisation in 2026/27. The risk rating remains '**High**'.

Workforce Director:

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 December 25.

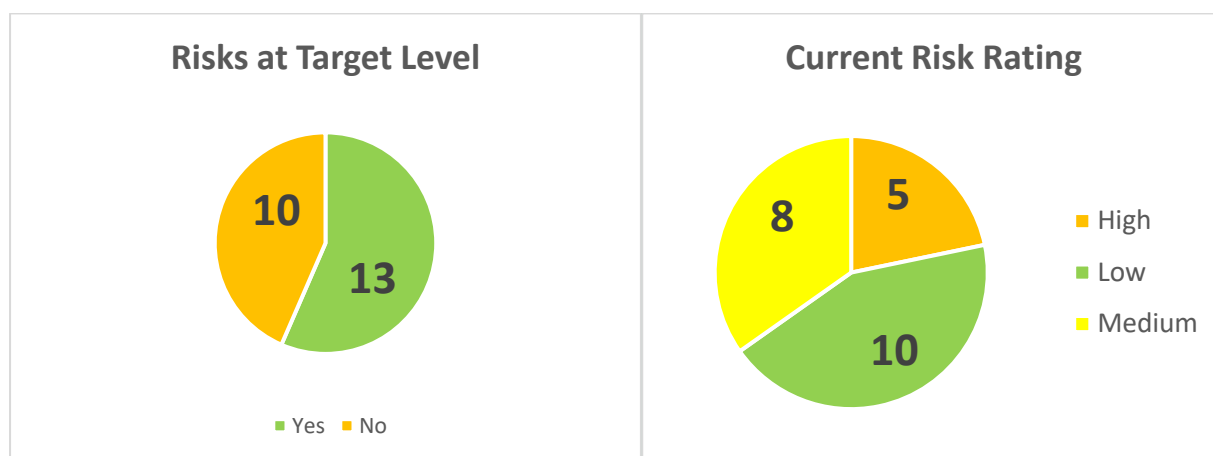
Nursing Director:

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 25. 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 13 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			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

InPhase, a new platform for TSH to record incidents, complaints, claims and risks, went live in March 2026. Currently the incidents, complaints and claims modules are in use. Work is underway to configure elements of the system to ensure staff can get relevant information to assist with their roles and reporting requirements. Following completion of the system development, the focus will move to using InPhase to record both Local and Corporate Risk Registers. The platform has been developed and is ready for testing, with a goal to begin by May 2026.

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 is 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	N/A
Financial Implications	N/A
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Clinical Governance Committee, Audit and Risk Committee, Staff Governance Committee, CMT
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	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	Governance Group	Target Level Achieved
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	Apr 26	Clinical Governance Committee	Clinical Governance Group	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 & E-Health Director	Finance & E-Health Director	Apr 26	Audit and Risk Committee	Finance, eHealth and Audit 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 & E-Health Director	Head of Corporate Planning and Business Support	Apr 26	Audit and Risk Committee	Security, Risk, Health and Safety 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	Apr 26	Staff Governance Committee	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	Apr 26	Clinical Governance Committee	Clinical Governance Group	Not at Target

Medium Risks – Review Quarterly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Governance Group	Target Level Achieved
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Major x Rare	Major Rare	Chief Executive	Board Secretary	May 26	The Board	CMT	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	May 26	Clinical Governance Committee	Clinical Governance Group	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	May 26	Clinical Governance Committee	Clinical Governance Group	At Target

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Governance Group	Target Level Achieved
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	May 26	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	June 26	Audit and Risk Committee	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	June 26	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance & E-Health Director	Head of eHealth/ Info Gov Officer	June 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Possible	Moderate x Rare	Director of Workforce	Training & Professional Development Manager	June 26	Staff Governance Committee	Workforce 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	June 26	Staff Governance Committee	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	Governance Group	Target Level Achieved
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	Apr 26	The Board	CMT	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	Aug 26	Audit and Risk Committee	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	Sep 26	Audit and Risk Committee	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	Governance Group	Target Level Achieved
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	Sep 26	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	At Target
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Aug26	Audit and Risk Committee	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 & E-Health Director	Head of eHealth	Apr -26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Negligible x Unlikely	Negligible x Unlikely	Finance & E-Health Director	Head of eHealth	Jun 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance & E-Health Director	Head of eHealth	Aug 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Rare	Moderate x Rare	Finance & E-Health Director	Head of eHealth	Apr 26	Audit and Risk Committee	Finance, eHealth and Audit Group Audit and Risk Committee	At Target

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026

Agenda Reference No: Item No: 10

Sponsoring Director: Director of Finance and eHealth

Author(s): Deputy Director of Finance

Title of Report: Finance Position Update to 28 February 2026

Purpose of Report: For Noting

1 SITUATION

This report provides an update on the Hospital's financial performance for Month 11 (M11), which is also submitted monthly to the Scottish Government (SG) alongside the statutory financial reporting template.

The Board is asked to note the Revenue and Capital Resource outturn and associated 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 The State Hospital (TSH) and SG continue to monitor progress against agreed targets – the most recent being 9 February 2026.

3 ASSESSMENT

3.1 2025/26 Budget

- The current budget comprises SG Revenue Resource Limit (core and non-core) allocations of £55,797k. An additional £1,651k has been assumed in the budget for new capital charges relating to the Enhanced Security Project. The total Annual Revenue Budget is £57,448k
- It is anticipated there will be remaining budget from the AFC Reform allocation – to be confirmed.
- As a result of the delayed start to the female service the full budget allocation of £3.1m has not been fully committed. It is likely there will be budget remaining at year end, this will be determined by the additional nursing costs incurred before year end.
- Outline budget plans have been agreed for 2026/27, as noted in 3.2. Savings plans have been identified with a small number of departments still to finalise their plans.

3.2 2026/27 Budget and SG engagement

The Hospital's three-year financial plan 2026-29 has been submitted to SG and was formally accepted by the Chief Finance Officer Health and Social Care in their letter of 26 March.

The plan is accepted with a forecast breakeven for 2026/27, and a savings target of £1.6m, of which £0.7m is identified as recurring.

The SG letter also highlights the importance of the undernoted, on which we will therefore ensure appropriate focus –

- delivery of savings schemes to start as early as possible in the year;
- any new emerging pressures or risks to be identified as soon as possible and mitigation discussed;
- progress to be maintained with the revised 15 Box Grid;
- full engagement to continue with our Board Support Lead; and
- engagement as appropriate with sub-national planning.

3.3 Financial position 2025/26 – allocated by Board Function / Directorate

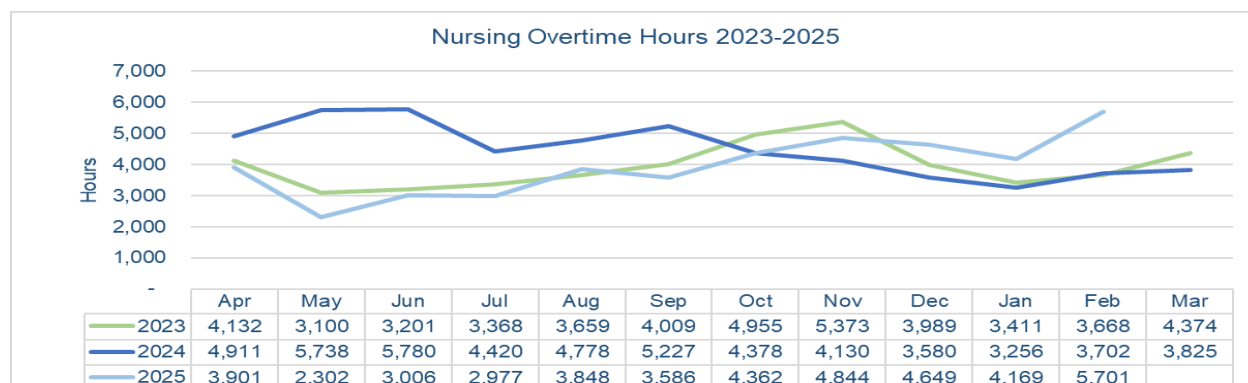
- Month 11 position: £109k overspend
- Year-to-Date Position: £360k underspend

Directorate Summaries:

Directorate	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance £'k	Budget WTE	Actual WTE	Comments
Cap Charges	4,518	4,139	4,142	(3)	0.00	0.00	Capital charges have increased by £1,651m this year as a result of new assets being added to the register. New capital charges will be fully funded by the Scottish Government.
Central Reserves	2,616	0	0	(0)	0.00	0.00	Unallocated RRL has been phased to period 12 and will be released as required. This includes unallocated budget for the women's services and AFC reform funding that have not been utilised.
Chief Exec	2,780	2,545	2,507	38	25.87	24.87	Vacancies within departments are resulting in a small underspend overall. 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 recurrently from reserves.
Finance	2,940	2,708	2,689	19	33.18	29.87	Underspend in training and vacancies across the directorate. £16k pressure within HR as a result of additional PVG certificates.
Human Resources Directorate	1,247	1,142	1,080	62	16.03	15.14	The benefit from the consultant vacancy earlier in the year has been offset by the cost pressure arising from additional sessions required to cover sick leave. The invoiced SLA charges included in the current position are under dispute with the Scottish Government. If these charges are credited, the financial position will worsen by approximately £100k.
Medical	3,868	3,625	3,571	53	20.68	19.74	Income has been received from exceptional circumstances patients, no further recharges are anticipated this financial year. The underachieved income pressure will grow.
Misc Income	(120)	(112)	(90)	(22)	0.00	0.00	see below for detailed narrative from nursing directorate
Nursing And Ahp's	30,284	27,695	27,521	174	444.16	461.06	Vacancies across the directorate are contributing to underspend, most utilities pressures have been funded from reserves.
Security And Facilities	9,315	8,539	8,500	40	124.83	123.88	
	57,448	50,281	49,921	360	664.75	674.56	

Key Drivers:

- The small year-to-date underspend continues, driven primarily by vacancies across all directorates. Although vacancies have existed for several years, reduced overtime usage and fewer hours worked in nursing have contributed to the underspend emerging this year.
- Nursing overtime hours have recently increased and are currently among the highest recorded in the last three years, this has negatively impacted the in-month position.



Nursing update – Provided by Associate Director of Nursing

- The main contributors to nursing overtime at The State Hospital continue to be increases in the daily operating model because of clinical acuity (across female service and male services), alongside ongoing vacancies and sickness absence.
- Recruit campaigns to manage the Band 5 vacancy gap continue ongoing with some success over recent months.
- Plans for further recruitment campaigns are also underway with consideration of summer campaigns to attract final year nursing students.
- Work is also underway to attend university careers fayres in addition to onsite recruitment events.
- Following Board approval to "over-recruit" to 105% further Band 3 recruitment drives were undertaken in December 2025 with interviews taking place in January 2026.
- Onboarding for Band 5 and Band 3 positions took place in January 2026 with further onboarding scheduled for March 2026.
- As detailed in previous updates the hospital now has one additional ward to care for female patients. This service was formally stood up at the end of July 2025. Recruitment to support the opening of the female service, whilst successful, did impact on Band 5 vacancy figures for the existing male services which continues to have impact.
- Due to clinical acuity within the female ward, there has been a need to increase the staffing levels being used to safely manage the service, which has had a negative impact on the level of overtime being utilised. Work has been completed to determine the level of funding required to manage this service going forward.
- 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 around effective roster management, effective use of allocated funding, and robust oversight of non-pay related spending. This coordinated approach to staff and finance management is demonstrating positive effects.
- The Director and Associate Director of Nursing continue to meet monthly with the Deputy Finance Director to ensure the Nursing Directorate remains on track to meet all financial savings and requirements.

Financial Pressures:

Sickness Absence

Increased costs have been recorded within Medical, Finance and Security & Facilities Directorates. Nursing and Human Resources directorates' sickness absences have been reduced.

Sickness Absence by Directorate	2024/25 FY £'k	2025/26 YTD £'k
Chief Exec	8	9
Finance	95	112
Human Resources Directorate	14	6
Medical	89	276
Nursing And Ahp's	2,070	1,903
Security And Facilities	364	516
Total	2,640	2,822

Sickness Backfill Costs

Backfill costs required to cover sickness absence represent an additional financial pressure. Nursing budgets include an extra 5% allocation specifically to support backfilling for sickness absence. However, other departments do not receive this additional funding, meaning any backfill required in other directorates creates an unfunded cost pressure as does any sickness absence within nursing above the 5% funded absence.

Sickness Backfill by Directorate	2024/25 YTD £'k	2025/26 YTD £'k
Nursing and AHPs	1,518	1,211
Security and Facilities		21
Total	1,518	1,409

M365

- M365 remains a pressure, this has been offset against non-recurring reserves.

Energy and Inflation Increases

- Utility spend is currently overspent by £145k, this is a reduction on previous years' costs. Costs are expected to increase in financial year 2026/27, with confirmation of anticipated costs awaited.

AFC Reform

- £1.4m recurring budget allocated to cover RWW pressures of reducing from 37 hours to 36 hours. A request to fund the initial half hour reduction for essential services has been submitted and we await confirmation of funding for 2026/27 – this equates to £400k.

Women's Services

- 2026 funding remains unconfirmed awaiting decision from SG.
- Estimated recurrent cost: £5.2m to provide current service rising to £6.3m at full capacity.

Enhanced Security Project

- Fully capitalised; staffing and project management costs are now reported as revenue pressure.
- £25k pressures are reported in Month 11. Year-to-date cost pressure is £125k.

Benefits:

Travel & Training

- Reduced spending due to online meetings/training.

Vacancies

- High vacancies continue to drive underspend, partially offsetting overtime costs.

ECP Patient Income

- Discussions continue 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).
- An estimated level of proposed charging, and draft Service Level Agreement, has been notified to SG in early March to be taken forward in discussion.

4 ASSESSMENT – SAVINGS

The current annual savings target is £1,920k, we have achieved 92% of the annual savings plans to date and are in line to fully achieve the savings targets set.

The recurring savings target of 3% against baseline funding will continue into 2026-27 to help improve financial and service sustainability across NHS Scotland. Savings will be benchmarked against other boards to allow us to assess our performance and highlight areas of opportunity.

Directorate	Annual Target £k	YTD Target £k	Savings Achieved £k	Suplus/ (Shortfall) £k
Chief Exec	70	64	62	(2)
Finance	128	117	114	(3)
Human Resources Directorate	37	34	33	(1)
Medical	113	103	103	0
Nursing And Ahp's	872	800	802	2
Security And Facilities	700	642	646	4
	1,920	1,760	1,760	0

5 CAPITAL RESOURCE LIMIT

With some movement in planned Capital CRL, the Scottish Government have given authority to TSH to repurpose this budget to replace aged machinery as identified and prioritised by Estates and Facilities. This is being purchased in March 2026.

Capital CRL 2025/26	Annual Plan £k	YTD Spend £k
Capital		
Anti Barricade and Observation Panels	53	53
E-health equipment	54	30
Kitchen Equipment/Doors	36	22
Defib & Vital Signs Machines	50	50
Hi Voltage Switch Room Door	22	0
Key Safes	20	18
TV protection Cabinets	20	20
Laundry Equipment	18	18
Records Office Upgrade	9	9
Capital CRL Allocation	282	220
BCP Funding		
Islay Repair	100	26
Patient Wander Path	185	0
Animal Shed Replacement	94	58
Fire Alarm Replacement	80	0
BCP Allocation	459	84
Additional Capital		
LED Lighting Replacement	282	120
Laptops	100	26
Additional Capital	382	146
Total CRL	1,123	450

6 RECOMMENDATION

The Board is invited 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 the financial position
Corporate Objectives Please note which objective is linked to this paper	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 Resources Directors Groups.
Workforce Implications	No workforce implications – for information only
Financial Implications	Reporting on financial outturn and budgetary compliance
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Deputy Director of Finance CMT Partnership Forum
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. 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 – no privacy implications

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026

Agenda Reference No: Item No: 11

Sponsoring Director: Director of Nursing and Operations

Author(s): Director of Nursing and Operations

Title of Report: Daytime Confinement (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.

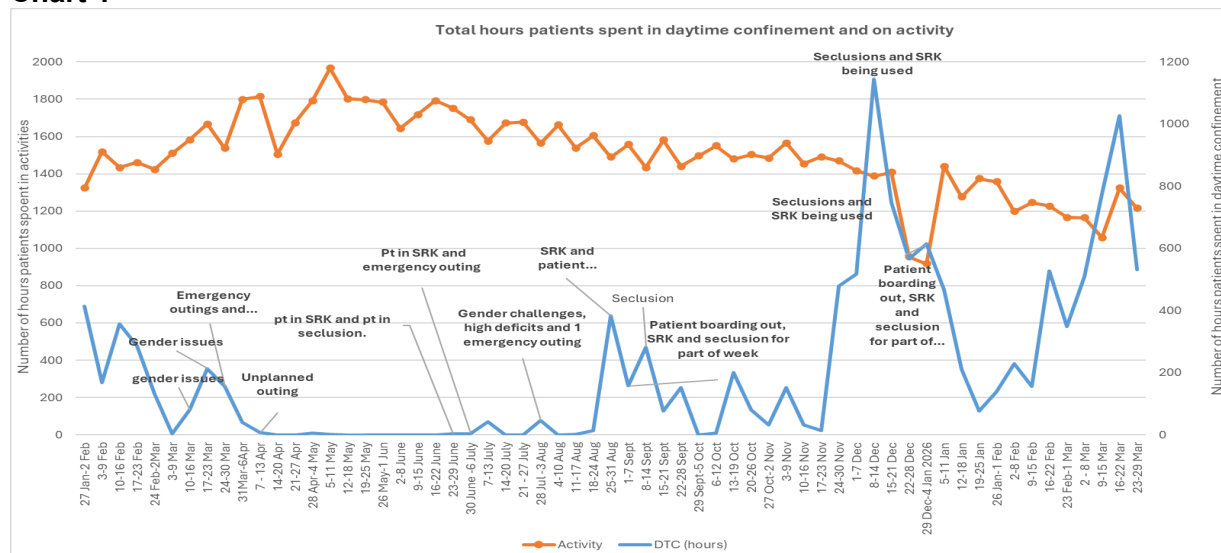
The data presented in the report covers the period up to and including the 29 March 2026.

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 but there has been good progress made.

3. ASSESSMENT

Chart 1



Hospital wide run chart (Chart 1)

February - DTC decreased from 1505.5 to 1258.8 hours. The number of activities being provided to our patients remained about the same across the reporting month with these ranging from 1165.9 hours week beginning 23 February and 1244.7 hours week beginning 9 February.

The Skye Centre delivered 82% of planned activity in the week commencing 16 February, with activity falling to a low of 72.1% in the week beginning 23 February. This reduction was primarily due to increased hours allocated to ward support and higher levels of short-term staff sickness. The greatest impact was on activity delivered by the Skye Activity departments, followed by a reduction in drop-in activity hours.

A total of 69 occasions equating to 204.25 hours were allocated to ward support to mitigate DTC. The majority of these hours occurred in the week commencing 2 February, reduced mid-month, and increased again in the final week commencing 23 February. The reduction in DTC hours during normal working hours reflects ward deficits being covered by other clinical services out with nursing.

March- DTC increased from 1258.8 to 2844 hours. The number of activities being provided to our patients decreased across the reporting month with these ranging from 1057.8 hours week beginning 9 March and 1323.4 hours week beginning 16 March.

The Skye Centre delivered 81% of planned activity in the week commencing 2 March, with activity falling to a low of 64.4% in the week beginning 9 March. This reduction was primarily due to increased hours allocated to ward support, impacting activity delivered across the Skye Centre Activity departments and the Hub activity staff group.

A total of 84 occasions, equating to 234 hours, were allocated to ward support to mitigate DTC. These hours peaked mid-month before decreasing in the week commencing 23 March. The reduction in DTC hours during normal working hours reflects ward deficits being covered by other clinical services out with nursing.

Operational Management

Meeting Structure and Progress

Oversight meetings continue. There is still work streamlining the process and ensuring the membership is right at all forums. The Directorate undertook a process mapping exercise on the 18th March to look at these meetings in more detail and ensure process is efficient and effective. Once the outputs of this are written up they will identify a more streamlined approach, with a agreed recording and auditing processes in place.

Recruitment

Over recent months the nursing department have undertaken sustained recruitment campaigns to close the vacancy gap created by the opening of the Interim Women's Service.

As noted in previous update reports, approval was given to over-recruit by 5% across the ward-based nursing workforce. Band 5 and Band 3 interviews were subsequently undertaken in early January 2026 and appointments offered to successful candidates with onboarding in March 2026.

On the 31st March 2026 the hospital also hosted a recruitment fayre, within the staff wellbeing centre, which was well attended and resulted in thirteen Band 5 offers being made to prospective candidates. HR colleagues are currently in contact with each of these individuals to establish onboarding timescales (i.e. there are a mixture of current Band 5s who should be able to start in May along with final year students whom we will explore Band 3 contracts until they are able to practice in Registrant roles).

In addition to the recruitment fayre members of the nursing team have been attending university recruitment events which have attracted positive interest, and further Band 5 interviews are scheduled for the coming weeks. On conclusion of these interviews, the senior nursing team will assess the overall nursing position and consider next steps.

In the meantime, the Directorate continue to monitor the impact on resourcing across the male wards as a result of the opening of the women's services, and over the coming period will engage in focused piece of work to address concerns about the impact of DTC on males wards as a consequence of ongoing support to the female service.

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. An audit is scheduled for April/May to monitor compliance with the process.

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. 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



THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	16 April 2026
Agenda Reference No:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Head of Clinical Quality Corporate Planning, Performance & Quality Project 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

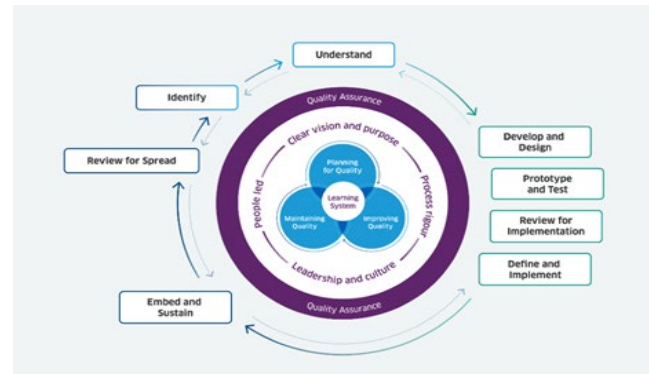
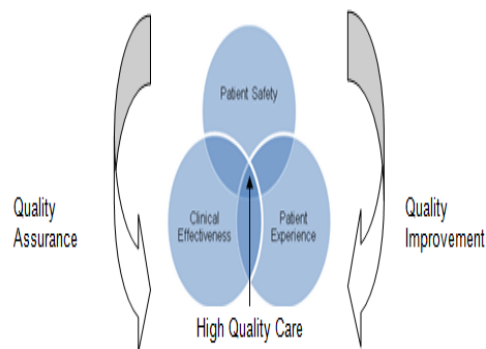
2 BACKGROUND

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 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 CPA oversight monitoring report . It should be noted that this is the first month staff have not completed a variance analysis tool and the data is being analysed from source (RiO).
- Updates on recent clinical audit activity.
- An update on quality improvement activities 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 invited to note the paper.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	The quality improvement and assurance report supports the TSH Clinical Quality Strategy 2024 – 29.
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 Meeting 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	This will be part of the project teamwork for any of the QI projects within the report.

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. 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.

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL – FEB/MARCH 2026

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. The Controlled Drugs and Diabetes Audits gave significant assurance to the organisation and the PMVA Seclusion and the Mechanical Restraint Audits both gave moderate assurance with improvement plans agreed through the Commissioning Groups.

- Controlled Drugs Audit
- PMVA Seclusion Audit
- Diabetes Audit
- Mechanical Restraint Audit

A number of other audits have been completed but have not been sent to their commissioning group for approval.

The Master Audit table (table 1) provides a summary of the most recent audit cycle 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									n/a		
Medicine Fridge Audit									n/a		
HEPMA Audit									n/a		
PMVA Post Physical audit			n/a				n/a	n/a	n/a		
Unvalidated progress notes									n/a		
Nurse progress note on each shift									n/a		
Controlled Drugs Audit						n/a			n/a		
RMO contact with patients									n/a		
Observations of Care									n/a		
PMVA Seclusion Audit						n/a	n/a	n/a	n/a		
Oxygen cyclinder checklist											
Epilepsy Audit		n/a			n/a	n/a	n/a		n/a		
Clinical Care Policy Audit							n/a	n/a	n/a		
PRN Audit						n/a	n/a		n/a		
Nutritional Screening Tool Audit											
Mechanical Restraint Audit				n/a		n/a	n/a	n/a		n/a	
Diabetes Audit		n/a					n/a		n/a	n/a	

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 was provided to the Clinical Governance Group in February 2026.

1.2 CPA oversight monitoring report

Monitoring of the transition from the paper based system to electronic reporting of staff attendance, provision of report and discussing the report with patients in the CPA process has revealed continuation of random variation. Key worker, OT and Pharmacy were furthest away from their attendance targets. Some improvements have been highlighted to Heads of Services to ensure that the data is being put into RiO to allow for robust data to be reported. Work is almost complete on a tableau dashboard that will give teams easier access to their governance data.

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. The following initiatives collectively support our commitment to delivering safe, person-centred care and operational 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.
- **The International Forum on Quality and Safety in Healthcare scheduled for March 2026:** Two posters were displayed (TSH3030: A 30-day quality improvement sprint- outcomes and lessons learned and Elevating Standards – Refining the Care Programme Approach (CPA) process in Scotland's High Secure Mental Health Facility). The State Hospital deliver a workshop at the Conference based on the TSH3030 QI sprint.
- **TSH3030:** Planning for the 2026 cycle of TSH3030 has commenced. This QI sprint will take place throughout May 2026 with four teams registered at the time of writing this report. Registration will close on the 15 April 2026. A Seminar Series was held in March to raise awareness of TSH3030, showcase successes from 2025/26, and encourage team participation.

2.3 QI Capacity Building

2.3.1 – Scottish Improvement Leaders Programme (SciL)

Cohort 53 – Three staff members 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 five concluded in February 2026, with four staff members participating in the course. A total of seven staff completed the Qi essential training through 2025-26.

2.4 Realistic Medicine

A seminar series is planned for April 2026 presented by the Realistic Medicine Lead providing an update on the work being undertaken by the team. An update report for 2025-26 and the TSH Realistic Medicine Action Plan for 2026-27 was submitted to the Scottish Government on the 31 March 2026 for consideration.

Scottish Government extended a provisional offer of continuation of funding for 2026/27 for the Clinical Lead role and Project Management role for one day per week at existing levels, this offer was accepted.

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 3 February to 31 March 2026, 35 guidance documents have been reviewed: 28 documents were considered either not relevant or were overridden by Scottish guidance and three were shared for information. Progress is being made via Clinical Governance Committee in relation to the HIS Clinical Governance Standards whilst decisions are awaited regarding maternity care and diabetic eye screening standards.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required
MWC	2	2	0
HIS	3	0	1 (2 pending decision)
National Institute for Health & Care Excellence (NICE)	30	1	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 is awaiting to be tabled at the Person Centred Improvement Steering Group (PCISG) and then at Physical Health Steering Group (PHSG) for final sign off.

The NICE guideline regarding Obesity was initially delayed due to the high number of recommendations to review and scheduling conflicts within the group. The gap analysis process has been completed, content reviewed and will be tabled at PHSG in April for final sign off. Work will be ongoing to cross match outstanding recommendations with the action plan from Supporting Healthy Choices to avoid any duplicate working.

Table 3: 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. PCISG meeting rescheduled from December 2025 and feedback on content agreement being sought. Final sign off by PHSG anticipated for end of April 2026 if possible.	September 2024	May 2026

Body	Title	Steering Group	Current Situation	Publication Date	Projected Completion Date
NICE	Overweight and obesity management	PHSG	Was progressed in absence of current Scottish guidance (publication anticipated March 2027). Evaluation matrix completed by SHC group. Content review completed and will be tabled at PHSG in April 2026 for final sign off. Work ongoing regarding cross matching of outstanding recommendations with existing SHC action plan.	January 2025	April 2026

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026

Agenda Reference No: Item No: 13

Sponsoring Director: Director of Nursing and Operations

Author(s): Director of Nursing and Operations
Associate Director of Nursing

Title of Report: Health and Care Staffing Annual Report

Purpose of Report: For Decision

1 SITUATION

This report provides an update on a number of key related areas, specifically:-

- **Health and Care (Staffing) (Scotland) Act – Annual Report**

This report is intended to provide members of The State Hospital's Board for Scotland with an update on the work undertaken over 2025-2026, to ensure compliance with the Health and Care (Staffing) (Scotland) (2019) Act.

Appendix A (attached) outlines the full evidence report which, subject to approval, will be submitted to Scottish Government for review.

- **An Update on eRostering**

This report will provide an update on the progress in the full implementation of Optima.

- **An update on Roster Compliance Audits (referred from Audit & Risk Committee)**

This report will also provide an update on the actions and outcomes from the Internal Audit outcomes on Rostering, with specific references to shift swaps and TOIL.

2 BACKGROUND

The Health and Care (Staffing) (Scotland) Bill was passed by parliament on 2 May 2019 and received Royal Assent on 6 June 2019 before finally being enacted in April 2024.

The Act is intended to provide a statutory basis for the provision of appropriate staffing in health and social care settings, enabling safe and high quality care and improve outcomes for service users. It will do this by ensuring that the right people with the right skills are in the right place at the right time. This is defined in section **121A: Duty to ensure appropriate staffing**. The Act does not apply to non-clinical staff.

Further duties included in the legislations are:

- 121B Duty to ensure appropriate staffing: Agency worker
- 121C Duty to have real-time staffing assessment in place
- 121D Duty to have risk escalation process in place
- 121E Duty to have arrangements to address severe and recurrent risks
- 121F Duty to seek clinical advice on staffing
- 121H Duty to ensure adequate time given to clinical leaders
- 121I Duty to ensure appropriate staffing: training of staff
- 121J Duty to follow the common staffing method
- 121L Training and consultation of staff

Section 2 of the Act **Guiding principles etc. in health and care staffing and planning** suggests that Boards must also have regard to guiding principles when securing the provision of Health Care from a Third Party.

In order to ensure progress towards, and compliance with, The Health and Care (Staffing) (Scotland) Act 2019, the Scottish Government RAYG (Red, Amber, Yellow and Green) has been adhered to in terms of the National Report.

Regular updates have been provided to Staff Governance Committee on the importance of sustained progress on each topic throughout 2025 given the key interdependencies in this area.

The movement towards full usage and benefit realization of SafeCare is in part reliant on full utilization of eRostering (Optima) which will improve the quality of information in SafeCare, along with removing the requirements for additional manual composite processes.

The full utilization of Optima (including payroll interface) will also remove the requirement for manual processes around rota management, which was recently highlighted through Internal Audit.

As an interim measure, and to ensure fairness and consistency, Roster Compliance Audits have been undertaken to provide reassurance on the process, with the Audit and Risk Committee requesting that updates on Audits should be provided directly to Staff Governance Committee.

3 ASSESSMENT

(i) Health and Care (Staffing) Scotland Act – Annual Report

A summary of the report outcomes is outlined below:

All Professional Groups		
Duty	Duty Title	RAG
121A	Duty to ensure appropriate staffing.	Substantial Assurance
121B	Duty to ensure appropriate staffing: Agency worker	N/A
121C	Duty to have real-time staffing assessment in place	Substantial Assurance
121D	Duty to have risk escalation process in place	Substantial Assurance
121E	Duty to have arrangements to address severe and recurrent r	Substantial Assurance
121F	Duty to seek clinical advice on staffing	Substantial Assurance
121H	Duty to ensure adequate time given to clinical leaders	Substantial Assurance
121I	Duty to ensure appropriate staffing: training of staff	Substantial Assurance
121J	Duty to follow the common staffing method	Substantial Assurance
121L	Training and consultation of staff	Substantial Assurance
N/A	Planning and Securing Services	Substantial Assurance

Throughout 2025 work has focused on supporting the successful rollout and integration of the Optima e-rostering and SafeCare real-time staff monitoring platforms across all wards. This is in addition to supporting ward-based staff to become proficient in their use of the revised MHL D Workload Tool, which was implemented in October 2025.

To ensure the ability to successfully deliver on these workstreams a small multidisciplinary team was established in late summer 2025, comprising of Nursing, Learning and Development, Admin, Nursing Practice Development, and the Lead Nurse for Workforce Planning. This team is overseen by the Associate Director of Nursing with regular onward updates provided to the Workforce Director and Director of Nursing, AHP and Operations.

As noted above, the hospital continue to engage in regular Board calls with colleagues at Health Improvement Scotland; the most recent being 19th January 2026 where the Board received positive feedback on the work being undertaken to ensure ongoing compliance with the Health and Care Staffing Act legislation.

(ii) Update on eRostering

- Optima

There are currently 42 rosters active rosters in Optima within the current roster cycle.

Rostering support continues to focus on the 11 Nursing rosters, with key workstreams including SafeCare compliance and implementation of the reduced working week. All Nursing rosters have now been updated to reflect recent shift changes, and ongoing training and support is being provided to Senior Charge Nurses as they develop their 6 April roster, incorporating both the reduced working week and revised night shift patterns.

Beyond Nursing, all Heads of Service and department leads have been asked to ensure their rosters are updated to reflect any new patterns required for the reduced working week. This work is being supported by the Rostering Project Manager and HR.

HR has undertaken significant work to ensure that all staff contracts within Optima are updated to 36 hours (and pro rata for part-time staff) by 2 February for Nursing and 2 March for non-nursing staff.

Work is also progressing to support the transition to a ward-based resource management model, utilising Optima's and SafeCare reporting functionality.

Data accuracy remains a critical priority across all rosters, particularly to ensure SafeCare provides reliable and accurate information for Nursing.

- Loop

We are working toward the Annual Delivery Plan target of ensuring all staff are signed up to Loop by 31 March 2026. Significant support has been provided to non-nursing areas to increase sign-ups, and current hospital-wide registration stands at 83%.

Managers continue to receive support to ensure that annual leave entitlements for 1 April 2026 are fully entered, with a target completion date of end of February 2026.

- Interfaces

Work has begun with RLDatix to implement payroll functionality for Supernumerary Staffing Register (SSR) staff. Training is scheduled for late February as part of this implementation.

(iii) An update on Roster Compliance Audits (referred from Audit & Risk Committee)

In early 2025, a review of roster compliance was undertaken by RSM as part of the 2024/25 Internal Audit Plan. The objective of the review was to test compliance with rostering protocols across the hospital, including shift swaps and the management of sickness and additional hours. The focus was on compliance with policy and protocols where system limitations do not exist, and to make sure staff are being paid for the hours worked and patient safety requirements are met for each shift. The review outlined a number of recommendations including:

- *“As part of the ongoing review of annual leave across 2023/24, management will assess the data accuracy and consider potential mitigations to reduce human error when amending annual leave, such as whether eRostering can be adapted to accurately record annual leave for staff.”*

Following publication of their final report in May 2025 the Associate Director of Nursing (ADoN) has continued to provide regular progress updates to RSM colleagues in respect to the above noted recommendation. A summary of this progress is noted below:

Annual Leave, Single Annual Leave (SAL) days, and TOIL monitoring continues to be recorded across a number of platforms at TSH (i.e. paper and digital platforms). This form of recording will continue to be necessitated until all elements of the e-rostering platforms are optimally functioning and embedded into practice across all wards. As noted in previous updates, issues with the interface between Optima (e-rostering platform) and SSTS cannot be addressed until a national solution found, and TSH continue to be part of these discussions.

When all wards are using Optima a review of all current rostering and shift-swap related policies/procedures will be conducted with the aim of phasing-out redundant protocols; as "rules" within Optima should negate the need for paper-based recording platforms (i.e. Optima will have the capability to record and monitor annual leave, TOIL etc).

In the meantime, to strengthen monitoring and governance practices Lead Nurses now undertake consistency checks across the various data recording platforms to ensure records of shift-swaps, TOIL, and hours worked are accurate and up-to-date. This was a new practice introduced in May 2025, following a fact-finding exercise, whereby it was established that traditional practice involved SCNs carrying out ad-hoc audits of their own wards and any issues raised to the overseeing Lead Nurse during managerial meetings (i.e. there was no formal governance processes in place).

Since May 2025 five-rounds of consistency checks have been undertaken by Lead Nurses across every ward, with the sixth round (Dec-January rotas) now underway. Following discussions in early October agreement was made to increase the sample size for consistency checking from 10% to 25% per ward. This increase was introduced to strengthen oversight and to increase confidence in current recording and monitoring practices. To further strengthen the process again, it has recently been agreed that each SCN will be responsible for authorising, recording and monitoring TOIL and shift swaps within their area. Previous practice of approval and recording could often involve up to three individuals (i.e. SCN approved TOIL, Charge Nurse updated Optima and SSTS and Hub receptionist updated paper TOIL records).

Following each round of consistency checks, Lead Nurses meet with their relevant SCNs to discuss results, any noted concerns, and any relevant action plan (s) required to remedy area of concern. A record of consistency checks, and subsequent conversations is documented and any follow-up actions taken within the agreed timescale.

Overall, there appears to have been a noted improvement in the standard of record keeping for TOIL, shift swaps, and the monitoring of hours worked, and in the process of auditing this. This is likely to be a result of the changes introduced thus far and the strengthened oversight and

accountability from Lead Nurses. Following the next round of consistency checks the ADoN and Lead Nurses will review the changes introduced to date and seek to clarify any further areas for improvement.

4 RECOMMENDATION

The Board is asked to endorse the Health and Care (Staffing) (Scotland) Act – Annual Report presented at Appendix A and to note the updates on ERostering and Rota Compliance Audits.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	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 and Staff Governance Committee.
Corporate Objectives	Better Workforce (4c): 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 and Staff Governance Committee.
Workforce Implications	Assurance of fair and equal treatment in line with Governance Standard
Financial Implications	None
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Workforce Governance Group.
Risk Assessment (Outline any significant risks and associated mitigation)	No
Assessment of Impact on Stakeholder Experience	N/a
Equality Impact Assessment	N/a
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/a
Data Protection Impact Assessment (DPIA) See IG 16. 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

HEALTH AND CARE (STAFFING) (SCOTLAND) ACT 2019 – THE STATE HOSPITAL ANNUAL REPORT 2025/2026.

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Report approval

1. The box below should be completed by the person signing off the report. An electronic signature is acceptable.
2. The Act requires the annual reports to be published by relevant organisations. Please enter a hyperlink to the webpage where the report can be found in the boxes below.

Name of organisation:	The State Hospital
Report authorised by:	Karen McCaffrey
	Director of Nursing & Operations
	10/02/2026
Location where report is published:	[hyperlink]

GUIDANCE ON USING THIS TEMPLATE

Purpose

This guidance has been developed to support relevant organisations in the completion of the below template which will form their annual report detailing compliance with the requirements of the [Health and Care \(Staffing\) \(Scotland\) Act 2019 \(the Act\)](#). Completed reports must be returned to hcsa@gov.scot by 30 April 2026.

Additional resources can be accessed here: [Health and Care \(Staffing\) \(Scotland\) Act 2019: statutory guidance - gov.scot](#)

If you require further assistance or have any queries, please contact hcsa@gov.scot.

Summary Section

3. The summary asks for an overview of how the relevant organisation has carried out all of the duties and requirements of the Act. This should include all NHS functions provided by all professional disciplines covered under the Act. You will be asked to provide an assurance level in respect of your overall compliance with the Act. Definitions for these assurance levels can be found at point seven.
4. Following receipt, the Scottish Ministers must collate reports from relevant organisations and lay a combined report before Parliament, along with an accompanying statement setting out how the information will be taken into account in policies for staffing of the health service. To enable this process, the information provided by relevant organisations should be comprehensive and pertinent to the staffing of the health service. To enable this, please complete the questions contained in the reporting template in sufficient detail, setting out the key achievements, outcomes, learning and risks and how this information has been used to inform workforce planning at the local level.

Individual duties / requirements

5. Following the summary section, the template seeks detail on individual duties/requirements of the Act in turn, asking relevant organisations to provide an assessment of compliance, and to provide details. Again, this should include all NHS functions, provided by all professional disciplines covered under the Act. Relevant organisations should provide detail to explain the assurance level in respect of the Duty, detailing evidence of compliance where appropriate, or gaps and areas of ongoing focus.

Evidence could, for example, include details of the organisational structures, systems and/or processes being used.

6. The duty description contains the legislative wording of the Act, outlining the duty requirements.

7. As outlined at paragraph 3, the template requests an overall level of assurance with regard to the relevant organisation's compliance with the Act/Duties, using the assurance categories as detailed below:

Level of assurance	System adequacy	Controls
Substantial assurance	A sound system of governance, risk management and control exists, with internal controls operating effectively and being consistently applied to support the achievement of objectives in the area audited.	Controls are applied continuously or with only minor lapses.
Reasonable assurance	There is a generally sound system of governance, risk management, and control in place. Some issues, non-compliance or scope for improvement were identified which may put at risk the achievement of objectives in the area audited.	Controls are applied frequently but with evidence of non-compliance.
Limited assurance	Significant gaps, weaknesses, or non-compliance were identified. Improvement is required to the system of governance, risk management, and control to effectively manage risks to the achievement of objectives in the area audited.	Controls are applied but with some significant lapses.
No assurance	Immediate action is required to address fundamental gaps, weaknesses or non-compliance identified. The system of governance, risk management and control is inadequate to effectively manage risks to the achievement of objectives in the area audited.	Significant breakdown in the application of controls.

8. The relevant organisation is asked to provide details of areas of success, achievement and learning associated with the particular duty or requirement, along with indicating how this could be used in the future. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to complete this with an appropriate level of detail.
9. The relevant organisation is then asked to provide details of any areas of risk where they have been unable to achieve or maintain compliance with the particular duty or requirement, or where they have faced any challenges or risks in carrying out their duties or requirements. In this section, relevant organisations are also asked what actions have been or are being taken to address this. Again, in order to provide meaningful information that can inform healthcare staffing policy, relevant organisations are asked to provide an appropriate level of detail.

ANNUAL REPORTING TEMPLATE

Summary

Please answer the following questions, to provide an overall assessment of how the organisation has carried out its duties under sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL of the National Health Service (Scotland) Act 1978 (inserted by section 4 of the Act), and in line with Sections 1 and 2 of the Act : [Guiding principles for health and care staffing and Guiding principles etc. in health and care staffing and planning.](#)

Please advise how the information provided in this report has been used or will be used to inform workforce plans.

Summary on how the information within this report has/or will inform future workforce plans/planning.

Examples include - but not limited to:

- Impacts and outcomes of real -time staffing assessment on workforce/workload planning
- How the outputs of the Staffing Level Tools and the application of the CSM have informed you workforce planning activity.
- Impact of the Health and Care Staffing Act has led to safe and efficient staffing.

To build on the development of the self-assessment and to monitor its progress.

To ensure our work plan ties in with the duties of the act identifying areas of good practice as well as areas of learning.

The level of assurance attached to each duty will provide us with a focus to prioritise our work plan.

Provides a resource for engagement with staff especially out with Nursing.

SafeCare has been rolled out across all eleven wards, and we have our first new MHLN workload two-week tool run commencing 23rd February 2026.

Significant progress has been made towards compliance within nursing with the investment of improved rostering practice in Optima and the implementation of SafeCare.

36 hour working week has been achieved which will take effect in April 2026.

Work to strengthen regular attendance by all Heads of Service continues to ensure all disciplines understand the impact of clinical decisions on nursing resource.

A well-established Workforce Governance Group monitors and reports on all Professional's workforce performance.

Please provide information on how your compliance to the Health and Care Staffing Act has led to improved outcomes for service users and workforce

As set out in the legislation, compliance with the Act should support the outcomes from the Health and Care Standards. Therefore, you should demonstrate/consider how implementation of the Act contributes to achieving these Standards

This should include - but not be limited to - information in relation to patient safety and quality of care measures and outcomes, patient feedback, staff wellbeing measures, and adverse event reporting; what this information has shown and any trends; and any actions taken as a result.

Staff engagement and awareness sessions have delivered across multiple disciplines

Staff feedback is gathered via a staff survey, 1:1s with line managers, iMatter, PDPs, and business/departmental meetings and will be captured within SafeCare

Robust data analysis of funded and in post establishment identified gaps in workforce in line with current clinical acuity.

Board approval to over recruit to 105% of Funded Establishment.

Robust systems and processes currently in place to manage rostering along with real time escalation of risk and mitigations taken.

Data collection and reporting of trends, training and awareness factored into resourcing decisions.

Patient engagement and feedback is crucial in ensuring we are listening to our service users. We have an established Patient Partnership Forum which strives to have a representative from each ward. Outcomes from this group are fed into the wider governance meetings. Staff also seek views from patients annually on 'What Matters to You' Patients are also represented on the Scottish Health Council.

The Mental Welfare Commission and the Scottish Health Council provide support to this forum and provides assurance the patient/carers voice is heard.

Person Centred Improvement Team collates and reports on the patient and carer experience and these are used in the triangulation of CSM.

The Workforce Governance Group oversees the compliance of PDP's, Turas, in person training, recruitment and retention etc and identifies areas of risk.

Health and Care Staffing Act Health Board Duty Compliance Assurance Levels

Please complete the table below with your Health Boards compliance assurance level for each duty.

DUTY	COMPLIANCE ASSURANCE LEVEL
Duty 12IA: Duty To Ensure Appropriate Staffing	Substantial Assurance
Duty 12IC: Duty To Have Real-Time Staffing Assessment In Place.	Substantial Assurance
Duty 12ID: Duty To Have Risk Escalation Process In Place.	Substantial Assurance
Duty 12IE: Duty To Have Arrangements To Address Severe And Recurrent Risks.	Substantial Assurance
Duty 12IF: Duty To Seek Clinical Advice On Staffing.	Substantial Assurance
Duty 12II: Duty To Ensure Appropriate Staffing: Training Of Staff	Substantial Assurance
Duty 12IH: Duty To Ensure Adequate Time Given To Clinical Leaders.	Substantial Assurance
Duty 12IJ: Duty To Follow The Common Staffing Method (CSM)	Substantial Assurance
Duty 12IL: Training And Consultation Of Staff	Substantial Assurance
Planning And Securing Services	Substantial Assurance
PLEASE INDICATE THE OVERALL LEVEL OF ASSURANCE OF THE ORGANISATION'S COMPLIANCE	
Substantial Assurance	

**Duty
Description**

Guiding principles etc. in health care staffing and planning

In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing.

Duty 12IA: Duty to ensure appropriate staffing.

(1) It is the duty of every Health Board and the Agency to ensure that at all times suitably qualified and competent individuals, from such a range of professional disciplines as necessary, are working in such numbers as are appropriate for -

- (a) the health, wellbeing, and safety of patients,
- (b) the provision of safe and high-quality health care, and
- (c) in so far as it affects either of those matters, the wellbeing of staff.

To ensure appropriate staffing levels TSH have a number of systems and processes in place. These include, but are not limited to:

- Daily (Mon-Fri) multidisciplinary pre-planning meetings chaired by ADoN
- Daily (Mon-Fri) multidisciplinary Site Safety meetings (Chaired by ADoN/Interim Director of Security)
- Twice daily resource huddles (Chaired by Lead Nurse)
- Twice weekly nursing resource planning meetings (Chaired by Lead Nurse)
- Pre-weekend safety briefings
- Weekend safety briefings chaired by On-Call Director

The outputs from each meeting have clear escalation routes to ensure the requirements of the duty (121A) are met.

TSH also receives evidence from those other disciplines named under the Act: AHP, Psychology, Risk & Resilience, Pharmacy, Medical, and Learning and Development.

Operational systems and processes are in place for each discipline. This varies according to the size and delivery of the department.

Routine updates are reported to Workforce Governance Group and to the Board providing details of our assurance towards compliance.

(2) In determining what, in a particular kind of health care provision, constitutes appropriate numbers for the purposes of subsection (1), regard is to be had to -

(a) the nature of the particular kind of health care provision

Workforce planning is agreed for each financial year. Thereafter, a monthly workforce report is produced for all Heads of Service to review, provide comment and consider/raise any areas of concern. The workforce report also outlines a month-month overview of recruitment progress, and vacancies across each of the Directorates within the hospital.

Datix is available to all staff to escalate risk, including resource risk.

LearnPro and in-person mandatory training is available to all staff. Training compliance is reported through the Operational Management and Workforce meetings to ensure full engagement and compliance with statutory and mandatory training.

Staffing requirements within the Nursing Directorate are agreed and determined by level of risk and by the hospital's Clinical Model delivery plan, taking into account skill and gender mix. Nursing staffing levels can vary in line with clinical acuity (increased with the need for higher nursing input). Resource requirements are reviewed on a twice daily basis to ensure adequate staffing in response to risk assessment.

Optima has been rolled out across the organisation and is being used to record day to day staffing activity. Additional benefits of Optima have still to be realised with the further roll out of SafeCare, eJob Plan, Bank, and Loop. The continued roll out of eRostering is monitored by the Director of Workforce. Areas of concern are escalated as required to the Corporate Management Team then the Board.

The newly developed MHL D workload tool has been uploaded into Safe Care. All eleven wards within the hospital have been using SafeCare Part 1 since October 2025, and a "soft launch" of SafeCare part 2 was supported over the months of December 2025 and January 2026.

A two-week tool run is scheduled for 23rd February 2026 across all eleven wards. Whilst TSH evolves its knowledge and skills in the use of SafeCare, to realise all the benefits of the digital platform, we will continue to report real time staffing via the already established and robust twice-daily resource huddles.

Staffing requirements within the Nursing Directorate are agreed and determined by level of risk and by the clinical model delivery plan – taking into account skill and gender mix. Nursing staffing levels can vary in line with clinical acuity (increased with the need for higher nursing input) and regularly reviewed via the weekly clinical team meetings and RMO reviews. The

newly developed MHL D workload tool has been uploaded into Safe Care. The 11 wards have been using SafeCare part 1 since October 2025 when a soft launch of SafeCare part 2 was supported over the months of December and January. A two-week tool run is scheduled for 23rd February 2026 across all eleven wards. Whilst we develop our knowledge and skills in the use of Safe care, we will continue to report real time staffing twice daily via the robust resource huddles.

(b) the local context in which it is being provided.

As noted above, the daily Site Safety huddles are routinely attended by all Heads of Service. Before each dayshift and backshifts, the local context of each ward areas staffing compliment is fully discussed and decisions are made to allow dynamic adaptations, with Multidisciplinary Team collaboration when necessary.

(c) the number of patients being provided it.

SafeCare has now been implemented across all eleven wards. The Nurse in Charge documents those staff on duty, records their professional judgement and documents patient levels of care across all three census periods (AM/PM/ND).

The new MHL D Workload Tool is uploaded to SafeCare however we still have to use the SSTS platform to upload the professional judgement. TSH ward-based nursing resourcing is reviewed on a dynamic basis via twice daily huddles and through our dedicated Senior Clinical Cover. (A Senior Nurse who is on each shift and has hospital-wide oversight of resourcing for each ward area).

With regard to consideration of patient numbers, as we provide clinical care within a high secure setting a minimum of 3 staff are required when patients are out with their rooms and a further member of staff is required to be able to respond to incidents across all wards irrespective of patient numbers. This means each wards-based area must have a minimum of four staff for full functioning and execution of daily operations.

(d) the needs of patients being provided it.

Staff feedback is collated via the twice daily resource huddles, iMatter, weekly business meetings, and Staff Survey's with direct feedback coming back to service leads via Staff Bulletins.

The Person Centred Improvement (PCIT) collate carer and patient feedback on a regular basis via a number of methodologies. This enables the hospital to look at changes to activity or service redesign. We have an established Patient

Partnership Group which meets weekly, in addition to the Person Centred Improvement Group which is chaired by the Director of Nursing.

Patient and Carer feedback feature on the agenda of our Clinical Governance Group and Patient/Carer's stories are also a standing agenda item on Board meetings.

The Mental Welfare Commission visit the hospital a minimum of twice yearly provide and provide routine feedback on the patient /staff experience. These visits celebrate areas of success as well as highlighting any areas for improvement. Any such areas are tracked through the development of an action plan which, again, is reported through our Clinical Governance Group.

(e) appropriate clinical advice.

The hospital has robust systems and processes in place to ensure clinical advice is available 24hrs per day, seven days per week:

- In-hours advice is available from all Heads of Service and/or Senior Clinical Cover (and can be escalated to the Associate Director of nursing and/or Director of Nursing).
- Out-of-hours the role of Senior Clinical Cover provides onsite senior clinical advice, which is supported by the hospital's Resident Doctor's and the On-Call Psychiatrist, and overseen by the On-Call Director.

Please provide information on the steps taken to comply with Duty 12IA.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems and processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

- **36 hour working week:** We have achieved the reduction to a 36 hour working week which will take effect in April 2026.
- **eRostering Roll Out:** All areas are now using Optima and SafeCare on a day-to-day basis. All staff will manage their leave via Loop by April 2026. Further roll out required, including eJob Planning, the 36 hour week and the challenges this brings will be determined based on how the Business as Usual model develops. Double keying remains a challenge with SSTS and eEES.

- Twice-Daily resource huddle changes: The Hub Co-ordinators (one nurse who represents three wards all located within the same hub building) attend the twice-daily huddles, which has enabled positive development of Charge Nurses. We have observed evidence of problem-solving in relation to ward-based staffing issues by demonstrating flexibility within a hub to minimise the impact directly to patient care.
- Work to strengthen regular attendance by all Heads of Service continues to ensure all disciplines understand the impact of clinical decisions on nursing resource.
- **Workforce Planning:** A well established Workforce Governance Group monitors and reports on all profession's workforce performance.

Vacancies and recruitment are closely monitored. A significant range and volume of activity aimed at mitigating ongoing challenges includes:

- Rolling recruitment drives to address specific vacancy challenges per Service.
- Positive traction on Agenda for Change job description reviews to aid recruitment.
- Increasing access to nursing training on an “earn as you learn” basis to “grow our own;”
- Consideration of Modern Apprenticeships in non-clinical areas.
- Workforce Governance Group reviewing succession planning.
- Retire and return is widely used for all professional groups across the Board. Partial retirement is now a further option to retain skilled members of staff.
- Exit questionnaire data is extremely important to the Board in terms of understanding why staff choose to leave our employment, and what can be done to improve the overall staff experience and increase retention rates.

Heads of service Input in relation to HCSA:

- AHP and Psychology are members of national groups and linking into national advancements to develop RSTS. Linking in with HIS to ensure compliance.
- Pharmacy (on an SLA at TSH) have specific resource plans in place to ensure delivery of service. If this is not achievable, resilience planning is in place to draw pharmacy input from NHS Lothian.

Please provide Information on your methods of monitoring compliance with Duty 12IA

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

Each meeting identified in Section 121A (above) is Chaired by a senior professional and has a set agenda structure for the Chair to follow. This provides a consistent approach and minimises areas for error or omission. The efficiency and impact of the meetings is routinely monitored and adjustments made as necessary. Both the Corporate Management Team and The Board receive regular updates by the relevant Directors (Medical, Nursing and Workforce) to provide assurances that TSH has robust monitoring arrangements in place to comply with Duty 121A.

The Risk Management Team review all DATIX records which are RAG rated. These are recorded and reported at the Health and Safety Committee. Learning opportunities and trends are reviewed with staff engagement so that improvements can be monitored and feedback is provided directly to those who escalated the risk.

All processes and systems take into consideration staff and patient wellbeing as well as escalation and/or mitigation of risk.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. The Human Resource Team provide expertise and support staff in areas of workforce including to all adhering to Once for Scotland and local policies and procedures	This should describe the situation: what is the success, achievement, or learning? For example, application of eRostering has allowed senior personnel to be able to see staffing in real-time across all areas, allowing staff to be reallocated as required to reduce level of risk. Recruitment and Retention: Work overseen by the relevant professional and workforce programmes, is ongoing. Efforts are impacted by challenges in workforce supply and the continued existence of vacancy gaps across a range of professions. However, a range of concerted improvement activities aimed at	This should describe how the success, achievement or learning could be used in the future. For example, continue the roll out of eRostering across the organisation, using learning from areas that have already implemented. • To ensure future attendance at recruitment fayres and online events. • Continue to evolve Social Media Communication Strategy promoting TSH as a positive place to work.

	mitigating ongoing challenges are underway. These include: • Rolling recruitment drives to address specific vacancy challenges per Department. • Positive traction on Agenda for Change job description reviews to aid recruitment • Increasing access to nursing training on an “earn as you learn” basis to “grow our own;” • Consideration of Modern Apprenticeships in non-clinical areas; • Workforce Governance Group reviewing succession planning; • Retire and return is widely used for all professional groups across the Board. Partial retirement is now a further option to retain skilled members of staff; • Exit questionnaire data is extremely important to the Board in terms of understanding why staff choose to leave our employment, and what can be done to improve the overall staff experience and increase retention rates The State Hospital developed a Recruitment and Retention Strategy that was aligned with the three-year workforce plan 2023-2025. The strategy recognised that a robust and efficient recruitment process significantly contributed to the delivery of our services. Equally, The State Hospital remained committed to retaining staff, recognising the resource required to recruit and induct new employees, as well as the skills, knowledge, and support that experienced staff brought to the organisation. The primary goal was to ensure we recruit the right people, in the right roles, at the right time.	• Promote a community presence within schools, colleges and universities • Gather feedback on the new corporate inductions • Survey feedback collated and reported in an action plan. • To monitor themes, escalating risks and taking actions from the exit interview process. • To ensure compliance with Once for Scotland policies for NHS. • Focusing on the individual nature of a situation by taking a person-centred approach • Face to face training sessions and a detailed special bulletin

The strategy focusses on 5 key areas:

- Visibility – Build the State Hospital brand across professions and communities.
- Systems – Use data to influence future decisions and upgrade current processes.
- Workforce Planning – Review workforce needs to ensure we have the right staff in posts.
- Recruitment Skills – Develop manager skills and enhancing current staff skills.
- Retention – Monitor staff experience and satisfaction through an onboarding survey and developing a proactive approach around leavers through the completion of meaningful Exit Interviews.

Visibility

- As part of our strategy to enhance The State Hospital brand across various professions and communities, we recognised several effective methods to achieve this goal, one of which was increasing our presence on social media platforms. With support from our communications team, all vacancies are now advertised on social media using a standard advert template. Additionally, the communications team developed employee profile posts. These profiles feature volunteers who share information about themselves, including their role at the State Hospital, their tenure, and why they enjoy working here. The State Hospital Facebook page has grown to 1.7k followers with posts reaching up to 8.2k people. Facebook is now the State Hospital's third largest applicant source after NHS Scotland Careers Website and Indeed.

- The State Hospital committed to increasing attendance at community events. We have established a team of employability ambassadors who support events at educational institutions and career fairs. Participating in these events helps enhance our brand visibility and reputation within the community and industry. It has allowed the organisation to showcase what it is like to work in a high secure setting, discuss career opportunities, and provide education on the type of roles available and the benefits for employee, thereby attracting both potential job seekers and future employees. During 2024 we attended ten educational institutes and held two talks via Microsoft teams.
- As part of our efforts to enhance visibility, the recruitment section of the State Hospital website was reviewed to provide potential applicants with more comprehensive information about working at the State Hospital. The main page of the website now includes a link to any current vacancies within the organisation, allowing for easy access for potential applicants. As the communications department continues to develop its services, we hope to add video blogs in the future.

Systems

Throughout the strategy period, significant efforts have been made to align the organisation's recruitment processes with national requirements.

- The eApproval function on Jobtrain, which went live in late 2022, has been successfully integrated into the organisation, with all job approvals now conducted through this

system. The State Hospital remains one of the few boards to have adopted this function.

- The adoption of the Yellowfin system, has streamlined the recruitment process and significantly improved overall efficiency.
- The system also communicates national recruitment KPIs, which are presented in the monthly Workforce Report.

Workforce Planning

- Workforce planning is crucial for NHS Scotland and the State Hospital to ensure that the right people with the right skills are in the right place at the right time to deliver high-quality care.
- Effective workforce planning helps address the changing needs of the population, manage workforce demographics, and ensure sustainable staffing levels.

Young People

- To ensure young people are provided with employment opportunities at the State Hospital, an organisational position was agreed upon based on a risk assessment. We will welcome applications from individuals under the age of 18 for non-clinical roles. However, to be eligible for clinical roles, applicants must be 18 years or older. A comprehensive guide was also produced to support managers in recruiting young people. This guide includes information on employing young people, employment law considerations, a risk assessment checklist, risk assessment guidance, and a risk assessment template. Work continues on

increasing the number of young people within our organisation.

Apprenticeships

- The organisation has relaunched its Modern Apprenticeship Guidance and is committed to increasing the uptake of apprenticeships. The guidance aims to support managers locally in bringing apprentices into the organisation. Further work is currently underway on how the organisation supports foundation apprenticeships, in collaboration with South Lanarkshire Council. These apprenticeships provide valuable opportunities for young people to gain hands-on experience and develop their skills in various fields, such as administration, facilities, and clinical roles. By supporting apprenticeships, we not only help young people kick-start their careers but also ensure a pipeline of skilled talent for the organisation. This initiative is part of our broader strategy to invest in the future workforce and address the ageing demographics within the organisation.

Work Placements and Demonstrator Programme

- Maximizing opportunities for accessing employment at the State Hospital required careful thought due to the organisation's unique nature. The State Hospital has frequently been asked to support work experience requests from students and other interested parties seeking to learn more about forensic mental health or gain experience in specific areas such as administration or human resources. To

	support managers with these requests and in order to maximize opportunities for people to access employment with our organisation, Work Placement guidance was developed. Work placements can range from brief 'tasters' lasting half a day to programs extending over one or two weeks, or even several months. Some work placements offer hands-on experience, while others provide insights, observation, and work shadowing. All can provide valuable experiences for individuals looking to pursue a career in the health sector and offer significant benefits to the organisation in terms of reputation, visibility, and social responsibility. Through national employability work, an opportunity arose with our neighbouring health board, NHS Lanarkshire, in developing the Demonstrator Programme between the two NHS boards within the Lanarkshire region. In collaboration with NHS Lanarkshire and South Lanarkshire Council the State Hospital agreed to host two Demonstrator opportunities. The Demonstrator Programme focuses on supporting parents aged 18 and over to re-enter the workforce or upskill within the NHS. This initiative aligns with the Scottish Government's No-One Left Behind agenda, targeting child poverty and reinforcing our commitment as an local employer and Anchor Organisation. The programme is designed with flexibility in mind, accommodating participants' childcare needs and new routines. With support from the Workforce team and South Lanarkshire Councils Key Worker, participants are	

provided with wraparound support in order for participants to build confidence, wellbeing and personal development with the goal of achieving permanent employment.

Supplementary Staffing Register

- The Supplementary Staffing Register for Nursing remains an essential tool for addressing staffing gaps within our service. It is a particularly valuable resource for those planning to retire and subsequently return to work in a more flexible capacity.
- There is significant potential for further development of this register within the organisation. Continued efforts from the nursing directorate are required to review and enhance the existing framework. By expanding this initiative, we can provide more opportunities for staff considering leaving the organisation to remain involved. Additionally, extending this resource to student nurses would be highly beneficial, offering them practical experience and easing the transition into professional roles.
- To maximize the register's impact, a strategic review and targeted enhancements by the nursing directorate will be crucial.

Succession Planning

- Alongside our strategic work, there was an initiative to develop a good practice approach to succession planning. There has always been a need to develop our staff, but in the past, succession planning often occurred in an ad hoc or unmanaged manner. In recent years, the changing workforce demographics

within the Nursing and AHP community have highlighted the need for more structured thinking regarding succession planning. This has posed challenges for the recruitment and retention of skilled staff, leading to delays in appointing key roles or diluting service quality and provision. To address this, we developed succession planning guidance for managers to understand their roles in this process. This guidance includes information such as guiding principles, tools for supporting succession planning, personal development plans, and other key aspects.

Recruitment

- A training presentation for new hiring managers was developed. This training encompasses a wide range of topics, including legislation, best practices for advertising, shortlisting, interviewing, and onboarding. Moreover, the program addresses legal issues in recruitment such as unconscious bias, equality, diversity, and inclusion, as well as reasonable adjustments within the workplace. This approach ensures that hiring managers are well-equipped to create a fair and inclusive recruitment process. This training is available to anyone involved in the recruitment and selection process to ensure compliance with workforce policies. By equipping our hiring managers with this knowledge, we aim to foster a more inclusive and equitable work environment, ultimately enhancing the overall quality of our hiring practices.

Nursing Directorate has the responsibility to oversee staff well being and attendance at work as well as ensuring we deliver a high quality of clinical care to our patients.	Effective real time staffing assessments - • The State Hospital has robust oversight and monitoring processes currently in place to determine real time staffing on a daily basis. • This process involves daily resource huddles which are routinely attended by Heads of Service. Before the AM/PM shifts, the local context of each area's staffing levels is fully discussed and decisions are made to allow dynamic adaptations. Overarching staff model Despite more recent overtime pressures, following the opening of the Women's Service at TSH the forecast for the year remains for a breakeven position to be achieved, with a savings target on track. To better understand the contributory factors to overtime, spend within the Nursing Directorate we continue to; • Review of Clinical Acuity • Review of the Nursing Predicted Absence Allowance (PAA) • Review of resourcing use within the new Clinical Model • Review ongoing efforts to ensure any instances of Daytime Confinement are as a last resort, and are only enacted following the agreed escalation and governance processes. • Review of requirements needed to reduce reliance on overtime • Review impact on nurse resourcing following the introduction of the Women's service.	• To continue to develop collaborative working amongst the multidisciplinary team, ensuring good working relationships • Provide a forum for sharing areas of concern and risk escalation and what actions have been taken

	Following a presentation and agreement last year to recruit an additional 10wte above the current funded establishment for 12 months, there has been a further agreement that we can recruit to 105% each year. Recruitment is ongoing and in the last quarter alone we employed over 25 nurses. Management Redesign – Nurse Directorate - Following retirements, senior posts within the Nursing Directorate became vacant, which provided an opportunity to revise job portfolios and consider opportunities to use the funding from these posts in a different way. There was an identified need to strengthen the operational management aspects of the Directorate, as well as free up Lead Nurses to increase the focus on supporting the professional and clinical aspects of practice. Therefore, the Nursing Directorate are exploring opportunities to introduce service manager post(s) to the directorate. Recruitment of these posts is planned for early in the new financial year. Effective roster management – Nursing - Following a Quality Improvement piece of work to support improved rostering practices, All SCN's and CN's were provided with training and support using an agreed Standing Operating Procedure. This was to ensure a consistent approach was used to create the 6 weekly rosters. We are now seeing the benefit of this investment with an improvement of skill mix and gender balance at the roster creation stage particularly on night shift. Work will continue to progress and	- Agreed over recruitment of 105% in progress. - Secure Job Descriptions and progress to advert and interview for Redesigned Structure

improve with the implementation of the reduced working week.

Reduced Working Week – Nursing

- The State Hospital requires to comply with the nationally agreed pay award to reduce the whole time equivalent working week to 36 hours by April 2026. A short life working group has been establishment to engage with the nursing workforce through face-to-face sessions and/or via a questionnaire. This engagement has enabled us to review our current shift systems and explore opportunities for a single approach to eRostering taking into account flexible working and or flexibility within the shift system, improved wellbeing and more efficiency in the management of the rosters. This will provide additional opportunities to develop a consistent rostering arrangement for all staff and maximise the potential from Health Optima when creating rosters. The engagement sessions have been concluded with a new shift pattern agreed and will be effective by April 2026.

Delivery of Overtime via Optima

- Following a test of change within the Clinical Admin Roster where that group of staff entered their availability into LOOP, and the manager was able to search this availability, thereafter, assigning and notifying staff of overtime allocation. We have progressed this function to Mull Hub and initial reports are positive. Further roll out to all hubs is planned

- SLWG established to support progress towards RWW in line with national requirements.

- Mull Hub Pilot to be rolled out to all other Hubs by Q3 2026

Medical: The Medical Director has overall accountable for the governance of the Medical Department in the Hospital. Day to day operational management of the Department is through the Associate Medical Director, supported by the PA to the MD/AMD.	for year 2026. Medical eJob Planning • All substantive Medical Staff have a yearly Job Planning Meeting with the Associate Medical Director (or Medical Director in the case of the AMD). Regular reviews of the efficient and effective use of consultants' time are critical during a period of rapid change in both medical technology and healthcare delivery systems. • Systems and processes are in place to ensure that robust medical coverage is in place. This includes out of hours via on call rotation and in the event of unplanned absence • Medic engagement in daily resourcing huddles to understand the impact of clinical acuity and associated impact of decision making • Introduction of systems and process in collaboration with pharmacy to ensure safe prescribing • Implementation of clinical model has ensured a progressive pathway through TSH. This service delivery change includes medics chairing newly developed service leadership teams and reviewing the impact of the clinical model on safe staffing/patient care. • Good outcome from NES visit and GMC survey re postgraduate training • Job Planning now delivered via eRostering	• Ongoing roll out of Optima Products

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. Financial Pressures	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with recruiting a particular staff speciality or recruitment in a remote / rural location. • The State Hospital continues to rely on overtime to fill nursing staff deficits. As detailed above a piece of work was commissioned to reduce the reliance on overtime within the nursing department and resulted in an additional 9.4WTE being recruited to support safe staffing over the 2025-2026 financial period. • Running in parallel to this recruitment is the noted risk of WTE loss through the Reduced Working Week (RWW). By April 2025 the hospital lost 8WTE hours to support the RWW. This will rise to approximately 12WTE by March 2026. • In addition to noted risks associated with the RWW, the introduction of the Women's service in July 2025 was given funding for a 4/4/2 shift pattern, however with the increase	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in recruiting in a particular speciality or remote / rural location, the relevant organisation may have investigated retire and return schemes or upskilling and career development for existing staff. It may also have looked at how the service could be redesigned. • Monthly Finance meeting continue to monitor nursing spend. These meetings are chaired by the Associate Director of Nursing along with the Associate Finance Director and are attended by all Senior Charge Nurses and the two Lead Nurses. • A financial review has also recently been undertaken to monitor the cost of the Women's Service.

Sickness	of complex admissions with high clinical acuity this service demands at least 10 members of staff dayshift and backshift. This resource pressure directly affects the care provided to our male patients and adds to the current financial pressures. Sickness remains above 5% despite efforts to reduce this. Within the Nursing Department there are multiple strands of work focused on reducing absence rates. Improvement activities include monthly finance meetings with each Senior Charge Nurse and absence RAG rating meetings which are chaired and supported by the Head of Human Resources.	Monthly meetings with Director of Nursing, Workforce and CEO. SCN's meet monthly with Head of HR. RAG escalation meetings with Head of HR, Lead Nurse with SCN and HR advisor for the area of concern >5% for 3 consecutive months.

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12IC: Duty to have real-time staffing assessment in place.

Duty Summary	(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the real-time assessment of its compliance with the duty imposed by section 12IA. (2) The arrangements under subsection (1) must, in particular, include— a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to— (i) the health, wellbeing, and safety of patients, (ii) the provision of safe and high-quality health care, or (iii) in so far as it affects either of those matters, the wellbeing of staff, (b) a procedure for the notification of any such risk to an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified.

	(c) a procedure for the mitigation of any such risks, so far as possible, by such an individual, and a requirement for that individual to seek and have regard to appropriate clinical advice, as necessary, in carrying out such mitigation. (d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c), (e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b), (f) training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (e) (g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12IC.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the real-time assessment of its compliance with the duty imposed by section 12IA.

- SafeCare has been rolled out across all eleven wards, and we have our first new MHLD workload two-week tool run commencing 23rd February 2026. During this early implementation phase, we will review the ward resourcing on a dynamic basis via daily resource huddles and the role of Senior Clinical Cover alongside the outputs of SafeCare. Discussions have been supported with HIS that our robust operational model currently in place provides reassurance that we are compliant with legislation until we have SafeCare fully embedded.
- No system is currently in place for AHP or Psychology however work is underway with the Workforce Lead, HIS, and other national groups to consider the roll out the MDPJ Tool.
- Appropriate medical care is in place in line with patient numbers to ensure safe delivery of care via the appropriate number of medic sessions. Safecare is currently being explored in consultation with RL Datix and HIS.

(2) The arrangements under subsection (1) must, in particular, include—

- (a) a procedure for the identification, by any member of staff, of any risks caused by staffing levels to—
- (i) the health, wellbeing, and safety of patients,
 - (ii) the provision of safe and high-quality health care, or

(iii) in so far as it affects either of those matters, the wellbeing of staff,

- All staff have the ability to raise a risk or concern regarding staffing levels through their Charge Nurse/Nurse in Charge, at the twice daily resource huddles, at ward handover discussions and business meetings.
- All staff have access to the Datix risk management system and can raise a Datix under the category of staff and sub category of staffing levels on the system with a text descriptor of what the risk or concern was.
- SafeCare, within the nursing is now also being used to raise, escalate if necessary and mitigate concerns.
- Specifically, within nursing, staff are able to submit unsafe practice forms for review by managers.

(b) a procedure for the notification of any such risk to an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified.

- Systems and processes vary across services. Risk management occurs at team level by a Charge Nurse/ SCN or equivalent. Resourcing risks are reporting via the daily resource huddles and the site safety briefing with membership inclusive of relevant lead professionals. Where safety/resource huddles are not appropriate or routinely used, then individual notification to their lead professional takes place if the risk cannot be mitigated in real time. The Additional Hours Protocol provides a standardised process linked to the resource huddles for daily management of resourcing deficits.
- SafeCare is another system where staff can escalate resourcing risks, however we are in the early stages of this implementation.

(c) a procedure for the mitigation of any such risks, so far as possible, by such an individual, and a requirement for that individual to seek and have regard to appropriate clinical advice, as necessary, in carrying out such mitigation.

- Dynamic risk assessment is inclusive of risk mitigation. Weekly clinical team meetings review each patient's risk and resource requirements. Where appropriate, these risks are reviewed by the RMO on an individual basis with input from the clinical team. Resource associated risks are reported via the twice daily resource huddle. Any risk not safely mitigated is escalated onto the datix system with the reporting line to the staff member's line manager in the first instance. This provides the first level of escalation to the lead with professional responsibility, first opportunity to mitigate the risk and provide clinical input. Severe risks such as a red datix also escalate directly to the executive leadership team. Via the role of Senior Clinical Cover, 24 hour senior clinical advice is available as required.
- Staff are also becoming more confident in using SafeCare to record and escalate such risks.

(d) raising awareness among staff about the procedures described in paragraphs (a) (b) and (c),

- The associated work around creating standardised processes and utilising current reporting, monitoring and risk management systems has supported the communication to staff required within the duty. With the implementation of SafeCare and MHLD Workload Tool all staff have been supported with training delivered by the use of SOP's, videos and probably the most effective, face to face learning. This engagement enabled staff to develop a clear understanding of the processes and systems to be accessed to assist them in the identification of risk. Over time this has allowed us to monitor and report on trends within risk escalation and mitigation.

(e) encouraging and enabling staff to use the procedures described in paragraphs (a) and (b),

- SafeCare has been rolled out across all eleven wards, and we have our first new MHLD workload two-week tool run commencing 23rd February 2026. During this early implementation phase, we will review the ward resourcing on a dynamic basis via daily resource huddles and the role of Senior Clinical Cover alongside the outputs of SafeCare. Discussions have been supported with HIS that our robust operational model currently in place provides reassurance that we are compliant with legislation until we have SafeCare fully embedded. out of SafeCare.
- SafeCare training will continue support changes in workforce. This is currently being discussed as part of staff induction.
- All staff have access to the Datix risk management system and can raise a Datix under the category of staff and sub category of staffing levels on the system with a text descriptor of what the risk or concern was. Staff are also able to submit unsafe practice forms to record staff shortages.

f) training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (e)

- Current H&S learning modules on risk assessment and H&S modules for managers and supervisors are currently in place via LearnPro.
- Internal engagement sessions have been delivered to service and professional leads.
- Face to face, mandatory training for clinical staff in the management of violence and risk prevention/mitigation is in place.
- Actions plans are developed and recorded to mitigate risk within the H&S Control Book. Training for delivery of this is mandatory for all line managers.

(g) ensuring that such individuals receive adequate time and resources to implement those arrangements.

- Current provision to ensure adequate time is established through staff PDPs, Appraisal Reviews, Job Planning, Time built into Job Descriptions etc. Given TSH is a small board the pool of lead professionals to address all systems and processes is limited. The activity

of lead professionals and senior decision makers related to management of risk escalation and management of risk is routinely incorporated into daily work activities.

Please provide information on your methods of monitoring compliance with Duty 12IC

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

Significant progress has been made towards compliance within nursing with the investment of improved rostering practice in Optima and the implementation of SafeCare. The next steps are to support staff during the two-week tool run using the newly named MHL D workload tool in SafeCare. Development sessions are planned to progress SafeCare within Medical, Psychology, and AHP. The board have invested resources to support this, and a work plan is being developed to support all disciplines achieve compliance with the duty.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. Nursing	This should describe the situation: what is the success, achievement, or learning? For example, areas that have implemented and are using SafeCare are able to accurately record risks that are identified and the mitigation measures implemented, and clinical advice received. Reports extracted from the system are demonstrating an auditable trail of decision-making. Time for Leaders The hospital's review of our Senior Clinical Cover role is ongoing with proposed plans to increase the amount of time available for SCNs to provide ward-based leadership, in addition to supporting the implementation of	This should describe how the success, achievement or learning could be used in the future. For example, this success is being used to demonstrate to other areas the benefits of using SafeCare and supporting its implementation. The outcome of these discussions are ongoing.

organizational initiatives and attendance at various groups/committees to ensure nursing representation.

Charge Nurse engagement with daily resource huddles

- Hub Coordinators continue to provide a key role within the daily huddles. This has provided opportunity for the development of the role of the Charge Nurse. This practice is now embedded within the huddles with their key role to provide a detailed report for their wards nursing resource, unfilled shifts, how these unfilled shifts will be mitigated and a clinical overview of their patients. Collaborative working has empowered this group of staff to make more evidence-based decisions pertaining to safe patient care whilst feeling supported by their peers.
- With the improvement in data recording over the last 12 months from the daily huddles and with the development of a live dashboard we are now able to gather all the required data for operational safety and functioning. The dashboard has been fully tested and it is hoped we will Go Live in Q1 of the new financial year. Data presented on the dashboard will provide the hospital with ongoing visuals and trends of the resource challenges by service, ward, and hub and will be used to make evidence-based decisions.
- Continue to develop the huddle and recording of data in line with HCSA.
- Continue to evolve the role of the Hub Coordinators ensuring attendance from all wards.
- Empower collaborative working by gaining a greater understanding of each other's role.
- Empowered Charge Nurses/Nurse in Charge to make evidence-based decisions to support safe patient care while feeling supported by their peers.
- Review out puts from the data collected and monitor trends and themes.

Multidisciplinary Working	Real Time Staffing Resource Training • Real time staffing training continues to be delivered and supported by HIS for all key members of staff. • During these sessions it was evident that we had a robust operational model as detailed above in place. The State Hospital has invested training and development in the use of Optima and SafeCare which will run alongside our operating model providing us with rich data. With the dedicated resource supported by the board and HIS we have made substantial progress in the use of SafeCare within ward rosters. The next step is to provide Senior Charges Nurses with the skills to audit the data entered for accuracy within their own area so that we can start to see consistency across all ward rosters and use this information at the daily huddles. • Work has already been undertaken to engage with Medics, Psychology and AHP's in the use of SafeCare. These staff are also represented at external forums where shared learning is crucial.	• Continue to support good rostering practices. • Review data collection with the SCN's from the two-week tool run. • Work towards using SafeCare in huddles to determine staffing levels. • Further engagement with other members of the Clinical Teams is being considered to ensure full compliance and will be delivered via training and on line sessions.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with encouraging and enabling certain professional groups to use the systems and processes.	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in engaging certain professional groups, what measures

eRostering	eRostering • Health Roster does not link with SSTS or eESS resulting in additional workload and errors. The requirement to run dual systems to ensure safe staffing whilst maximizing the benefits of eRostering is also a challenge as the preferred / priority system is still SSTS due to its paying function of staff salaries. This again creates additional workload. • The system has limited capacity to report on a site basis – which is current TSH practice. Progress has started to move from a central resourcing management to a ward-based practice with one hub now managing their resources via Optima and SafeCare. This unfortunately adds additional workload until we move completely to ward based management. • Moving to a customer success model has had its limitations with limited onsite support. • Moving from a dedicated eRostering Project Team to Business As Usual model slowed down the implementation and evolution of Health Optima and other products such as SafeCare, however since September 2025 the board has supported additional resources which has enabled us to prioritise areas of work to be undertaken to meet the needs of the legislation.	have been put in place with regard to increasing this such as using professional networks, staff representatives etc.? • Monitor the efficiency of the Business-as-usual model. • Continue to roll out towards a ward-based management for resourcing. • Utilise national eRostering team support

	SafeCare - With the support of a dedicated member of staff we have identified areas of inconsistency in the data outputs. Further exploration of this on the test site and with external experts we have identified issues in changing the demand template alongside increased clinical acuity. This was to prevent us having to create additional shifts. During discussions it became apparent that we had not been given the detailed training required from RL Datix as they had moved on before we started our SafeCare implementation. This has created additional work to make the demand templates align within Funded establishment as well as review our current training towards key member of staff. Fixed shift patterns - Within nursing we have fixed shifts patterns, this does not lend itself to being able to use Health Optima to its potential. The creation of rosters is workload intensive with additional layers of governance. As stated in the duty 121A The State Hospital requires to comply with the nationally agreed pay award to reduce the whole time equivalent working week to 36 hours by April 2026. Staff engagement enabled us to review our current shift systems and explore opportunities for a single approach to eRostering taking into account flexible working and or flexibility within the shift system, improved wellbeing and more efficiency in the management of the rosters. This will provide additional opportunities to develop a consistent	- Utilise dedicated member of staff to identify training gaps to minimise inconsistent data recording in Safe Care. - Continue audits to ensure good Health Roster practise prior to link with payroll etc.

	rostering arrangement for all staff and maximise the potential from Health Optima when creating rosters.	

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12ID: Duty to Have Risk Escalation Process in Place.

Duty Summary	(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the escalation of any risk. (a) identified during the real-time assessment of its staffing levels in accordance with arrangements put in place under section 12IC, and (b) which it has not been possible to mitigate in accordance with the arrangements put in place under that section. (2) The arrangements under subsection (1) of this duty must include: a) A procedure for the initial reporting of a risk as described in subsection (1), by an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, to a more senior decision-maker, b) A requirement for any such decision-maker to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, c) A procedure for the onward reporting of the risk, as necessary, to a more senior decision-maker in turn, and a requirement for that decision-maker in turn to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it, d) A requirement for the arrangements put in place under paragraph (c) to escalate further in order to reach a final decision on the risk, including in appropriate cases by the reporting of the risk to the members of the Health Board. e) A procedure for the notification of every decision made following the initial report, and the reasons for it, to: (i) any individual who was involved in identifying the risk in accordance with the arrangements put in place under section 12IC(2)(a), (ii) any individual who was involved in attempting to mitigate the risk in accordance with the arrangements put in place under section 12IC(2)(c), (iii) any individual who was involved in reporting the risk in accordance with the arrangements put in place under paragraph (a), (c) or (d) of this subsection, and (iv) any individual who gave clinical advice in accordance with the arrangements put in place under section 12IC(2)(c), or under paragraph (b), (c) or (d) of this subsection, f) A procedure for those individuals to record any disagreement with any decision made following the initial report, g) A procedure for those individuals to be able to request a review of the final decision on a risk (other than a final decision made by the members of the Health Board or the Agency) made in accordance with the arrangements put in place under section 12IC(2)(c) or, as the case may be, paragraphs (b), (c) or (d) of this subsection, h) Raising awareness among staff about the procedures described in paragraphs (a) to (f), i) Training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of healthcare, and other senior decision-makers, in how to implement the arrangements put in place under paragraphs (a) to (h), and j) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

Please provide information on the steps taken to comply with Duty 12ID.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for the escalation of any risk.

(a) identified during the real-time assessment of its staffing levels in accordance with arrangements put in place under section 12IC, and

(b) which it has not been possible to mitigate in accordance with the arrangements put in place under that section.

The hospital has a clearly defined escalation process to provide guidance and assurance in regard to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery.

Daily Control Measures:

- Daily Resource Huddle Purpose: to pre-plan daily activity and co-ordinate MDT working (participation includes heads of patient led departments (Skye Centre, AHP, Psychology, Nursing), Senior Clinical Cover, Clinical Resource Administrator, Person Centred Improvement Team, and Business Development Manager). Any escalation or issues from this meeting are taken to the next meeting for authorisation if required.
- Daily Site Safety Meeting- Purpose: To review operational stability across the whole organisation. To discuss any identified areas of risk across the organisation and implement mitigation measures and agree escalations and adaptations to working. Chaired by the Interim Director of Security, Estates and Resilience /On-Call Senior Manager and all relevant operational heads of department attend. This meeting is minuted and reports to the CEO and Directors.
- Pre-Planning meeting takes place Mon-Friday at 16:00hrs. This is chaired by the Associate Director of Nursing and all relevant Heads of Service (or nominated Deputy) attend. This meeting is minuted and gives attendees the opportunity to raise and plan for any impact that may occur within the next 24hrs. The meeting also allows for operational teams to prepare for arrival to site the following day.
- Hub Co-Ordinators meeting - Purpose: To ensure delivery and implementation of agreed daily operations following the two meetings above and also ensure co-ordination of activities and staffing across the site. This meeting takes place AM and PM.

Further Control Measures:

- Tuesday Resource Planning Meeting (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors), ensuring senior oversight and escalation.

- Weekend planning meeting Purpose: Dedicated meeting reviewing the upcoming weekend to highlight/discuss available resources, operational issues, review of escalations for overtime, activity plans, contingency plan if required. (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/ Medical Directors)
- Weekend Site Safety Huddle Purpose: same as Daily Site Safety (consists of On-Call Director, Clinical Security, Liaison Manager, Senior Clinical Cover and On-Call Medical staff). This meeting is minuted and reports to the CEO and Directors.

(2) The arrangements under subsection (1) of this duty must include:

(a) A procedure for the initial reporting of a risk as described in subsection (1), by an individual with lead professional responsibility (whether clinical or non-clinical) in the area where the risk was identified, to a more senior decision-maker)

- Opportunity for this is covered in the daily resource meeting and the daily site safety as outlined above.

b) A requirement for any such decision-maker to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it.

- As above; the attendance at both the resource and the site safety meeting have senior decision makers who provide guidance and expertise in the decision-making process. A minute of discussions is recorded and any outstanding risks are escalated if necessary.

c) A procedure for the onward reporting of the risk, as necessary, to a more senior decision-maker in turn, and a requirement for that decision-maker in turn to seek and have regard to appropriate clinical advice, as necessary, in reaching a decision on the risk, including on how to mitigate it.

- The Site Safety meeting is minuted and sent out each day to the Board of Directors and all relevant Heads of Service, A further update is also provided to the Associate Director of Nursing following the PM huddle, and any outstanding concerns escalated as necessary.

d) A requirement for the arrangements put in place under paragraph (c) to escalate further in order to reach a final decision on the risk, including in appropriate cases by the reporting of the risk to the members of the Health Board.

- Fully outlined in 121D (1)

e) A procedure for the notification of every decision made following the initial report, and the reasons for it, to:
(i)any individual who was involved in identifying the risk in accordance with the arrangements put in place under section 12IC(2)(a),
(ii)any individual who was involved in attempting to mitigate the risk in accordance with the arrangements put in place under section 12IC(2)(c), (iii)any individual who was involved in reporting the risk in accordance with the arrangements put in place under paragraph (a), (c) or (d) of this subsection, and
(iv)any individual who gave clinical advice in accordance with the arrangements put in place under section 12IC(2)(c), or under paragraph (b), (c) or (d) of this subsection.

- The Lead Nurses, who are part of the Daily Site Safety and Daily Resource Meeting take responsibility for any ongoing nurse staffing decisions. If required appropriate escalations will be made to the Director of Nursing/Associate Director of Nursing (in hours) or the On-Call Director (out-of-hours).
- If required, the On-Call Director will brief other Directors, and the CEO as necessary.

f) A procedure for those individuals to record any disagreement with any decision made following the initial report.

- A process is in place to mitigate risk and support the escalation process to effectively manage daily resources, operations, and safety. Daily huddles provide the forum of multidisciplinary discussion of risk and its planning and agreement to mitigate. Incident Reporting is in place to oversee and manage risk appropriately with all staff having access. Unsafe practice forms provide a record of disagreement and operational outcomes. The roll out of SafeCare will provide all the information relating to risk and mitigation in the one place.

g) A procedure for those individuals to be able to request a review of the final decision on a risk (other than a final decision made by the members of the Health Board or the Agency) made in accordance with the arrangements put in place under section 12IC(2)(c) or, as the case may be, paragraphs (b), (c) or (d) of this subsection.

- As outlined above 121D (2) f

h) Raising awareness among staff about the procedures described in paragraphs (a) to (f).

- All staff are fully aware of the processes and procedures in place in and feedback and outcomes are given to all operational areas by the operational leads who attend the meetings following any decisions which have been reached at the daily resource and also the site safety meeting, particularly when it affects the patient's day.

i) Training individuals with lead professional responsibility (whether clinical or non-clinical) for particular types of healthcare, and other senior decision-makers, in how to implement the arrangements put in place under paragraphs (a) to (h).

- Full training in regard to resilience / business continuity is given to all senior leaders with responsibility in this decision making process.

j) Ensuring that such individuals receive adequate time and resources to implement those arrangements.

- The Business Continuity Plan clearly outlines the steps to be taken for escalation and de-escalation of risk. Each member of staff who has the responsibility within the decision-making process is aware of this and has been part of plan's development and review.

Please provide Information on your methods of monitoring compliance with Duty 12IC

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- Self-Assessment returns from all service leads for all professions and functions are submitted to the Workforce Governance Group and from there an action plan is developed to support and achieve compliance with the duty.
- A bench marking exercise will be completed to provide a baseline of compliance across all the professions within the Board - this will be monitored by the Workforce Governance Group on a bi-monthly basis. It should be noted there has been significant progress towards compliance within the nursing workforce.
- Development sessions are tabled to progress within Medical, Psychology, and AHP.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. <u>Business Continuity Plan</u>	This should describe the situation: what is the success, achievement, or learning? For example, senior decision-makers in paediatric nursing were identified and a chain of escalation communicated to all personnel. Individuals are now much better aware of who to contact during any particular shift in the event that a risk needs to be escalated. • The hospital has a clearly defined escalation process to provide guidance and assurance in regard to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery. • Daily Control Measures (as described above) • Further Control Measures (as described above) Tableau Resource Dashboard • A resource dashboard has been developed to record escalations of risk and how these are mitigated from the various huddles identified above. This has provided us with rich information regarding resource trends. Optima and SafeCare	This should describe how the success, achievement or learning could be used in the future. For example, The procedures for identifying the chain of escalation that were used in paediatric nursing are now being trialled and rolled out across other areas. • Continue to develop our digital data collection • Consistent communication with our workforce. • Continue to develop our understanding of workforce challenges.

	• Nursing resource practice within the State Hospital was managed centrally with staff being moved across the site to minimize the impact directly on patient care. • This practice did not support the implementation of Optima being the primary source to manage operations; however, we have made progress to de-centralize the management of nursing resources to enable Senior Charge Nurses to manage their own nursing resource. • One Hub manages their resources and escalations via Optima with the other 3 hubs planned to follow in Q1 2026.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. <u>eRostering</u>	This should describe the situation: what is the challenge or risk identified? For example, there may be difficulty with ensuring relevant individuals involved in reporting, mitigating, escalating, or giving clinical advice on a risk are notified of decisions made and the reasons for them. Some of the challenges that the hospital is working to overcome include:	This should describe what actions have been / are being / will be taken to address the situation. For example, if there is difficulty in notifying relevant individuals about decisions made and the reasons for them, what measures have been put in place to ensure this happens, such as providing training, increasing awareness and auditing to identify root causes? • Project Plan has been developed with the key focus being on nursing and significant progress has been seen with the support of a dedicated member of staff.

	- Health Roster does not link with SSTS or eESS resulting in additional workload and errors. - Rostering demand template in Optima is linked to the funded establishment for each roster however, there are occasions where the required core shifts are either above or below the funded establishment. Accuracy is reliant on user input and staff are struggling to connect the funded requirement versus the actual resource required via creating/removing additional shifts as needed via a manual process.	Further action is for the project plan to include realistic timescales to include Medics, AHP's and Psychology.

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12IE: Duty to have arrangements to address severe and recurrent risks.

Duty Summary	Duty to have arrangements to address severe and recurrent risks. (1) It is the duty of every Health Board and the Agency to put and keep in place arrangements to— (a) collate information relating to every risk escalated to such level as the Health Board or the Agency (as the case may be) consider appropriate in accordance with the arrangements put in place under section 12ID (2). The hospital has a clearly defined escalation process to provide guidance and assurance in regard to safe staffing levels. The following below outlines the measures in place in order of escalation and delivery. Daily Control Measures: Daily Resource Huddle Purpose: to pre-plan daily activity and co-ordinate MDT working (participation includes heads of patient led departments (Skye Centre, AHP, Psychology, Nursing), Senior Clinical Cover, Clinical Resource Administrator, Person Centred Improvement Team, and Business Development Manager). Any escalation or issues from this meeting are taken to the next meeting for authorisation if required.

- Daily Site Safety Meeting- Purpose: To review operational stability across the whole organisation. To discuss any identified areas of risk across the organisation and implement mitigation measures and agree escalations and adaptations to working. Chaired by the Interim Director of Security, Estates and Resilience /On-Call Senior Manager and all relevant operational heads of department attend. This meeting is minuted and reports to the CEO and Directors.
- Pre-Planning meeting takes place Mon-Friday at 16:00hrs. This is chaired by the Associate Director of Nursing and all relevant Heads of Service (or nominated Deputy) attend. This meeting is minuted and gives attendees the opportunity to raise and plan for any impact that may occur within the next 24hrs. The meeting also allows for operational teams to prepare for arrival to site the following day.
- Hub Co-Ordinators meeting - Purpose: To ensure delivery and implementation of agreed daily operations following the two meetings above and also ensure co-ordination of activities and staffing across the site. This meeting takes place AM and PM.

Further Control Measures

- Tuesday Resource Planning Meeting (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/Medical Directors), ensuring senior oversight and escalation.
- Weekend planning meeting Purpose: Dedicated meeting reviewing the upcoming weekend to highlight/discuss available resources, operational issues, review of escalations for overtime, activity plans, contingency plan if required. (membership replicates the above as well as Workforce Lead, Head of Risk and Resilience, Learning and Development department, HR/Nursing/Security/ Medical Directors),
- Weekend Site Safety Huddle Purpose: same as Daily Site Safety (consists of On-Call Director, Clinical Security, Liaison Manager, Senior Clinical Cover and On-Call Medical staff). This meeting is minuted and reports to the CEO and Directors.

(b) identify and address those risks which are considered to be either or both—

- (i) severe,**
- (ii) liable to materialise frequently.**

- Opportunity for this is covered in the daily resource meeting and the daily site safety as defined above.

- Risks are also recorded on the Corporate Risk Register and these are reported to the Health & Safety Committee. This allows us to monitor and review severe and frequent risks and take necessary steps to further mitigate.

(2) The arrangements under subsection (1) must, in particular, include a procedure for—

(a) the recording of a risk as described in subsection (1)(b),

- As above the attendance of both the resource and the site safety meeting have clinical operational involvement at Senior Level. Escalations are discussed and decisions are minuted in both forums.
- We are also rolling out SafeCare where risks and escalations can also be recorded.

(b) the reporting of any such risk, as necessary, to a more senior decision-maker, including in appropriate cases to the members of the Health Board or the Agency (as the case may be).

- The Site Safety meeting is minuted and sent out each day to all senior operational and clinical managers and also reported directly to the directors and CEO. A further update is also given following the PM hub co-ordinators meeting in regard to resources across patient led and clinical areas. Any identified risk is discussed, and mitigation options are considered. Escalation processes are in place if further measures are required beyond the Site Safety process.

(c) the mitigation of the risk, so far as possible, and a requirement for appropriate clinical advice to be sought and had regard to in carrying out such mitigation.

- The Site Safety meeting is minuted and sent out each day to all senior operational and clinical managers and also reported directly to the directors and CEO. A further update is also given following the PM hub co-ordinators meeting in regard to resources across patient led and clinical areas. Any identified risk is discussed, and mitigation options are considered. Escalation processes are in place if further measures are required beyond the Site Safety process.

(d) the identification of actions to prevent the future materialisation of the risk, so far as possible.

- Our Business Continuity Plan clearly defines our process for identification and escalation. Any new identified risk is mitigated and any learning is taken and plans adjusted accordingly. The level of governance around daily staffing ensures any identified actions are carried out and mitigations are delivered.

Please provide information on the steps taken to comply with Duty 12IE.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account of all of the points detailed in the duty description above by providing detail for each consideration.

- We reviewed our meeting structure and also those who attended to ensure we had the right staff attending with the right knowledge and skills to raise and escalate risks. We revised and updated our Business Continuity Plans to mitigate risk and to support the escalation process.
- All disciplines covered under the act are represented at all meetings and are instrumental in supporting decisions surrounding risk and risk escalation/mitigation.

Please provide information on your methods of monitoring compliance with Duty 12IE

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- Each meeting identified above is chaired by a senior professional and has a set agenda structure for the Chair to follow. This provides a consistent approach and minimises areas for error or omission. The efficiency and impact of the meetings is routinely monitored and adjustments made as necessary. Oversight at these meetings by Senior members of staff provides the board with assurances that we have robust monitoring arrangements in place to comply with this duty.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. <u>Business Continuity Plan</u>	This should describe the situation: what is the success, achievement, or learning? For example, a recurrent risk was identified in the capacity of one laboratory, leading to a delay in testing samples and communicating sample results. Following investigation, the process for booking in samples was streamlined and an admin coordinator was appointed. This has improved performance, and the lab is now meeting its targets.	This should describe how the success, achievement or learning could be used in the future. For example, the organisation is now looking at whether the changes implemented in one lab could be applied to other labs, to improve wider perf To be refreshed annually to ensure risks remain relevant and fit for purpose

<u>Patients</u> <u>Training Compliance</u> <u>Incident recording platform</u>	• Business Continuity Plan is fully operational. The escalation process outlined within the plan is discussed on a daily basis at several risk related meetings across TSH. • Patient engagement and feedback is crucial in ensuring we are listening to our service users. This enables us to look at changes to activity or service design. We have an established Patient Partnership Forum which is chaired by the Person-Centred Improvement Lead, which strives to have a representative from each ward. Outcomes from this group are fed into the wider governance meetings. Staff also seek views from patients annually on ‘What Matters to You’ Patients are also represented on the Scottish Health Council. • Key mandatory training is a priority on the organization’s risk register. We are now within a compliant range to meet those targeted training courses such as PMVA & SRK training. • Resource incidents are recorded using our Incident Recording platform. This platform is used to record a variety of incidents, events and/or near misses. As noted above, regular reports are provided to the relevant committees detailing trends noted across staffing, including resource-related incidents. Regular reporting ensures that severe and recurrent risks are managed quickly and effectively. Following an increase in a risk, the relevant risk register will be updated and	• Reviewed annually to ensure risks remain relevant and fit for purpose. • To ensure patients and carers are represented in our consultation process in matters which affect their care and treatment. • Ongoing monitoring of Training Compliance • Ongoing monitoring

	mitigations put in place to reduce the risk again. For severe risks, more regular reviews of the risk are required, severe risks are graded as either High or Very High using the national risk matrix and are monitored by the Corporate Management Team and the relevant committees. The hospital also has a Significant Adverse Event Review Process (SAER) which can be utilised to investigate severe incidents to provide learning and ultimately reduce the likelihood of the risk happening again.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. No concerns to note for this reporting period.	This should describe the situation: what is the challenge or risk identified? For example, collation of information in a particular NHS function has identified a risk that materialises frequently, however identification of actions to prevent future materialisation has not improved the situation.	This should describe what actions have been / are being / will be taken to address the situation. For example, if identification of initial actions to prevent a recurring risk has not improved the situation, further steps may include establishing a working group to investigate and make recommendations, observing practice in the area, interviewing staff, addressing the staff skills mix, allocating additional assistance, redesigning the service etc.

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12IF: Duty to Seek Clinical Advice on Staffing.**Duty
Summary****Duty to Seek Clinical Advice on Staffing.****(1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for—**

- (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL,
- (b) recording and explaining decisions which conflict with that advice.

(2) The arrangements under subsection (1) must, in particular, include—

(a) where a Health Board or the Agency (as the case may be) reaches a decision on a matter which conflicts with the clinical advice it has received—

- (i) a procedure for the identification of any risks caused by that decision,
- (ii) a procedure for the mitigation of any such risks, so far as possible,
- (iii) a procedure for the notification of any such decision, and the reasons for it, to any individual who gave clinical advice on the matter,
- (iv) a procedure for any such individual to record any disagreement with the decision made on the matter,

(b) a procedure for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the Health Board or the Agency (as the case may be), on at least a quarterly basis, about the extent to which that individual considers that it is complying with the duties imposed by—

- (i) this section, and
- (ii) sections 12IA to 12IE and 12IH to 12IL,

(c) a procedure for such individuals to—

- (i) enable and encourage other employees to give views on the operation of this section, and
- (ii) record such views in reports made in accordance with the arrangements put in place under paragraph (b),
- (d) raising awareness among individuals with lead clinical professional responsibility for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (c), and
- (e) ensuring that such individuals receive adequate time and resources to implement those arrangements.

(3) Every Health Board and the Agency must have regard to the reports received in accordance with the arrangements put in place under subsection (2)(b).

Please provide information on the steps taken to comply with Duty 12IF.	
Please provide information to demonstrate compliance. Information submitted here should outline how systems & processes take account <u>of all of the points</u> detailed in the duty description above by providing detail for each consideration. Duty to Seek Clinical Advice on Staffing. (1) It is the duty of every Health Board and the Agency to put and keep in place arrangements for— (a) seeking and having regard to appropriate clinical advice in making decisions and putting in place arrangements in relation to staffing under sections 12IA to 12IE and 12IH to 12IL, (b) recording and explaining decisions which conflict with that advice. • Professional leads are in place for all services and provide representation on multiple TSH governance groups, service leadership teams, clinical team meetings, and daily resource huddles. • The Board operates a model of Triumvirate service management: this consists of Nursing Directorate, Security Directorate and Medical Directorate to ensure TSH service decisions (admission, treatment and recovery, LD, Women’s Service and transitions) are jointly discussed and agreed in collaboration. • The role of senior clinical cover (provided by and on duty SCN) and the duty RMO are available 24 hours a day for senior clinical advice. In other services it is the most senior clinical leader on duty who provides clinical advice. • There are different mechanisms to evidence clinical advice has been sought via the daily resource and site safety huddles. Clinical advice related to staffing decisions is fed back via the hub coordinator at hub/ward teams. Data from these huddles is and shared with relevant parties including executive level on a daily basis. • Additionally, a daily 24 hour report is generated each night highlighting clinical advice given for the preceding 24 hours. This document captures clinical decision-making regarding events such as seclusion reviews, observation level reviews, emergency suspension of detention outings, and SRK review. (2) The arrangements under subsection (1) must, in particular, include—	

(a) where a Health Board or the Agency (as the case may be) reaches a decision on a matter which conflicts with the clinical advice it has received—

- (i) a procedure for the identification of any risks caused by that decision,
- (ii) a procedure for the mitigation of any such risks, so far as possible,

- Clinical conflicts are managed and documented through clinical pauses which are then uploaded into the electronic patient record. These Multi-disciplinary discussions are reviewed by the Associate Medical Director and Associate Nursing Director and mitigated/escalated as required.
- TSH committees and groups provide governance over risks, issues and mitigations which may have arisen from any conflict with clinical advice.

(iii) a procedure for the notification of any such decision, and the reasons for it, to any individual who gave clinical advice on the matter,

(iv) a procedure for any such individual to record any disagreement with the decision made on the matter,

- All discussions are recorded within various TSH committee/group meeting notes, clinical pauses, meeting minutes or other local processes, and the Associate Medical Director/Associate Nursing Director is sited and involved in that decision making process. Disagreements or concerns would be recorded within these processes to ensure this is auditable and any actions, feedback or further risk assessment can be captured.

(b) a procedure for individuals with lead clinical professional responsibility for a particular type of health care to report to the members of the Health Board or the Agency (as the case may be), on at least a quarterly basis, about the extent to which that individual considers that it is complying with the duties imposed by—

(i) this section, and

(ii) sections 12IA to 12IE and 12IH to 12IL,

- All clinical leads attend and contribute to the Workforce Governance Group a monthly basis. Risk and issues can be raised at the meetings which are minuted and actions will be generated to ensure compliance. The Workforce Governance Group provides governance to the Board for assurance. The Self-Assessment report is generated by the Senior Nurse Workforce Lead and submitted for feedback/further input prior to submission to HIS or Scottish Government.

(c) a procedure for such individuals to—

(i) enable and encourage other employees to give views on the operation of this section, and

(ii) record such views in reports made in accordance with the arrangements put in place under paragraph (b),

- There are a range of ways that we collect feedback from staff, and this will be reflected in compliance monitoring of the different duties in such a report, for example, as detailed in 12IC, 12IH, 12IJ, 12IL.

- There are questions within the staff survey regarding staff opinion on how well they believe their views are listened to and acted upon by the organisation.
- Line Managers also conduct their own staff engagements exercises along professional lines and via iMatter, PDPs, and business meetings.

(d) raising awareness among individuals with lead clinical professional responsibility for particular types of health care in how to implement the arrangements put in place under paragraphs (a) to (c),

- HCSA engagement sessions and training for individuals with lead clinical professional responsibility remain ongoing with support from HIS and the Senior Nurse Workforce Lead.
- Work is commencing on ensuring that the HCSA is introduced to all new starts via their Corporate Induction. SWAY presentation has been shared with all clinical service leads.
- A bespoke on line training module has been created and tested and is planned for the roll out to all staff in the new financial year.

(e) ensuring that such individuals receive adequate time and resources to implement those arrangements.

- This duty is linked to implementation of Duty 12IH. Current provision to ensure adequate time to implement is established through staff PDPs, Appraisal Reviews, Job Planning, Time built into Job Descriptions etc. Given TSH is a small board the number of lead professionals to address all systems and processes is limited and workload is an ongoing issue. Group/committee reporting/attendance is under review by each department to avoid unnecessary duplication of attendance/workload. Directorate performance reviews provides a forum for all service leads to report on their priorities and successes as well as highlighting emerging issues.

(3) Every Health Board and the Agency must have regard to the reports received in accordance with the arrangements put in place under subsection (2)(b).

- The governance structure of the HCSA feeds into the Workforce Governance Group with any risks / concerns escalated to Staff Governance then ultimately the Board.

Please provide Information on your methods of monitoring compliance with Duty 12IF

Staff have the mechanism to seek clinical advice through the following routes which provides the assurance that there is an escalation route. All of the meetings detailed below are minuted highlighting risk raised and if it is able to be mitigated/escalated. Feedback is given directly to staff seeking the clinical advice.

- Daily (Mon-Fri) multidisciplinary pre-planning meetings chaired by ADoN
- Daily (Mon-Fri) multidisciplinary Site Safety meetings (Chaired by ADoN/Interim Director of Security)
- Twice daily resource huddles (Chaired by Lead Nurse)
- Twice weekly nursing resource planning meetings (Chaired by Lead Nurse)
- Pre-weekend safety briefings
- Weekend safety briefings chaired by On-Call Director

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. Resource team in place	This should describe the situation: what is the success, achievement, or learning? For example, the views of employees included in the reports prepared by individuals with lead clinical professional responsibility for a particular type of healthcare identified a potential improvement in working practices in one area. • We are now in the 3rd year of having a resource team to provide operational oversight of clinical resources. This has enabled the SCN's time to focus on their individual clinical area and to foster collaboration with multidisciplinary team members at various forums. SCN's are now invested with time to meet monthly with the Associate Nursing Director and the Senior Management Accountant to develop their knowledge around how their decision-making impacts on their budget. A dashboard has been created for each SCN to be able to monitor in post, vacancy, sickness, overtime,	This should describe how the success, achievement or learning could be used in the future. For example, the potential improvement is being trialled in the one area and if successful will be rolled out across other areas in the organisation. • Develop and support SCN's to become responsible for their own staffing within their own ward area. Quarterly performance reviews with the Director of Nursing supported by HR and Finance continue to evolve.

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of	This should describe the situation: what is the challenge or risk identified? For example, in compiling reports made to the members of the Health Board, there are good	This should describe what actions have been / are being / will be taken to address the situation.

escalation, challenge or risk relates to. Introduction of the Women's Service July 2025	mechanisms in place for the Medical Director to enable and encourage medical employees to give their views, but the mechanisms for seeking the views of other professional groups for which they are responsible, such as pharmacy employees, are not well established. Hence, the views of these employees are not being sought or incorporated into the reports. The workforce assumptions on the Funded Establishment required for this service has not been realised. This service continues to put pressure on all the other wards in the hospital. Recruitment is a constant priority.	For example, if the views of all professional groups are not being sought, what measures have been put in place to engage these groups and proactively seek out their opinions. To continue to gather workforce information and recruit to all vacancies to minimise the impact on other patient areas.

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12IH: Duty to ensure adequate time given to clinical leaders.

Duty Summary	In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties, including, in particular, time— (a) to supervise the meeting of the clinical needs of the patients in their care, (b) to manage, and support the development of, the staff for whom they are responsible, and (c) to lead the delivery of safe, high-quality, and person-centred health care.
Please provide information on the steps taken to comply with Duty 12IH.	

Information submitted here should outline how systems & processes take account of all of the points detailed in the duty description above by providing detail for each consideration.

In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that all individuals with lead clinical professional responsibility for a team of staff receive sufficient time and resources to discharge that responsibility and their other professional duties, including, in particular, time—

- (a) to supervise the meeting of the clinical needs of the patients in their care,
- (b) to manage, and support the development of, the staff for whom they are responsible, and
- (c) to lead the delivery of safe, high-quality, and person-centred health care.

- Job Planning is in place for medical employees.
- All other professions out with medical, have leadership time monitored through one-to-one meetings and the PDPs held between manager and clinical leaders. PDP completion rates are monitored by the Workforce Directorate department.
- All services/professions are benchmarking the duty to ensure adequate time is given to leaders however this can be challenging due to the small nature of the board and the same people tasked with organisational priorities.
- Through the measures outlined above, as well as line management and professional leadership support at all levels, clinical leaders will be supported to have the time and resources to undertake these roles or seek support and highlight risks where this is not sufficient.
- Lead clinicians are identified via multiple TSH systems such as LearnPro, SSTS, eEES, TURAS, and SafeCare. Staff job descriptions reflect the specific leadership responsibilities, requirements and expectations within each role which are managed by relevant line managers. Work has progressed within nursing with skills identified within eRostering to aid staff being allocated in the right place at the right time.
- Job descriptions, job planning and work plans are all assessed at appropriate times via appraisal, 1:1s and PDP, job planning, development sessions, service change and redesign.
- Job planning sign off completion rates can be monitored through their respective systems. Workforce Governance reports are provided monthly to all service leads to highlight areas of risk such as hard to fill posts, vacancies, onboarding and leavers.
- Access to eRostering systems to support workforce planning is currently being rolled out within. During this transition period, all professional leads have access to annual PDPs/appraisals and medics have access to job planning. Discussion time with line managers to agree levels of time and resource to discharge their responsibilities and clinical workload are a core component of annual appraisal meetings and are escalated as required via board governance structures.

Please provide information on your methods of monitoring compliance with Duty 12IH

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

The Workforce Governance Group oversees the compliance of PDP's, Turas, in person training, recruitment and retention etc as well as looking at themes or trends for why staff leave the organisation.

If areas of risk are identified these will be escalated to the Senior Clinician who will receive a report to address this area of noncompliance.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. Management Redesign	This should describe the situation: what is the success, achievement, or learning? For example, senior physiotherapists and team leaders convened a working group to determine what sufficient time and resources would look like for individuals with lead clinical professional responsibility for a team of staff. The outcome of the project was a determination of time and resources for different team leaders, and feedback so far has been positive. Two senior posts within the Nursing Directorate became vacant, which provided an opportunity to revise the portfolios and consider where we required to use the funding from these posts in a different way. There was an identified need to strengthen the operational management within the directorate, as well as free up lead nurses to increase the focus on supporting the professional and clinical aspects of practice. Therefore, we aim to introduce two service manager posts to the directorate, and they will assume line management responsibility for the SCNs and responsible and	This should describe how the success, achievement or learning could be used in the future. For example, the positive outcome experienced as a result of the working group has led to this model being extended to other AHP areas and trialled to see applicability. Prepare Job descriptions and advertise posts.

Nursing director supported absence review meetings Heads of clinical department development day. Psychology - have held development days to focus on planning for new clinical model. Have also introduced weekly consultant huddles.	accountable for the operational service delivery. Recruitment of these posts is planned for early in the new financial year. • Over the last 12 months a significant investment has been made to support our SCN's and CN's develop into their role as clinical leaders. An area of concern was the level of sickness absence and to ensure we had robust systems in place to manage this. Along with the introduction of 'Once for Scotland' Policies and a task and finish group, SCN's now have monthly meetings with Human Resources to ensure staff are being supported appropriately whilst absent. Improvements have been noted however we are still above the 5% P.A.A. • Psychologists will have time allocated as part of their workplan for leadership duties. AHP's will have time allocated as per their job descriptions/work plans. • Development days have taken place to create joined up working and team building. • Each service has an allocated lead for psychology who is also a member of the Service Leadership Teams. They will have oversight of the clinical needs of the service and how these are to be met. Care will be delivered in line with the national psychology specification and the Matrix. Governance of this will be through the HoP.	• Continue to develop these meetings, monitor trends, manage absence and tailor to individual needs. • Ongoing programme

AHP Clinical Leads monthly meeting to focus on service planning and delivery.	• AHP dedicated development sessions have taken place with a focus on service planning and delivery. AHP's have senior clinicians allocated to each service and who are members of the SLT. As with psychology they have oversight of the clinical needs of the AHP services and governance via Lead AHP.	• Ongoing programme
Financial Review Meetings	• In preparation for SCN's to have the autonomy to be budget holders for their ward area the Director of Nursing introduced monthly Finance Meetings led by the Senior Management Accountant. Due to the way in which deficits are covered by overtime or excess hrs SCN's needed to have an overview of how this management was having an impact on their budget. A dashboard has been developed for each ward and provides key information re sickness absence, overtime, unfilled shifts etc which can also be monitored over time for trends. These dashboards have been up and running for just over 12 months.	• Continue to develop these meetings, monitor trends, and tailor to individual needs.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, the process in place to identify the roles, and therefore individuals, with lead clinical professional responsibility for a team of staff does not consistently identify who these	This should describe what actions have been / are being / will be taken to address the situation. For example, if the process in place to identify the roles, and therefore individuals, does not consistently identify who those individuals

	individuals are, and therefore sufficient time and resources for these individuals to discharge their responsibilities has not been considered.	are, what measures have been taken to address this? This could involve working with all staff groups, clinical areas, and teams to identify job titles / roles, utilising HR processes, and information and or utilising eRostering to identify team leaders etc.
Small board	• Small board – majority of organisational tasks become the remit of a small group of the same senior individuals to take forward, can become person-dependent. Due to the size of the board, streamlining of meetings has proved challenging.	• Streamlined reporting processes freeing up staff as best we can, e.g. Lead Nurses have been assigned different key areas of responsibility and meetings to which they are required to attend.
Wellbeing of staff	• Wellbeing of all staff. Lots of good support being provided however, workload makes it very difficult for nursing staff to attend/utilise excellent resources.	• Wellbeing is a focus within the Nursing Directorate, SCN meetings with Director of Nursing have identified a need to consider how we support the wellbeing of a Senior Charge Nurse who due to workload doesn't find time for themselves.
36 Working Week	• Progression towards a 36-hour working week is noted as a risk factor in ensuring protected time for learning however the implications of this are being monitored through the hospitals Workforce Governance Group.	• Engagement and partnership working have resulted in the State Hospital being ready to implement the 36hrs working week in April 2026.

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12II: Duty to ensure appropriate staffing: training of staff.

Duty Summary	In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that its employees receive— (a) such training as it considers appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b), and (b) such time and resources as it considers adequate to undertake such training.
Please provide information on the steps taken to comply with Duty 12II.	
Please provide information to demonstrate compliance. Information submitted here should outline how systems & processes take account <u>of all of the points</u> detailed in the duty description above by providing detail for each consideration. In complying with the duty imposed by section 12IA, every Health Board and the Agency must ensure that its employees receive— (a) such training as it considers appropriate and relevant for the purposes set out in section 12IA(1)(a) and (b), and (b) such time and resources as it considers adequate to undertake such training. • TSH Learning and Development Centre for professions, provides educational support through Practice Development/Education Facilitators (Nursing, medical and AHP specific) and identified development, learning facilitators in other professions to deliver identified new knowledge and skills requirements. All new employees undergo corporate induction and orientation. • Workforce Directorate monitor and report on all staff training to ensure compliance. This includes all face-to-face mandatory training, PDP completion, and LearnPro modules. This is reported via local governance routes including Staff Governance, Workforce Governance, partnership forum and directorate performance frameworks. • PDP completion is monitored through the TURAS platform along with the completion of mandatory and essential training at one to one meetings between managers and staff within all professions. • Training on legislation delivered to each group of staff named. • Training within the organisation is clearly determined along the lines of Mandatory, Essential and Development requirements for each profession and role. • All training is supported with protected time to complete and attend all training requirements. • Protected time is agreed within PDPs. • Different professions have different set national training curriculums. These are supported through line management and departmental budgets. • Nursing staff are issued with their off duties every six week and these off duties include rostered shifts for training. All other staff are managed by the learning and development timetable of when they are due to attend training – this is supported by line managers.	

- Flexible approach to staff completion of online learning access to training available from multiple devices and locations including areas out with the clinical setting. Access to online learning, Staff can choose when to complete e learning. The learning and development department monitor and report on training compliance and if necessary, risk is escalated to the corporate risk register.

Please provide Information on your methods of monitoring compliance with Duty 12II

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

The Workforce Governance Group oversees the compliance of PDP's, Turas, in person training.

If areas of risk are identified these will be escalated to the Senior Clinician who will receive a report to address this area of noncompliance

The Learning and Development Centre work alongside the workforce Governance Group providing an overview of staff attendance at in person training as well as reasons why staff do not attend training. When a member of staff does not attend for training this is escalated to the service lead/ SCN.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. Learning & Development	This should describe the situation: what is the success, achievement, or learning? For example, the psychology department in conjunction with HR, has just completed a project to promote more accurate capturing of information relating to continued professional development for psychology colleagues. Feedback from employees is that they have found the new system much easier to use and are now recording relevant CPD. • Corporate training programme exists and is reviewed annually by service leads to ensure all statutory and mandatory training is current and relevant. Compliance reporting and monitoring is embedded within the directorate performance framework.	This should describe how the success, achievement or learning could be used in the future. For example, AHP colleagues have now expressed interest in the new system and are undertaking a project to establish whether they could implement something similar. • Staff will have their training records uploaded into Health Roster.

Nursing	• Courageous conversation training is being delivered to Charge Nurses /SCN' s to support them manage absence. This along with the Once for Scotland policies has enabled managers to understand other available options for absence and how they can be supported make flexible decisions to support staff. • Rostering practices with senior Clinical staff have improved with training and development. A more consistent picture is being seen when rosters are presented for approval. Learning and development attend the weekly resource planning sessions where any with training/resourcing are discussed and solutions found.	• During the quarterly meetings with SCN's reflect on the use of the policies and learn from shared experience. • Continue to work closely with the Learning and Development Team ensuring we are proactively managing staff training
HR	• Once for Scotland Policies awareness sessions completed and HR department are now actively supporting line managers to utilise the new policies. Each department head has an allocated HR advisor to ensure consistent application of policies. Further organisational training regarding HR matters continues including – investigation training, counter fraud training etc.	• Ongoing review of training delivered and continuing support from HR advisors.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. Increased Clinical Acuity/Introduction of Women's Service	This should describe the situation: what is the challenge or risk identified? For example, clearly defined processes and procedures exist for some groups of staff, e.g. nursing and midwifery, but do not exist for other groups of staff, e.g. healthcare scientists. • Training is now considered in the weekly resource meeting, to ensure oversight of our risk escalation processes when training is cancelled. Training is generally cancelled when severe resourcing issues are evident and to minimise the impact to patient care. This can be the cause of increased clinical acuity, boarding out or more recently the impact of the introduction of the Women's Service.	This should describe what actions have been / are being / will be taken to address the situation. For example, if procedures and processes are not in place for healthcare scientists, please list the measures which need to be put in place to address this, such as working with HR and healthcare scientist representatives to define an appropriate training programme, assess training needs of employees and plan for required training to be undertaken. • To ensure those staff whose training is cancelled is rearranged at the earliest opportunity.

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12IJ: Duty to follow the common staffing method.

Duty Summary	(1) In relation to health care of a type mentioned in section 12IK, a Health Board or the Agency (as the case may be) must, no less often than at the frequency specified in regulations by the Scottish Ministers, use the common staffing method set out in subsection (2). (2) The common staffing method means that a Health Board or the Agency (as the case may be)— (a) uses the staffing level tool and the professional judgement tool as prescribed in regulations under subsection (3) and takes into account the results from those tools, (b) takes into account, in so far as relevant, any measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H (1) by the Scottish Ministers (including any measures developed as part of a national care assurance framework), (c) takes into account— (i) its current staffing levels and any vacancies, (ii) the different skills and levels of experience of its employees, (iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care, (iv) the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care including, in particular, those to which this section does not apply, (v) the local context in which it provides health care, (vi) patient needs, (vii) appropriate clinical advice, (viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides, (ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE, (x) comments by patients, and by individuals who have a personal interest in their health care (for example family members and carers within the meaning of section 1 of the Carers (Scotland) Act 2016), which relate to the duty imposed by section 12IA, and (xi) comments by its employees which relate to the duty imposed by section 12IA, (d) identifies and takes all reasonable steps to mitigate any risks, and (e) having followed the steps described in paragraphs (a) to (d), decides what changes (if any) are needed as a result to its staffing establishment, and to the way in which it provides health care.
Please provide information on the steps taken to comply with Duty 12IJ.	

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

(1) In relation to health care of a type mentioned in section 12IK, a Health Board or the Agency (as the case may be) must, no less often than at the frequency specified in regulations by the Scottish Ministers, use the common staffing method set out in subsection (2).

- TSH is currently using SafeCare and the newly named MHLD workload tool alongside Professional Judgement. Since summer 2025 we rolled out SafeCare part 1 to all wards in preparation for the new named tool in October 2025. During November and December 2025, we delivered a soft launch of SafeCare part 2 when we started to enter the patient census using the agreed levels of care descriptors. We have agreed all wards will have their two-week tool run commencing 23rd February 2026. We will require to use both SSTS and SafeCare during this tool run supported by HIS.

Access to resources includes: HIS speciality specific toolboxes, training videos, templates FAQs as well as real time face to face support from the dedicated team within the

(2) The common staffing method means that a Health Board or the Agency (as the case may be)—

(a) uses the staffing level tool and the professional judgement tool as prescribed in regulations under subsection (3) and takes into account the results from those tools.

- MHLD & Professional Judgement tool is approved for use however as above; HIS continue to provide support, training, and development updates in conjunction with TSH's Senior Nurse Workforce Lead.

(b) takes into account, in so far as relevant, any measures for monitoring and improving the quality of health care which are published as standards and outcomes under section 10H (1) by the Scottish Ministers (including any measures developed as part of a national care assurance framework),

A range of quality measures such as Clinical Quality Indicators, patient safety data, KPIs, risk assessments, physical health steering group, and annual delivery plan etc. are utilised for CSM triangulation and input into workforce. In addition, clinical quality monitor and report on clinical incidents, risk, daytime confinement, complaints/compliment etc. on a monthly basis via various governance routes within TSH.

(c) takes into account—

(i) its current staffing levels and any vacancies,

- Funded establishment, actual staffing (including vacancies/onboarding) is reported via a monthly workforce report. BOXI provides a viable reporting mechanism to monitor the use of additional hours and the PAA absence. With Optima going forward, we will be able to use roster perform to provide this workforce information.

(ii) the different skills and levels of experience of its employees,

- Nursing Ward funded establishments are reviewed regularly to ensure the appropriate gender/skill/experience is in place to support CSM. Ongoing recruitment takes into consideration the age profile and gender/skill requirements and this is reported monthly via the workforce report. TSH aspires to recruit to a 60/40 registered/non-registered split.

(iii) the role and professional duties, in particular, of any individual with lead clinical professional responsibility for the particular type of health care,

- The Charge Nurses and Senior Charge Nurses play an influential role in supporting the triangulation of the CSM. They support evidenced based decision making when considering having the right staff in place to deliver high quality of care. They verify data, consider Clinical Quality Indicators, risk assessments etc and support junior members of staff to feel confident when making staffing resource decisions.

(iv) the effect that decisions about staffing and the use of resources taken for the particular type of health care may have on the provision of other types of health care including, in particular, those to which this section does not apply,

- Reports are submitted to TSH oversight groups for review including Workforce Governance and Clinical Governance. Group members include a wide range of multi professionals who can review patient delivery of care and consider any potential impact of changes to delivery of patient care from an MDT approach.

(v) the local context in which it provides health care,

- The local context for each clinical service is discussed in the daily resource huddles with data captured. Each area is able to input concerns around skill mix, psychological safety results, staff experiences, capacity and demand, and supplementary staffing usage.
- Line management is able to review areas such as missed care results, iMatter scores, staff experiences, age profile of employees, capacity and demand, PAA v actual, etc.

(vi) patient needs,

- Patient needs are considered at local level by line management and a weekly clinical team meeting. On a daily basis, specific patient needs and activity are considered at the resource huddles to minimise the risk to patient care. This information can be recorded on SafeCare during the 3 census periods.
- In addition, the patient voice is considered and managed via the Person Centred Improvement Team via the Patient Partnership Group which includes patient representation. This group is externally supported by the Scottish Health Council.

(vii) appropriate clinical advice,

- Clinical advice from involved professionals is sought via the weekly clinical team meetings, service leadership teams, clinical pauses, and the daily resource huddles. Out of hours, clinical advice is provided by the role of Senior Clinical Cover, on call medic, and an on-call director.

(viii) any assessment by HIS, and any relevant assessment by any other person, of the quality of health care which it provides,

- Clinical advice from involved professionals is sought via the weekly clinical team meetings, service leadership teams, clinical pauses, and the daily resource huddles. Out of hours, clinical advice is provided by the role of Senior Clinical Cover, on call medica, and an on-call director.

(ix) experience gained from using the real-time assessment arrangements under section 12IC (1) and the risk escalation processes under sections 12ID and 12IE,

- At present, risk is reported via Datix and via unsafe practice forms.
- Staff can raise red flags via SafeCare but this practice is in evolution

(x) comments by patients, and by individuals who have a personal interest in their health care (for example family members and carers within the meaning of section 1 of the Carers (Scotland) Act 2016), which relate to the duty imposed by section 12IA, and

- TSH has a robust patient partnership forum which has patients from each hub acting as a voice for the patients within their own areas and ensuring feedback of provided. Person Centred Improvement Team collates and reports on the patient and carer experience and these are used in the triangulation of CSM. The Mental Welfare Commission and the Scottish Health Council provide support to this forum and provides assurance the patient/carers voice is heard.

(xi) comments by its employees which relate to the duty imposed by section 12IA,

- Staff feedback is gathered via a staff survey, 1:1s with line managers, iMatter, PDPs, and business/departmental meetings and will be captured within SafeCare.

(d) identifies and takes all reasonable steps to mitigate any risks

- Risk is reported via Datix, unsafe practice forms and a robust operational support plan as described in 121A. Staff can raise red flags via SafeCare but this practice is in evolution.

(e) having followed the steps described in paragraphs (a) to (d), decides what changes (if any) are needed as a result to its staffing establishment, and to the way in which it provides health care.

- Changes to staffing establishments are reviewed in conjunction with service redesign, workforce planning input, clinical/professional advice. These changes are reported and monitored through workforce governance group and if necessary escalated to staff governance then to the Board.

Please provide Information on your methods of monitoring compliance with Duty 12IJ

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- Significant progress has been made towards compliance, with bespoke training sessions delivered in person and via SOP's, Videos etc. Compliance reports are presented to all SCN's with areas of improvement identified. The Associate Director of Nursing chairs a monthly oversight meeting which focusses on the roll out of Safe Care and the implementation of the MHLA & PJ Tools. Progress is noted and details of actions required. Risks if any are recorded and escalated if necessary. A SLWG has been established to deliver on the actions from the oversight monitoring group lead by a Lead Nurse and supported by representatives from all wards, Learning and Development Centre, Nurse Practice Development and the Senior Nurse Workforce Planning.
- Monthly Finance Meetings take place with SCN, LN and management accountant to determine whether working within the parameters of Funded Establishment.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, application of the common staffing method in adult inpatient provision identified some areas where the staffing establishment needed to be changed, and some areas with	This should describe how the success, achievement or learning could be used in the future. For example, following completion of the trials regarding changes in staffing establishment and service redesign, decisions will be taken

Nursing	potential for service redesign. These changes are now in progress and will be trialled to monitor the outcomes. • The Monthly workforce report has evolved to provide us with a range of workforce information including vacancies, hard to fill posts, secondments, fix term, leavers and retire and returns. • SafeCare has been rolled out to all wards, with training being delivered to Band 5, 6, 7 • Training and SOP's have been developed for the Professional judgement version 4 which will be recorded during the 2 week tool run 23rd February 2026. • Awareness sessions have been delivered to one Hub on the Common Staffing Method. Plans to expand this to all other Hubs. • The supplementary staffing register has remained static in the last 3 months. Changes to pension plans has allowed experienced staff to return as full time members of staff whilst partially retiring. This provides a vehicle to ensure experience, skills, and gender are being maximized. • A test of change has been running now for 12 months to resource a post to work alongside the Outings Coordinator. This will minimize the impact on wards to resource planned outings on a daily basis. Initial data is proving positive with a dramatic reduction on the reliance on ward based staff to fill this activity. • Day time Confinement (DTC) continues to be monitored.	about their formal adoption. A summary of this exercise could then be used as case studies to inform training for staff about the use of the common staffing method. • Workforce report shares data highlighting vacancies across the clinical area looking at skills, gender, experience. This report supports managers to be proactive around recruitment which plans to reduce gaps in vacancies. • HR support planning ahead for any known leaver or planned retirements that can be considered for proactive recruitment. HR have developed a redeployment register for staff who are unfit/not appropriate for substantive role – this allows use of their skills in different areas. • Further training is required to be delivered to clinical leaders on the use of the common staffing method due to workforce changes in personnel • Continue to promote positive engagement and feedback to the workforce on areas of staffing levels, risk and escalation.

	• Senior members of nursing are present at all forums across TSH including the daily resource huddles to allow feedback to staff on issues surrounding staffing, gender, skill mix and DTC. • In addition, charge nurses now attend all daily resource huddles for input and work collaboratively to help manage resources efficiently and to minimise the effect on patient care due to DTC. • The State Hospital was represented in the development of the new MHLD workload which was named in legislation October 2025.	

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. Gender sensitive tool	This should describe the situation: what is the challenge or risk identified? For example, the common staffing method was followed at the required frequency in all areas except emergency care provision with an explanation of why this was not completed, e.g. lack of knowledge / training of personnel. • The existing Gender sensitive tool used within the hospital has been in place for approximately fifteen years and requires a full	This should describe what actions have been / are being / will be taken to address the situation. For example, if the common staffing method was not followed in emergency care provision and this was due to lack of knowledge / training, what measures were put in place to address this, e.g. identifying key personnel, provision of training, assistance from experienced personnel in other areas etc. • Continue to work with Customer Success Manager to identify a solution.

Introduction of the Women's Service July 2025	review, in line with the principles of the Health and Care Staffing Act. SafeCare will support us with this when fully embedded. Gender has been identified as a skill in Optima but it is difficult to clearly see where there are gaps. • The workforce assumptions on the Funded Establishment required for this service has not been realised. This service continues to put pressure on all the other wards in the hospital. Recruitment is a constant priority.	• To continue to gather workforce information and recruit to all vacancies to minimise the impact on other patient areas.

COMPLIANCE ASSURANCE LEVEL

Substantial Assurance

Duty 12IL: Training and consultation of staff

Duty Summary	In complying with the duty imposed by section 12IJ, every Health Board and the Agency must— (a) encourage and support its employees to give views on its staffing arrangements for the types of health care described in section 12IK, (b) take into account and use any such views it receives to identify best practice, and areas for improvement, in relation to such staffing arrangements, (c) train employees (including, in particular, employees of a type mentioned in the third column of the table in section 12IK (1)) using the common staffing method on how to use it (d) ensure that those employees receive adequate time to use the common staffing method, and (e) provide information to employees engaged in the types of health care described in section 12IK about its use of the common staffing method, including about— (i) the results from using the staffing level tool and the professional judgement tool under paragraph (a) of section 12IJ (2), (ii) the steps taken under paragraphs (b), (c) and (d)] of that subsection, and (iii) the results of its decision under paragraph (e) of that subsection.

Please provide information on the steps taken to comply with Duty 12IL.

Please provide information to demonstrate compliance.

Information submitted here should outline how systems & processes take account **of all of the points** detailed in the duty description above by providing detail for each consideration.

In complying with the duty imposed by section 12IJ, every Health Board and the Agency must—

(a) encourage and support its employees to give views on its staffing arrangements for the types of health care described in section 12IK,

- HCSA is incorporated within the corporate training plan 2026-2027. There is a requirement to adapt NES, HIS, and Turas resources to ensure they reflect TSH systems and procedures.
- HIS continue to support the integration of the new MHL D Workload tool on the SafeCare platform as we plan for the scheduled two-week tool run.
- CSM awareness sessions are currently being refreshed to include the use of MHL D on SafeCare
- All SCNs and charges nurses have access to a dedicated team of staff as well as access to TURAS resources and HIS learning.
- An online eLearning resource had been developed and tested which will include opportunities to provide feedback. Additionally, the incorporation of a feedback option within iMatter is being explored. Staff surveys allow opportunity for staff to provide feedback alongside business meetings and 1:1 with line manager.

- Daily resource huddles allow full discussion of staffing risks, mitigations, and positive/negative outcomes.

(b) take into account and use any such views it receives to identify best practice, and areas for improvement, in relation to such staffing arrangements,

- Staff involvement and engagement is evidenced via iMatter, PDPs, staff surveys, and training evaluation forms.
- Daily resource huddles provide opportunities for staff to engage in solution-oriented collaborative working. Feedback from these meetings is delivered at hub level by the attending hub coordinator.
- The State Hospital was represented within the SLWG in developing the first new MHL D tool to be uploaded onto SafeCare.

(c) train employees (including, in particular, employees of a type mentioned in the third column of the table in section 12IK (1)) using the common staffing method on how to use it

- Face to face and/or teams training sessions have been delivered continuously to staff in areas of SafeCare, Loop, Rostering Skills and Professional Judgement since Q2 2025 in preparation for the new MHL D Workload Tool.
- Resources have been developed to support staff and are easily accessible within their local drives. An online training module has been developed and tested which will be mandatory for all staff in scope of legislation. Staff are also encouraged to complete HIS TURAS learning resources.

(d) ensure that those employees receive adequate time to use the common staffing method,

- Adequate time to undertake CSM duties will be monitored and assured via one-to-one meetings and the PDPs held between manager and clinical leaders. All services/professions are benchmarking the duty to ensure adequate time is given to leaders however this can be challenging due to the small nature of the board and the same people tasked with organisational priorities.

(e) provide information to employees engaged in the types of health care described in section 12IK about its use of the common staffing method, including about—

- (i) the results from using the staffing level tool and the professional judgement tool under paragraph (a) of section 12IJ (2),
- (ii) the steps taken under paragraphs (b), (c) and (d)] of that subsection, and
- (iii) the results of its decision under paragraph (e) of that subsection.

- TSH is currently using SafeCare and the newly named MHL D workload tool alongside Professional Judgement. Since summer 2025 we rolled out SafeCare part 1 to all wards in preparation for the new named tool in October 2025. During November and December 2025, we delivered a soft launch of SafeCare part 2 when we started to enter the patient census using the agreed levels of care descriptors. We have agreed all wards will have their two-week tool run commencing 23rd February 2026. We will require to use both

SSTS and SafeCare during this tool run supported by HIS. All data reported during the tool run will be received from HIS and SSTS and verified by each SCN/LN. This information along with quality information indicators, risk assessments, staff demographics will assist us determine safe staffing from an evidenced based perspective.

Please provide Information on your methods of monitoring compliance with Duty 12IL

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- Significant progress has been made towards compliance, with bespoke training sessions delivered in person and via SOP's, Videos etc. Compliance reports are presented to all SCN's with areas of improvement identified. The Associate Director of Nursing chairs a monthly oversight meeting which focusses on the roll out of Safe Care and the implementation of the MHLD & PJ Tools. Progress is noted and details of actions required. Risks if any are recorded and escalated if necessary. A SLWG has been established to deliver on the actions from the oversight monitoring group lead by a Lead Nurse and supported by representatives from all wards, Learning and Development Centre, Nurse Practice Development and the Senior Nurse Workforce Planning.
- Monthly Finance Meetings take place with SCN, LN and management accountant to determine whether working within the parameters of Funded Establishment.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to.	This should describe the situation: what is the success, achievement, or learning? For example, key personnel who were very experienced in using the common staffing method were engaged to train and mentor other personnel involved in the process.	This should describe how the success, achievement or learning could be used in the future. For example, those key personnel have now decided to meet regularly in a forum to discuss shared learning and to ensure the common staffing method is used consistently across all relevant areas in the organisation.

Learning & Development	• A corporate training programme exists and is reviewed annually by service leads to ensure all statutory and mandatory training is current and relevant. There is input from all Heads of Service. Compliance reporting and monitoring is thereafter embedded within each Directorate Performance framework and monitored through the monthly Workforce Governance meetings. • Optima is now being used across all rosters within TSH. Compliance of using Optima has improved in the last year with all rosters achieving more than 80% compliance. Loop will be the system to manage leave requests and unavailability by all staff by April 2026. Nursing rosters are currently being updated to reflect the newly agreed shift pattern effective April 2026. Nursing particularly have been fully engaged these last 12 months with Optima, SafeCare and Loop where they are now starting to see the benefits of the system although there is still an added workload related to double keying of data being cited as an area of concern. • Consultation with staff continues to improve with the strengthening of nurse membership engagement at resource forums. This has also enabled a process for hub-based staff to raise staffing concerns/queries and receive feedback either in person or by formal communication. • There has been significant work undertaken to engage with our workforce focusing on staff wellbeing and development. This work has helped to inform our Organizational Development Strategy.	• Agreement to include the common staffing method awareness sessions as part of the mandatory training for registered nurses. • Consider the use of SafeCare to be integrated within the nurse induction programme. • Shared training resources to continue to be adapted and refreshed to meet the needs of TSH recording of training compliance. • Explore the evolvement of using red fags in SafeCare as an additional route in escalating risk, not just Datix reporting. • Continue to develop our communication and engagement strategies with ward-based staff to ensure inclusion as the workforce changes with recruitment and leavers. • SWAY presentation has been shared with nursing leaders as a useful resource.

Nursing	• Training and Professional development manager alongside the Senior Nurse – Workforce Planning have developed an online training module which has been tested and will be uploaded on Turas. This will be mandatory for all staff to complete. A flexible approach to delivering awareness training sessions in the use of the CSM is currently underway for all Band 5,6,7. • The SWAY presentation was shared to all service leads as a useful resource and was used as the foundation to build our on line module. • Optima and SafeCare has been fully implemented across all Nursing, AHP, Medical and Psychology. • Nursing has now established structures and reporting processes in place within their Directorate to ensure escalation of rostering concerns are addressed. • The SCN now manage their rosters to ensure they are accurate, and this continues to be supported with interim Rostering Project Manager support to aid the development of local rostering issues and support with SafeCare. Significant training was undertaken with all Nursing, AHP and Psychology to ensure their Optima and SafeCare were accurate.	• The Rostering Project Manager and the SafeCare Compliance group meet monthly to review progress of Rostering and SafeCare. A Project plan has been established which is monitored and updated to track completion of target dates in relation to both these products.

Areas of escalation, challenges, or risks

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to. Nursing	This should describe the situation: what is the challenge or risk identified? For example, issues were identified with a lack of training on the CSM for personnel in emergency care provision due to time constraints. - Nursing is testing moving away from a centralised approach to managing resourcing and have SCNs in charge of their wards. Work has been ongoing with the Rostering Project Manager and RLDatix to support the use of SafeCare to manage resources. - This has proved challenging to provide confidence to the Senior Clinical Cover who require to have site wide knowledge of where all staff are as we are a small board and inter dependent in times of crisis. Work has progressed with eHealth to produce a site wide report from Optima to provide this assurance. This is currently being tested out on PreProd. - The eRostering implementation roll out across the hubs has taken longer than predicted due to the significant challenges we have encountered in this process. This continues to be an ongoing challenge	This should describe what actions have been / are being / will be taken to address the situation. For example, arranging and delivering training; the provision of mentoring from experienced personnel; or the adoption of job planning which ensures adequate time is available for designated personnel to undertake training on the common staffing method. - The board have supported a dedicated member of staff to work with nursing colleagues and support them progress through these challenges. - A live detailed workplan has been developed and is reported quarterly at Workforce Governance Committee. - Processes in consultation with staff are being tested whilst we make this decentralisation to provide assurance that we are confident we have the right staff arriving for work.

	particularly with the settings in SafeCare not been fully explained to us as we did not receive in depth training from RL Datix before they moved on. We have been learning from other boards, testing things out on PreProd ourselves and when find something we can't explain it becomes apparent it has been down to the lack of skills and knowledge we have in the system and how it should be configured.	

COMPLIANCE ASSURANCE LEVEL
Substantial Assurance

Planning and Securing Services

Duty Summary	Guiding principles etc. in health care staffing and planning (1) In carrying out the duty relating to staffing imposed by section 12IA of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to the guiding principles for health and care staffing. (2) In planning or securing the provision of health care from another person under a contract, agreement or arrangements made under or by virtue of the National Health Service (Scotland) Act 1978, every Health Board and the Common Services Agency for the Scottish Health Service must have regard to— (a) the guiding principles for health and care staffing, and (b) the need for the person from whom the provision of health care is to be secured to have appropriate staffing arrangements in place. - Guiding principles and staffing arrangements are always considered when planning and securing services. Work continues with procurement colleagues to ensure that these are clearly set out in the processes and can be evidenced to support annual reporting. - In addition, procurement of health care services from another provider falls within the SG guidelines whenever an SLA or other agreements are signed.
Please provide information on the steps taken to comply with section 2(2) of this Duty.	
Please provide information to demonstrate compliance. Information submitted here should outline how systems & processes take account <u>of all of the points</u> detailed in the duty description above by providing detail for each consideration. As a small Special Health Board, we have a number of long-standing SLA's in place with other local Territorial Boards. These are reviewed approximately every 3 years (or earlier if necessary), and the budget holder/stakeholder will discuss with the provider the staffing levels and skills required. They will then work with Procurement around costs and other considerations such as service providers personnel clauses, scope of service, data protection, confidentiality of Caldicott, compliance with legal obligations etc and a new SLA would then be drafted and signed by both parties. In the rare occasion when more than one Board can provide the service, a	

non-regulated Tender process would be carried out. The TSH is governed by the National Procurement policies which provides assurance to the process of an SLA's.

Please provide Information on your methods of monitoring compliance when planning and securing services

This should include details of the local arrangements in place to monitor compliance with the duty, including mechanisms for escalating and addressing areas of non-compliance.

- All external members of staff who provide a service within the organisation are invested by a security induction to ensure they remain and deliver safe practice in accordance with our policies and procedures. For those delivering a service directly to patients on a regular basis they will also be provided with PMVA or Breakaway training. This has enabled us to provide expert care to patients particularly in areas of Spiritual & Pastoral Care, Patient Advocacy Service, palliative care, Primary Care, Volunteers and language interpreters when we cannot provide this expertise from within our workforce. The volunteers provide a key role to those patients who have no family or friends in their life. The hospital also supports students in their learning from open universities, other hospitals and across many disciplines. These staff are supported within their specialism and asked to provide feedback on their learning experience. Feedback both formally and informally is positive.

Areas of success, achievement, or learning

Area of success / achievement / learning	Details	Further action
This should include details of the NHS function / professional group etc. that the area of success, achievement or learning relates to. Nursing	This should describe the situation: what is the success, achievement, or learning? For example, when procuring from private hospitals, the organisation has incorporated the requirements of the Act into the tender process. • The Supplementary Staffing Register has enabled us to support staff work more flexibly. The register is made up of retire and return members of staff at Band 3 and Band 5 grade who are fully aware of their roles and responsibilities. We have also opened up this	This should describe how the success, achievement or learning could be used in the future. For example, the learning from tendering with private hospitals is now being used to implement arrangements in other types of procurement. • To continue to develop the SSR and to widen the membership.

Area of escalation / Challenge / Risk	Details	Further action
This should include details of the NHS function / professional group etc. that the area of escalation, challenge or risk relates to.	This should describe the situation: what is the challenge or risk identified? For example, there may have been difficulties in planning or securing services in a speciality area due to a lack of assurance around the appropriateness of staffing arrangements.	This should describe what actions have been / are being / will be taken to address the situation. For example, engaging with service providers to ensure that they understand what information and assurance is required, seeking alternative service providers etc.
International Recruitment	The TSH doesn't currently have a visa programme in place to allow international recruitment. Potential candidates must be established in the UK to apply for posts.	Discussions to change/update practice are still in preliminary stages. Overseas applicants are currently being addressed nationally.

Substantial Assurance

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026
Agenda Reference No: Item No: 14
Sponsoring Director: Director of Workforce
Author(s): Director of Workforce
Title of Report: Whistleblowing Report
Purpose of Report: For Decision

1 SITUATION

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

As part of the National Standards, each Health Board is required to provide quarterly updates on the number of whistleblowing cases, along with producing an Annual Report which should detail the work undertaken in the implementation of the Standard.

2 BACKGROUND

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

3 ASSESSMENT

a) Quarterly Update

The Quarter 4 update is from 1 October 2025 to 31 December 2025.

No formal Whistleblowing cases were raised during this quarter either direct to The State Hospital or indirect via the INWO.

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

b) Annual Report

The Annual Report details the work undertaken to raise awareness of, develop and improve our approach to implementation of the Standards within the Board, and our proactive approach to developing a supportive speak-up culture. Annual Report attached at Appendix A.

c) Correspondence in response to questions from the Cabinet Secretary

The Cabinet Secretary wrote to Chief Executives and Whistleblowing Champions on 5 March 2026 requesting their assistance in gathering a national picture of the state of whistleblowing and to provide assurance around both whistleblowing, the implementation of standards and a positive speak up culture.

Several set questions across a number of key themes were provided by the Cabinet Secretary.

The response from Shalinay Raghavan, our Whistleblowing Champion is attached as Appendix B and from Gary Jenkins, Chief Executive, as Appendix C.

4 RECOMMENDATION

The Board is asked to

- a) Endorse the content of the Annual Report at Appendix A and
- b) Endorse the content of the letters to the Cabinet Secretary at Appendix B and C.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Workforce Plan
Corporate Objectives Please note which objective is linked to this paper	4. Better Workforce Support the Independent National Whistleblowing Standards and support this workstream locally including promoting awareness for staff.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	N/A
Risk Assessment (Outline any significant risks and associated mitigation)	N/a
Assessment of Impact on Stakeholder Experience	Na
Equality Impact Assessment	N/a
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
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



THE STATE HOSPITALS BOARD FOR SCOTLAND

WHISTLEBLOWING ANNUAL REPORT

1 April 2025 to 31 March 2026

1. INTRODUCTION

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

The SPSO worked with NHS National Education Scotland (NES) on the development of training materials, and these are now available to all staff through the TURAS Learn Website. There are two training modules: one for raising general staff awareness of whistleblowing, and a more detailed programme for managers or others who may receive concerns. This provides additional support and guidance on best practice, should a concern be raised through the policy.

In addition to this, the Scottish Government revised and promoted the role of the Whistleblowing Champion as a formal Non-Executive member of each NHS Board, with our appointment finalised in December 2022. Their role is to ensure that the systems are in place to enable staff to raise concerns, and that the culture of the organisation supports the full application of these systems, by valuing staff concerns.

The State Hospital supports and encourages an environment where employees, both current and former, contractors, trainees and students, volunteers, non-executive directors and anyone working within the Board can raise concerns.

The aim of this Annual Report is to be transparent about how Whistleblowing concerns are handled, highlight actions taken and any improvements.

This is the fifth Annual Report and is for the reporting activity from 1 April 2025 until 31 March 2026.

The Executive Lead is the Director of Workforce.

2. BACKGROUND

Whistleblowing is an important process to enable an individual to speak up about any Whistleblowing concerns they may have in the organisation with respect to quality and safety in patient care and service delivery. The way we respond to Whistleblowing concerns raised is important, so that individuals feel that their concerns will be valued and handled appropriately, and that the organisation will take on board what they have to say.

In line with the organisation's values, The State Hospital encourages Whistleblowing concerns to be dealt with at the earliest opportunity and where possible in real time within the management structures that our staff work in within the organisation. Alternate routes for raising Whistleblowing concerns include the Whistleblowing Champion Non-Executive Director, Senior Managers, trade unions and other staff.

3. CONCERNS RAISED

Since 1 April 2025 to 31 March 2026 there were no Whistleblowing concerns raised direct to the Board.

No cases have been raised by any other contractors or anyone linked to the Standard during this time.

4. ACTIONS

The State Hospital remains committed to the development of a Positive Speak Up Culture and has been working closely with the Non-Executive Whistleblowing Champion to focus on several key areas: -

- a) Continuing to raise awareness of the role of Non-Executive Whistleblowing Champion, with communication briefs in relation to Speaking Up generally and to Whistleblowing more specifically.
- b) Arranged two-in-person walk in clinics with the Whistleblowing Champion on site to increase visibility and accessibility.
- c) Raising general awareness of (i) a Positive Speak Up Culture, with links to clinical performance, concerns, equalities, inclusive environment (ii) the Whistleblowing Process, which was largely completed in the lead up to, and over, Speak Up Week.
- d) Ensure multiple routes are available to our staff who require support in any way, principally through our Wellbeing Centre. Draft poster attached.
- e) Continuation of a confidential Contact Forum quarterly with the Non-Executive Whistleblowing Champion to provide support and establish any general trends.
- f) Ensuring continued high compliance with Whistleblowing Standards Modules: 99% on General Awareness and 89% on Managers.
- g) Seminar Series on Psychological Safety run by OD Manager.
- h) New Leadership and Management Framework have strong links to how we encourage and support a Positive Speak Up Culture, including building trust with teams, how to sensitively handle difficult conversations, and how to actively listen.
- i) As part of the Speak Up Week awareness, we highlighted the standards, the approach and importantly how to access support or to make a complaint under whistleblowing standards. We also provided reassurance over how such a concern would be handled

The State Hospital participated in the "Speak up Week" which took place from 29th September to 3rd October 2025, with focus and alignment to the National message of Listen, Act, Build Trust. Staff Bulletins were circulated to the service with updates from a number of contributors, National Seminars were publicised on our screens and hubs were set up in community areas to provide further information on Speak Up and the work that we are doing at TSH in relation to Speak Up.

5. FUTURE ACTIONS

Organisationally, we will have a two-stage approach to development of our Positive Speak Up Culture, to ensure both immediate action and also neat alignment with our longer-term plans. This will entail the following:

- **Step 1: Short-Term Approach – Speak Up & Psychological Safety**

Immediate action, to provide assurance, and build confidence that staff can raise concerns safely, managers will respond appropriately and consistently, reinforce that concerns are acted on and followed up and leadership is visible and engaged

This will include a focus on: -

1. Line Manager Capability and Consistency
2. Visible and Safe Routes to Speak Up
3. Real-Time Assurance and Risk Monitoring
4. Explicit Staff Support After Speaking Up
5. Fast Escalation and Closing the Loop
6. Visible Senior Leadership Presence and Active Listening

Stage 2: Mid & Long-Term Culture Change Programme (From October)

Our formal Culture Change Programme will be launched in October, allowing adequate time for preparation, engagement and leadership readiness.

The process will be:

Step 1: Understand the Current Culture (Diagnosis)

Deployment of the Affina OD culture assessment, designed by Professor Michael West.

Step 2: Define the Desired Culture (Define)

Application of the four-domain Behaviour Framework:

1. How we work together
2. How we lead and support others
3. How we deliver safe, high-quality care
4. How we grow and improve

Step 3: Enable the Cultural Shift (Enable)

Use of Self-Determination Theory (Autonomy, Competence, Relatedness) to support behaviour change.

Alongside these core programmes of work aimed at our culture, we will also:

- Continue to raise awareness raising of the importance of Speaking Up and ensuring numerous routes to support this.
- Support the launch of our Nursing Partnership Forum, as another means of local engagement to support Active Listening and constructive Partnership working.
- Recruit additional confidential contacts, along with reviewing training and support for our current Confidential Contacts.

6. REPORTING

Reporting of any concerns raised through Whistleblowing is reported through Partnership, Workforce Governance Group, Corporate Management Team, Staff Governance and the Board.

All Whistleblowing Complaints are recorded locally via the DATIX system and then updated as and when the case is investigated and concluded.

All the relevant Committees received quarterly updates on any concerns raised which was finally discussed at Board on the following dates:

28 August 2025	Quarter 1 update, 1 March to 30 June 2024
23 October 2025	Quarter 2 update, 1 July to 30 September 2024
26 February 2026	Quarter 3 update, 1 October to 31 December 2025
16 April 2026	Quarter 4 update: 1 January to 31 March 2026

7. QUALITY AND PATIENT CARE

Whistleblowing remains an important Policy and process for staff, students and volunteers to enable them to speak up about any concerns they may have in the organisation with respect to quality and safety in patient care. The information in this report has no direct impact on patient care, except in those circumstances when the whistleblowing process is used to highlight patient safety concerns or other quality matters in the organisation. Any recommendations or actions that come out of future whistleblowing cases will help to improve quality of The State Hospital services and patient care.

8. CONCLUSION

Whilst there were no formal cases raised via Whistleblowing in the past year, we remain active committed to supporting the development of a Positive Speak Up Culture, with clear assurance on the implementation of national standards and clear alignment with our short- and medium-term plan to promote, develop and embed positive culture change.

This is an integral element of our approach to Organisational Health, which will closely align to 'Speak Up' and Whistleblowing and ultimately Staff Experience, in terms of developing an inclusive environment where staff feel safe to raise their concerns in a safe and secure environment.

Appendix B – Letter to Cabinet Secretary from Non-Executive Whistleblowing Champion

The State Hospital

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Mr N Gray MSP
Cabinet Secretary Health and Social
Care
The Scottish Government
St. Andrews House
Edinburgh, EH1 3DG

Date 16 April 2026
Our Ref SR/rp
Enquiries to Stephen Wallace
Direct Line 01555 842122
E-mail stephen.wallace@nhs.scot

Dear Mr Gray

Whistleblowing Update

I refer to your letter of 5th March 2026 in relation to Whistleblowing within The State Hospital.

Please find my responses to the specific questions below:-

Culture and Leadership, Staff Experience and Confidence

- 1. How are you fostering and demonstrating a positive speak-up culture across the Board, and what evidence do you have of its impact on staff confidence? How do you use iMatter data and other feedback mechanisms to assess perceptions of whistleblowing safety, including identifying any hotspots, good practice, or areas requiring additional support across staff groups, roles, teams or locations?***

Our key workforce priority, identified through our Workforce Plan, is to prioritise our Organisational Health, with a key component of this work being driven through our Organisational Development (OD) Strategy. Some of the key themes which support building a positive staff experience this year are:

- Leadership and Management Capability

The role of the line manager, and our leaders within the organisation, are crucial in fostering a positive speak up culture. The confidence of staff to speak up will correlate directly with the effectiveness of their line manager, therefore our local leadership framework is based on 'what leaders are, what leaders know and what leaders do'.

- Working Environment

The impact of the working environment, both physically and psychologically, is also crucial to organisational health, to staff experience and again to staff's confidence to speak up without fear. Over the last 6 months, our OD team have led a Seminar Series on Psychological Safety, with very positive feedback, along with a number of sessions on the role of the Team and Team Dynamics. We are also undertaking a culture assessment process as part of culture change, with the pilot of this process taking place within our Workforce Directorate. This area of work is particularly important given the unique challenges of the State Hospital.

- Health Dashboards

The creation of Directorate/Service/Team Dashboards will be a significant step to collating all relevant data (including IMatter) and feedback to present one summarised progress report, which in turn will identify those areas with high trust and confidence in their team and managers. The outcomes will allow managers to reflect on and consider actions to improve performance in terms of staff experience and their working environment and to ensure relevant support to those areas which need it most.

- Equalities and an Inclusive Environment

Another important area of alignment with a positive speak up culture is the area of equalities, and we are particularly committed to working with our staff to understand what we do well and not so well in the workplace. I also act as the Non-Executive Champion for Equalities and support the work of our Workforce Equalities Group. Some of our feedback to date from a lived experience survey highlighted the ongoing challenges of staff feeling safe to speak up and this has been identified as a key area of focus across this remit.

- Communication and Engagement

Finally, direct two way and constructive communication will assist in building trust and rapport, which in turn will help to promote a positive speak up culture. We are also particularly conscious of ensuring we complete our feedback loop, by promoting a 'You Said, We Did,' approach in our communication responses to, for example, Speak Up, iMatter and our Lived Experience Survey.

As part of our commitment to and demonstration of our 'Listening Approach', the development of a local Nursing Forum, will create more opportunities for staff to raise concerns (and speak up) to support the broader development of our service.

2. How visible and accessible are you, as Whistleblowing Champion, to staff, and how do you assure yourself that staff feel able to approach you?

We have taken significant steps forward over the last 12 months at the State Hospital in terms of accessibility and visibility. Speak Up week 2025 was used as a vehicle to reinforce the importance of speaking up in all senses, whilst also highlighting how staff can raise concerns and access support, directly or indirectly.

I issued regular communications on the importance of Speak Up and in particular Whistleblowing and I have also arranged quarterly in person sessions on site to meet with staff.

The Non-Executive Directors (NXDs) at TSH also take part in planned, informal walk rounds where we independently visit all areas of the site, with no Executive Officers no fixed agendas and no notes, speaking directly to staff and promoting visibility and awareness. We have visited clinical and non-clinical areas and teams, encouraging an informal approach which supports meaningful engagement. The NXD's recognise the need to provide collective

support to promote the importance of Speaking Up and Whistleblowing within the State Hospital.

As both the champion for Whistleblowing and Equalities, this face-to-face engagement has been a great opportunity for me to meet with staff, introduce myself and listen to any concerns and also promote my quarterly walk in sessions on site. I am keen to see this development continue over the next 12 months.

3. What arrangements and channels are in place across the Board to enable staff to speak up, and how well are these understood and accessible?

A copy of documentation we use to highlight routes to Speak Up is enclosed.

Speaking up is featured regularly in our communications with staff throughout the year and we also periodically ensure that accessibility is highlighted for staff on a regular basis.

All relevant information is hosted on a resource hub, including how to access, details for confidential contacts etc. We have a small team of confidential contacts on site, who meet regularly, but we also have agreement with NHS Lanarkshire that we can access their contacts in the event that any individuals would wish someone entirely independent and out with our Board.

4. *How do you monitor and evaluate the effectiveness of your speak-up arrangements, and what improvements have been made as a result?*

Ongoing engagement with our staff is crucial in this regard. Whilst we have taken significant steps forward in demonstrating the importance of speaking up, of highlighting the role of the Champion, of illustrating both the routes and where to access support, it is apparent from communication with our staff that we have work to do in building up greater trust and psychological safety and thereby ensuring that staff feel confident to highlight their concerns through an established route.

5. *What training and support is provided to line managers to ensure they are confident and competent in responding appropriately and effectively to concerns raised by staff?*

Our training and learning support again align with key pieces of work outlined in Q2, specifically the OD strategy and the emphasis on a healthier, safer, compassionate organisational culture. Some key elements are listed below:

a) Leadership & Management Development Framework (Management Essentials)

All managers complete the organisation's Core Management Training, which covers the essential policies, processes, and behaviours required to support staff safely and competently. This includes:

This foundation ensures all managers understand their responsibilities, the organisation's expectations, and the standards required when staff raise concerns.

b) Leadership & Management Development Framework (Five-Tier Pathway)

Our tiered pathway builds increasingly advanced capability in areas critical to responding to concerns, including compassionate leadership, psychological safety, performance conversations, influencing, and decision making.

Across tiers, managers receive:

- Training on having difficult or sensitive conversations.
- Coaching, supervision and reflective practice opportunities.
- Masterclasses, peer-learning sessions, and applied learning around people management.

c) Wellbeing, Psychological Safety & Inclusive Line Management Support

We provide dedicated resources and training to ensure managers recognise issues early, respond appropriately, and create the conditions where staff feel safe to speak up:

Upskilling for healthy and inclusive line management, including:

- early intervention skills
- recognising wellbeing concerns
- holding supportive conversations
- practical adjustments and supportive actions managers can take

d) Staff Support Systems for Managers

Managers are supported by a wide network of internal services when handling staff concerns, including:

Wellbeing Centre

- Peer Support Networks
- Staff Care specialist
- HR partners and Occupational Health

These are highlighted within core induction and staff wellbeing materials.

This ensures managers are not managing sensitive concerns in isolation and know where to escalate and seek advice.

e) Proactive Team Development & Culture Work

Through our OD workstreams, managers receive structured support to build teams with strong relationships, clear expectations, and healthy communication – all of which increase staff confidence in raising concerns. This includes:

Regular team development sessions aligned with OD strategy commitments.

- Tools for creating psychologically safe environments.
- Use of health dashboards to identify early warning signs and intervene proactively.

This supports managers to act early, respond consistently, and follow through.

f) Continuous Coaching, Reflective Practice & Peer Learning

Managers have access to:

Coaching (internal and cross-Board).

- Coaching supervision and reflective practice spaces.
- Peer networks through the Coaching Matters programme.

These spaces help managers develop the confidence and emotional regulation needed when responding to concerns.

Governance and Process

6. How does your Board ensure there are clear, accessible and trusted processes for raising concerns, including those relating to Board members?

We ensure that the NHS Scotland Whistleblowing Policy, and therefore the National Standards, are readily accessible within the workplace, whilst also regularly signposting staff to this process, and the relevant supports, through Team Brief and posters in the workplace. Regular discussions about Whistleblowing at board level provides a source of assurance to board members regarding whistleblowing processes and how they can also avail themselves of this.

Additional support and assistance, on a confidential basis, is available through our Corporate Services Team (who administer the whistleblowing process), our HR team who can appropriately signpost and advise in respect of Business-as-Usual routes or through a confidential contact if required.

7. Please provide assurance that reporting arrangements align with the Governance section of the Whistleblowing Standards.

I am satisfied that reporting arrangements for The State Hospital align with the governance section of the whistleblowing standards.

8. What are your average investigation timescales and how do you assure yourself of investigation quality and fairness?

Not applicable. We have had no investigations in the last 12 months in line with Whistleblowing Standards.

9. *How does the Board engage with whistleblowing matters, and how regularly does it review and discuss its overall whistleblowing approach?*

Whistleblowing is a standing agenda item, and features on four board meetings per year, updates on the quarterly return to the INWO and provides general reassurance to the Board in terms of our approach to Whistleblowing.

We also discuss preparations for Speak Up Week in detail, along with the Annual Report/response to Scottish Government.

Whistleblowing also features within our Staff Governance Agenda, specifically around the promotion of a positive Speak Up Culture (under the relevant Staff Governance Strand).

I also regularly attend the Whistleblowing Champion Network and ensure that I am fully up to date and can feed back on relevant whistleblowing challenges which are pertinent to the Board.

Protection and Fairness

10. *What systems are in place to protect whistleblowers from detriment and how is this monitored over time?*

Again, we have no recent examples of which to respond to this question, but our focus is (a) protecting confidentiality at all costs (with the full process managed only by our Corporate Services Team), (b) investigations being carried out outwith our organisation if necessary (to support confidentiality, along with providing assurance of independence) given the small size of our workforce and finally (c) regular reviews following any concerns, both in terms of required improvement actions being completed and also general wellbeing check with the individual who raised the concern.

Learning and Improvement

11. *What themes or trends have emerged from whistleblowing cases this year and what actions have followed?*

We have had no formal whistleblowing cases and are therefore unable to examine themes or trends as such. However, as noted in earlier questions, there is a clear theme around the confidence of staff to 'speak up' and this is an area we are working proactively to address. This involves the promotion and development of psychological safety, improving how we communicate, improving how managers receive and respond to complaints and more generally changing the cultural approach.

12. *How is learning from whistleblowing cases implemented and shared internally?*

We have a robust approach to lessons learned from a number of routes which includes Employment Relation (ER) Cases, Significant Adverse Event Reviews and Feedback and

Complaints in which we ensure that learnings are captured, shared, agreed for relevant actions, timescale and overall responsibility.

These actions are captured and reviewed to ensure actions have been closed down. This is monitored through our formal governance structures including the Board's Standing Committees.

Any learning from Whistleblowing cases will be managed in accordance with this process (with due consideration of ensuring confidentiality).

13. Can you give an example of a whistleblowing success story from your board this year – an occasion where policy or practice has changed because a whistleblower spoke up and was listened to?

An employee raised a concern through the Whistleblowing email last year, which was not classified as a Whistleblowing concern. However, we took the opportunity to fully review his concerns, which related to the stocking of controlled drugs and availability.

His concerns were anonymously reviewed with the Pharmacy Team, who agreed that the levels of available stock could be reduced, thereby minimising the time taken to count drugs and releasing greater time to care for patients.

We wrote to the employee to advise of the actions taken following his concerns, the positive impact of the change (and of speaking up) and to thank the employee for raising the concern.

I trust this response provides assurance around the positive and proactive approach at the State Hospital around supporting a 'Speak Up' Culture and also our commitment in ensuring that we have a robust process and support mechanism in place and are engaging proactively with our staff to highlight how they can raise any concerns within the workplace.

Yours sincerely

Shalinay Raghavan
Whistleblowing Champion
The State Hospital

Appendix B – Letter to Cabinet Secretary from Chief Executive Officer

The State Hospital

Carstairs
Lanark
ML11 8RP
Telephone 01555 840293
<http://tsh.scot.nhs.uk>



Mr N Gray MSP
Cabinet Secretary Health and Social
Care
The Scottish Government
St. Andrews House
Edinburgh, EH1 3DG

Date	16 April 2026
Our Ref	SR/rp
Enquiries to	Stephen Wallace
Direct Line	01555 842122
E-mail	stephen.wallace@nhs.scot

Dear Mr Gray

Whistleblowing Update

I refer to your letter of 5th March 2026 in relation to Whistleblowing within The State Hospital.

Please find my responses to the specific questions below:-

Culture and Leadership, Staff Experience and Confidence

- 1. How are you fostering and demonstrating a positive speak-up culture across the Board, and what evidence do you have of its impact on staff confidence? How do you use iMatter data and other feedback mechanisms to assess perceptions of whistleblowing safety, including identifying any hotspots, good practice, or areas requiring additional support across staff groups, roles, teams or locations?**

We are progressing a number of key strands of work that foster and demonstrate a positive speak up culture. Principally, the development of our culture is driven by our Organisational Development Strategy, and our core aim of prioritising Organisational Health and in turn supporting positive staff experience. The key themes, which align closely to a positive speak up culture are: (a) Leadership and Management Capability: and acknowledging the confidence of staff to speak is normally directly linked to the effectiveness of their manager. (b) Working Environment: The importance of staff feeling safe and able to speak freely. This has included a focus on Psychological Safety, Team Dynamics and a broader cultural assessment process, which will also consider iMatter data.

This OD work coupled with our progressive work on equalities, again raises focus on how we ensure staff feeling safe to speak up and along with improved two way communication and engagement. As part of our commitment to and demonstration of our 'Listening Approach', the development of a local Nursing Forum, will create more opportunities for staff to raise concerns (and speak up) to support the broader development of our service.

Perhaps most importantly our health dashboards will be a significant step to bring all relevant information into one overall report, clearly illustrating those areas with high trust and confidence in their team and management. The outcomes will allow managers to reflect on and consider actions to improve performance in terms of staff experience and their working environment and to ensure relevant support to those areas which need it most.

2. How visible and accessible are you, as Chief Executive, to staff, and how do you assure yourself that staff feel able to approach you?

Individually, I like to ensure that I am very visible, accessible and approachable to both staff and patients at The State Hospital, principally by visiting different services and areas of the site, attending local service and team meetings, along with attending staff and partnership meetings and events.

Given the nature of our site, it is not uncommon for staff to take the opportunity to speak to me as I pass through the site and I always ensure that my door is open to any staff who wish to come and speak to me.

I expect a similar approach from my executive team and recognise the value of positive role modelling in shaping and developing culture in this way.

Organisationally, we can continue to develop this trust which is key in ensuring that all staff feel safe and confident to speak to me directly.

3. What arrangements and channels are in place across the Board to enable staff to speak up, and how well are these understood and accessible?

Speaking up is featured regularly in our communications with staff throughout the year and we also periodically ensure that accessibility is highlighted for staff on a regular basis.

All relevant information is hosted on a resource hub, including how to access, details for confidential contacts etc. We have a small team of confidential contacts on site, who meet regularly, but we also have agreement with NHS Lanarkshire that we can access their contacts if any individuals would wish someone entirely independent and out with our Board.

A copy of documentation we use to highlight routes to Speak Up is enclosed.

4. How do you monitor and evaluate the effectiveness of your speak-up arrangements, and what improvements have been made as a result?

Direct engagement with our staff is critical in understanding how they feel, and whether they feel able to speak up, in any capacity. This alongside our Health Dashboard will be crucial in evaluating the effectiveness of our arrangements.

Whilst we have taken significant steps forward in demonstrating the importance of speaking up, of highlighting the role of the Champion, of illustrating both the routes and where to access support, it is apparent from communication with our staff that we have work to do in building up greater trust and psychological safety and thereby ensuring that staff feel confident to highlight their concerns through an established route.

5. What training and support is provided to line managers to ensure they are confident and competent in responding appropriately and effectively to concerns raised by staff?

Firstly, we continue to monitor compliance in completion of the National Whistleblowing training and have a compliance figure of AMOUNT.

Secondly, several of our L&E and OD strands will directly align and support the development of capability amongst managers ensuring that they respond appropriately and effectively to concerns raised by staff. These include: -

- Leadership & Management Development Framework (Five-Tier Pathway)
- Wellbeing, Psychological Safety & Inclusive Line Management Support
- Staff Support Systems for Managers, including Wellbeing Centre, Peer
- Proactive Team Development & Culture Work
- Continuous Coaching, Reflective Practice & Peer Learning

These spaces help managers develop the confidence and emotional regulation needed when responding to concerns.

Governance and Process

6. How does your Board ensure there are clear, accessible and trusted processes for raising concerns, including those relating to Board members?

We ensure that the NHS Scotland Whistleblowing Policy, and therefore the National Standards, are readily accessible within the workplace, whilst also regularly signposting staff to this process, and the relevant supports, through Team Brief and posters in the workplace. Regular discussions about Whistleblowing at board level provides a source of assurance to board members regarding whistleblowing processes and how they can also avail themselves of this.

Additional support and assistance, on a confidential basis, is available through our Corporate Services Team (who administer the whistleblowing process), our HR team who can appropriately signpost and advise in respect of Business-as-Usual routes or through a confidential contact if required.

7. Please provide assurance that reporting arrangements align with the Governance section of the Whistleblowing Standards.

I am satisfied that reporting arrangements for The State Hospital align with the governance section of the whistleblowing standards.

8. What are your average investigation timescales and how do you assure yourself of investigation quality and fairness?

Not applicable. We have had no investigations in the last 12 months in line with Whistleblowing Standards.

9. How does the Board engage with whistleblowing matters, and how regularly does it review and discuss its overall whistleblowing approach?

Whistleblowing, is a standing agenda item, and features on four board meetings per year, updates on the quarterly return to the INWO and provides general reassurance to the Board in terms of our approach to Whistleblowing.

Whistleblowing also features within our Staff Governance Agenda, specifically around the promotion of a positive Speak Up Culture (under the relevant Staff Governance Strand).

Protection and Fairness

10. What systems are in place to protect whistleblowers from detriment and how is this monitored over time?

Again, we have no recent examples of which to respond to this question, but our focus is (a) protecting confidentiality at all costs (with the full process managed only by our Corporate Services Team), (b) investigations being carried out with our organisation if necessary (to support confidentiality, along with providing assurance of independence) given the small size of our workforce and finally (c) regular reviews following any concerns, both in terms of required

improvement actions being completed and also general wellbeing check with the individual who raised the concern.

Learning and Improvement

11. What themes or trends have emerged from whistleblowing cases this year and what actions have followed?

We have had no formal whistleblowing cases and are therefore unable to examine themes or trends as such. However, as noted in earlier questions, there is a clear focus around the confidence of staff to 'speak up' and this is an area we are working proactively to address. This involves the promotion and development of psychological safety, improving how we communicate, improving how managers receive and respond to complaints and more generally changing the cultural approach.

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Yours sincerely

Gary Jenkins
Chief Executive

Speak Up. Be Heard. Make Change

We genuinely want to listen, but we need you to speak up.

If something's not right, don't just chat about it in the corridor. Tell us. Raise it. Share it.

If we don't know, we can't act. Your voice matters. Your experience matters.

Let's build a workplace where concerns lead to change.

SPEAK UP

DON'T JUST SPEAK OUT

Your manager should be your first point of contact, but there are multiple avenues available for raising concerns.



1

YOUR LINE MANAGER OR THEIR LINE MANAGER

Raise any issues or concerns directly with your manager(s).

2

HUMAN RESOURCES

Contact HR to discuss your concern and get advice on how to handle it.

3

TRADE UNIONS

Seek advice and support from your trade union.

4

CONFIDENTIAL CONTACTS

Raise issues confidentially with designated contacts.

5

PEER SUPPORT

Talk to trusted colleagues and peers.

6

OCCUPATIONAL HEALTH

Access OH services for guidance and support.

7

WHISTLEBLOWING

Report serious concerns anonymously.



THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026
Agenda Reference No: Item No: 15
Sponsoring Director: Director of Workforce
Author(s): Head of HR
Title of Report: Staff Governance Report
Purpose of Report: For Noting

1 SITUATION

This report provides an update on overall workforce performance to 31 March 2026.

2 BACKGROUND

Key workforce metrics are presented 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

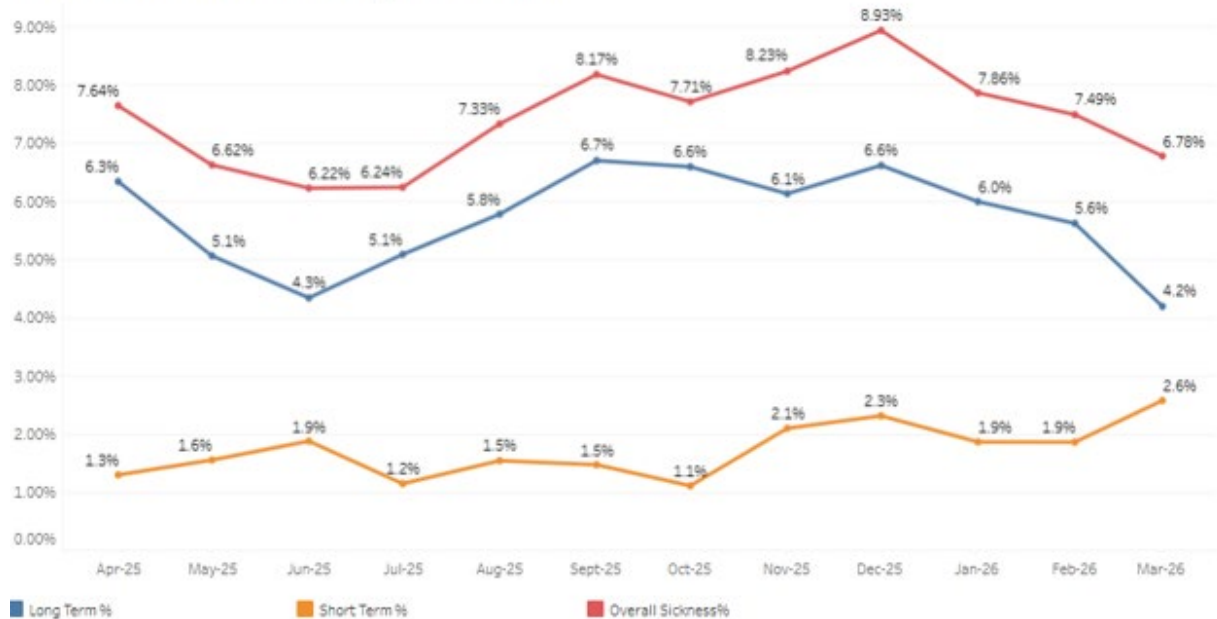
TSH Sickness Absence current position

Following a winter peak in December (8.93%), Sickness Absence has continued to reduce and is predicted to be 6.78% in March 2026. This is illustrated in graph 1 below.

The overall State Hospital sickness absence rate for 2025/26 was **6.69%**, against a corporate target of **5%**. However, this represents an improvement from **7.69% in 2024/25**, equating to a **1%**.

GRAPH 1 – all staff

Sickness Absence 12 Month Rolling To: March 2026

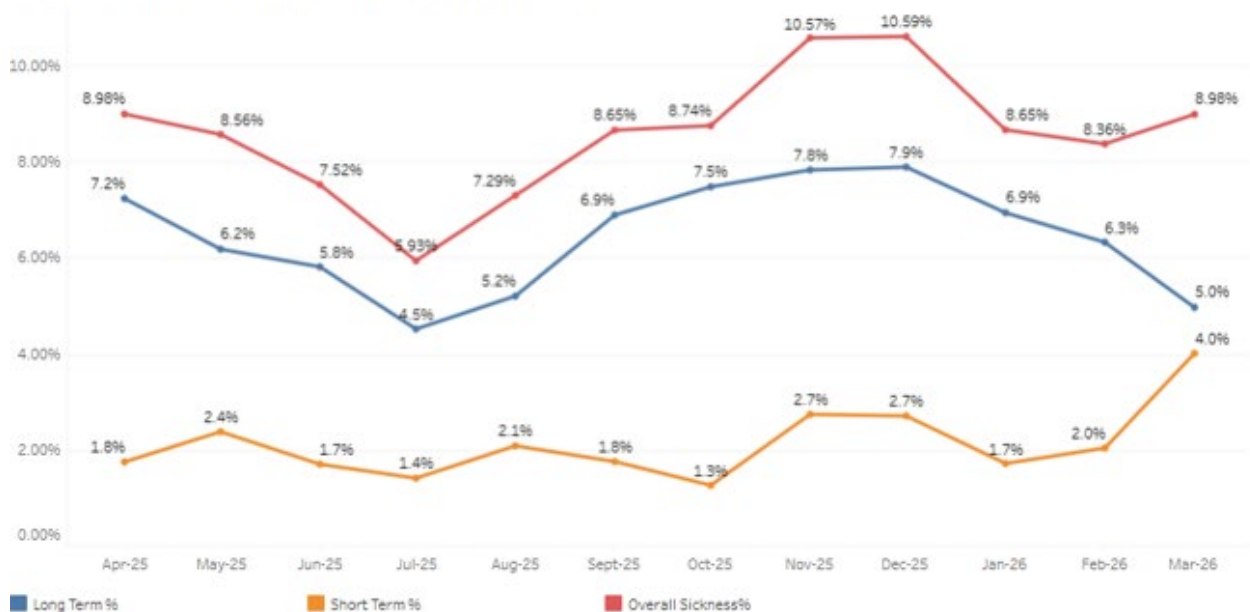


Nursing Sickness Absence

There has been a slight increase in absence within Nursing as outlined below (from 8.36% to 8.98%) however this is a notable decrease from peak in November / December 2025. For comparison, the absence rate in Nursing in March 2025 was 11.44% (an improvement of 2.46%).

GRAPH 2 – nursing hubs

Sickness Absence 12 Month Rolling To: March 2026



ATTENDANCE MANAGEMENT OBSERVATIONS

Patterns/Trends for TSH:	Short-term absence: 2.6% (February was 1.9%) an increase of 0.7% Long-term absence:4.2% (February was 5.6%) a decrease of 1.4%			
Identified Departments of Concern:	Mull 1 Mull 3 Security	15.62% 15.24% 11.6%		
	Escalated meetings have been scheduled for the areas of concern as well as utilisation of wellbeing support for challenging areas.			
Identified Departments of Improvement:	Arran 1 Arran 2 Lewis 1 Lewis 2 Lewis 3 Psychology	5.85% from 11.5% in Jan 26 (-5.65%) 3.64% from 8.14% in Nov 25 (-4.5%) 2.86% from 11.72% in Feb 26 (-8.86%) 6.7% from 11.91% in Jan 26 (-5.21%) 2.78% from 7.07% in Jan 26 (-4.29%) 0.55% from 7.35% in Feb 26 (-6.8%)		
Reasons:	Key reasons for long-term absence: Anxiety/Stress/depression/other psychiatric illnesses, injury fracture, other muscular skeletal Key reasons for short-term absence: Back problems, Injury Fracture and Other known causes			
	Compliance with the agreed pathway for muscular skeletal illness will be monitored further to address the level of short-term absence for this reason.			
Activity:	Since January 2026, 33 people have been invited to a formal stage meeting (29x Stage 1, 2x Stage 2 and 2x Stage 3). 42% of staff are monitored for 3–6 months, with the largest group (34%) monitored for 6 months. 17% are monitored for 7–9 months, with 9 months being the most common period in this group. 9% are monitored for 12 months. Escalated Performance Meetings have taken place with Lewis and Arran Hub Wards since January 2026			
Secure Environment Comparison:	Rowanbank Orchard	Absence 9.38 % 6.98 %	Short 4.96 % 4.61 %	Long 4.42% 2.37%

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. The table below reflects the January 2026 position.

Sickness Absence Statistics by NHS Board								
1st January 2026 - 31st January 2026								
	Absence Rate			Instances			Absence Reason	
	Total	Long Term ¹	Short Term ²	Total	Long Term ¹	Short Term ²	Yes	No ³
Scotland	6.95	4.33	2.62	41,891	12,408	29,483	38,784	3,107
NHS Ayrshire & Arran	7.19	4.55	2.63	2,427	740	1,687	2,281	146
NHS Borders	6.70	3.75	2.95	764	187	577	675	89
NHS National Services Scotland	5.20	3.37	1.84	576	156	420	538	38
NHS 24	12.17	8.05	4.13	812	243	569	792	20
NHS Education For Scotland	2.53	1.72	0.81	223	54	169	167	56
Healthcare Improvement Scotland	5.08	3.22	1.85	95	28	67	92	3
Public Health Scotland	4.07	2.36	1.72	188	44	144	170	18
Scottish Ambulance Service	9.79	6.69	3.11	1,482	511	971	1,419	63
The State Hospital	7.26	5.25	2.01	133	62	71	128	5
National Waiting Times Centre	6.25	4.00	2.25	558	186	372	519	39
NHS Fife	7.30	4.82	2.47	2,091	709	1,382	1,977	114
NHS Greater Glasgow & Clyde	7.12	4.62	2.50	9,887	3,407	6,480	9,406	481
NHS Highland	6.98	4.24	2.74	2,619	693	1,926	2,143	476
NHS Lanarkshire	8.07	5.51	2.56	3,295	1,178	2,117	3,033	262
NHS Grampian	5.51	2.97	2.54	3,668	796	2,872	3,220	448
NHS Orkney	5.47	2.95	2.52	152	35	117	144	8
NHS Lothian	6.31	3.54	2.78	6,333	1,532	4,801	5,802	531
NHS Tayside	7.16	4.47	2.69	3,326	952	2,374	3,085	241
NHS Forth Valley	8.35	5.37	2.98	1,705	557	1,148	1,674	31
NHS Western Isles	6.54	2.88	3.66	263	40	223	253	10
NHS Dumfries & Galloway	6.62	3.50	3.12	1,101	260	841	1,081	20
NHS Shetland	5.48	3.08	2.40	193	38	155	185	8

Whilst our focus remains on trying to get as close to 5% absence target: we want to ensure that we continue to sustainably lower the baseline of absence throughout 2026.

Our Maximising Attendance approach continues with:-

- Regular RAG Reviews (4 of 11 Nursing wards below 5%) and significant improvement across Arran and Lewis Hubs
- Audit and monitoring of consistent Pathways usage
- Manager development
- Accountability and performance management for areas which require additional support
- Utilisation of bespoke wellbeing support on appointment of new Wellbeing Officer (commenced 7th April 2026)

(b) RECRUITMENT /ESTABLISHMENT/ SUPERNUMARY STAFFING

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

TIME TO HIRE	85 days	KPI is 75 days
	Areas which are above the national KPI is the advert period continues to run longer than the KPI. This is sometimes unavoidable for hard-to-fill posts. The time between contract issue to start date remains significantly above target however this is due to accommodating candidate's notice periods.	
VACANCIES ADVERTISED	9 posts were advertised in March totalling 30 vacancies (including Staff Nurse positions).	
NURSING RECRUITMENT	Ward-Based Nursing 13 WTE Permanent Nursing Assistants commenced on 9 March 2026 5 WTE Registered Nurses commenced in March 202	

	An in-person recruitment event took place on 31st March 2026 attended by 28 prospective nurses. Interested staff nurses were given the opportunity to be interviewed during the day and as a result 5 already qualified nurses were successful and will commence in June 8 further student nurses were successful and will commence in August 2026 on obtaining their registration. External advert for more registered nurses closed on Sunday 5th April and the recruitment process continues aligned to the June induction.

- **ESTABLISHMENT (Organisation Wide)**

- **Planned establishment:** 667.21 WTE
- **Actual establishment:** 629.24 WTE
- **Variance:** -37.97 WTE

- **Ward Based Nursing (Excluding SCN)**

- **Planned establishment:** 298.86 WTE
- **Actual establishment:** 288.76 WTE
- **Variance:** -10.10 WTE

Concerted recruitment efforts have reduced the resourcing gap (from 18WTE in February) which has resulted in initial decreases across Nursing OT and Excess and SSR usage.

OT & EXCESS	54.77 WTE (decreasing from 61.85WTE in Feb)
NURSING	34.32 WTE (decreasing from 39.40 WTE in Feb)
SSR	10.57 WTE (increase from 11.1 WTE in Feb)

(c) **EMPLOYEE RELATIONS - LIVE CASES**

- There is one formal Grievance which commenced in March
- There is one formal Conduct case which commenced in March
- One bullying and harassment case has progressed to formal investigation.

A detailed paper was presented to Staff Governance Committee in February 2026 outlining learning and reflections from a recent complex case.

(d) **LEAVERS**

- There were 8 leavers in March 2026.
- One retired and returned to the SSR.
- 4 were from the Occupational Therapist Team & 3 were from the Security & Estates Directorate.
- This takes the total leavers for 25/26 to 50, with 25 completing Exit Interviews (50% response rate).
- Turnover trend graphs were presented to Partnership Forum in March 2026 which showed the sustained reduction in turnover since the peak in 2023. This will now be updated to reflect the end-of-year position and updated to Staff Governance Committee with Exit Interview feedback in due course.

(e) JOB EVALUATION – JANUARY 2026

Progress & Status

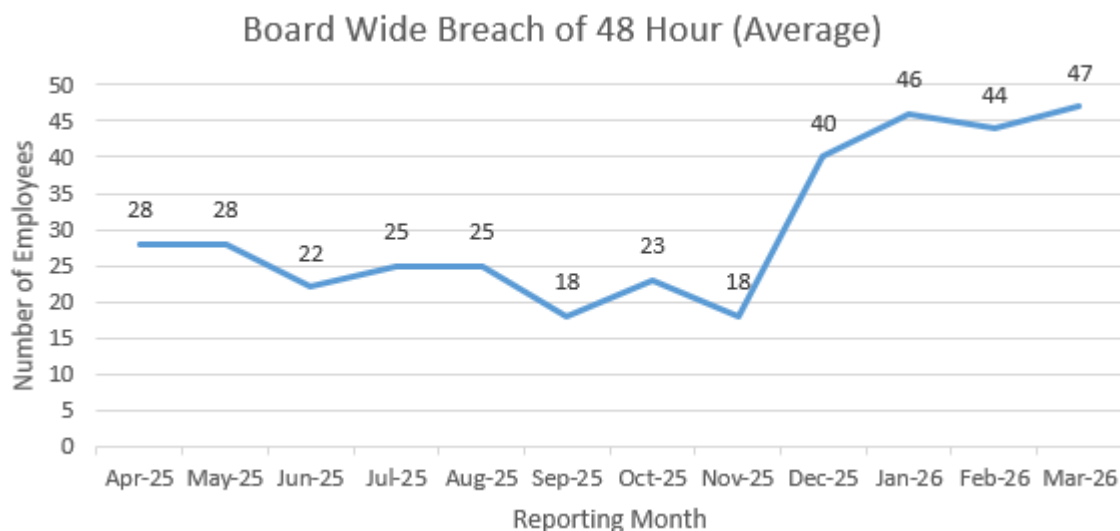
- Two jobs were received since January 2026, and both have been given outcomes.
- 3 requests via the job-sharing protocol were completed.

(f) WORKING TIME REGULATIONS OVERVIEW - Board Wide Breach of 48 hour (average)

Board wide, there were 47 staff who breached the average 48 hour working week as defined by WTD as highlighted above. This number has slightly increased from the 44 staff last month as part of the ongoing increase due to reliance on substantive staff to cover deficits as outlined in the graph below.

Monthly reports are issued to Heads of Service to highlight those who are breaching, along with whether a waiver has been completed.

Graph 3 – WTD breaches



(g) PPR COMPLIANCE

Graph 4 – PDP compliance



Since December 2025 compliance improved as predicted with a further decrease in March.

4 RECOMMENDATION

The Board is invited to note the content of the report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Support delivery of Staff Governance Standards and Workforce Plan
Corporate Objectives Please note which objective is linked to this paper	Better Workplace
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	WGG
Risk Assessment (Outline any significant risks and associated mitigation)	None
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).	
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).	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	16 April 2026
Agenda Reference:	Item No: 16a
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Annual Review of Standing Documentation
Purpose of Report:	For Decision

1 SITUATION

This report provides an update to the Committee on proposed changes to Standing Documentation covering updated changes to Procurement Legislation related to tendering and contracting and bringing TSH in-line with other public bodies.

2 BACKGROUND

The Board is required annually to approve the Standing Documentation i.e. Standing Financial Instructions, Scheme of Delegation and Standing Orders (covered under a separate Board paper). These were approved by the Audit and Risk Committee on 19 March 2026.

3 ASSESSMENT

3.1 Standing Financial Instructions

There are no amendments noted nor required.

3.2 Scheme of Delegation

There are no major amendments noted nor required, other than some minor updates to role / committee titles, and updated delegations for Corporate Governance para 2.1; Planning & Performance paras 4.2, 4.3; and Clinical Governance paras 6.4, 6.5.

These were fully updated in 2022/23 to reflect updated legislation and procurement regulations post-EU, updated tender thresholds to comply with Procurement Act 2014, updated tender waivers from £5k to £10k (last update 2016) and updated TSH Procurement Policy, and there are no further legal updates having effect currently.

Consideration was given, by review of the levels of approval / tender waiver thresholds, to the fact that pricing has gone up by about 25% since we changed it in 2022/23. However, the SG procurement thresholds are being changed this year (which will be required to go through Holyrood) so it is recommended that we would be better to wait until next year and tie in with that change – which could be significant since the SG levels were last set in 2014.

4 RECOMMENDATION

The Board is asked to approve the review of Standing Documentation.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP?	Ensures that the Board's standing documentation is up to date in respect of Scottish Government guidance and possible changes to Senior staff's portfolios.
Corporate Objectives	3 – Better Value 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 eHealth and Workforce Director groups. j) Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations?	Director of Finance and eHealth, Head of Procurement, Head of Corporate Governance Audit & Risk Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	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 – no privacy implications

THE STATE HOSPITALS BOARD FOR SCOTLAND

STANDING FINANCIAL INSTRUCTIONS

VERSION 22

Version Control Log		
Version	Date	Description
1		Approved by Board
2	11 May 06	Approved by Audit Committee on May 2006
2.1	5 June 06	Approved by the Board on June 2006
3.1	21 June 07	Above changes approved by Board June 2007
4.0	24 April 08	Approved by the Board June 2008
5.0	30 April 09	Annual review of SFIs
5.1	16 July 09	Approved by the Board June 2009
5.2	24 Sep 09	Changed to reflect portfolio changes. Approved by Audit Committee September 2009.
6	15 Apr 10	Approved by Board 17 June 2010
7	Apr 11	Approved by audit committee 7/4/11
8	19 Apr 12	Update all references with regard to circulars issued in year Update for SGHD name change to SGHSCD Update for revised CFS partnership agreement Update for key procurement principles Updated for staff title changes Update of SIC to Governance Statement
9	4 April 13	Approved by Audit Committee 25 April 2013 after removal of reference to Vice Chair
9.1	29 April 13	Approved by Board 2 May 2013
10	April 14	Annual review of SFI's – no changes made. Approved by Audit Committee 24 April 2014. Approved by Board 26 June 2014
11	April 15	Updated section 4.1.4 to include additional report. Updated section 16.1.3 from Finance Director to Security Director. Updated section 9.5.3 re authorisation of payroll change forms. Approved by Audit Committee 2 April 2015 after changes to reflect that Remuneration Committee is no longer a sub committee and changed section 14.3.1 & 14.3.5 to Public Sector Internal Audit Standards.
11.1	May 15	Added section 15.7 as per SG guidance re CFS
12	March 16	Updated section 2.6.2 from Nursing Director to Finance Director. Updated Section 4.1.4© to reflect changes in Annual Accounts reports. Updated section 9.7 to reflect updated guidance from SG. Approved by Audit Committee 24 March 2016.
12.1	June 16	Amended section 10.3 re tender waiver limit from £3k to £5k. Approved by Audit Committee & Board 23 June 2016.
13	March 17	Approved by Audit Committee 23 March 2017 subject to inclusion of statement re secondment of HR Director – see section 1.3.15 Approved by Board 4 May 2017

14	March 18	Updated section 2.6.2 to reflect depute Accountable Officer as being Nursing & AHP Director and not Finance Director. Updated section 3.6 to change Monitoring Returns to Financial Performance Returns. Updated section 5 in relation to Project Bank Accounts. Updated section 9.6 to reflect that payments to employees would be by bank credit only. Updated section 13.1.1 to include reference to General Data Protection Regulations. Updated section 16.1.10 to include new rules imposed in October 2017 around patient gambling. Approved by Audit Committee 5 April 2018. Approved by Board 28 June 2018
15	March, May 2019	Updated references to Local Delivery Plan – amended to Annual Operational Plan Updated section 5.3.2 – reflect requirement of two directors’ signed authorisation to open any bank account in the name of the Hospital Removed section 17 – Funds held in Trust – no longer applicable to the Hospital with no endowment funds in place Approved by Audit Committee 28 March 2019. Approved by Board 20 June 2019
16	March 2020	Amended wording re secondment of HR Director (1.3.15) Approved by Audit Committee 26 March 2020 Approved by Board 18 June 2020
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19	March 2023	Updated section 6.2.3 – updated job title Approved by Audit Committee 6 April 2023 Approved by Board 27 April 2023
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1 INTRODUCTION

1.1 General

- 1.1.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Financial Directions issued by the Scottish Ministers under the provisions of the National Health Service (Scotland) Act 1978, the National Health Service (Financial Provisions) (Scotland) Regulations 1974, Section 4, together with the subsequent guidance and requirements contained in The Health Act 1999, NHS Circular No 1974 (GEN) 88 and Annex, and NHS MEL 1994 (80) for the regulation of the conduct of the Board, its members and officers, in relation to financial matters they shall have effect as if incorporated in the Standing Orders (SOs) of the Board.
- 1.1.2 These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Board. They are designed to ensure that its financial transactions are carried out in accordance with the law and Scottish Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation of Powers to the Board (Standing Orders Section 20 a)) and the Scheme of Delegation adopted by the Board.
- 1.1.3 These SFIs identify the financial responsibilities that apply to everyone working for the Board. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial operating procedures.
- 1.1.4 Statutory Instrument (1974) No 468 requires NHSScotland Finance Directors to design, implement and supervise systems of financial control and NHS Circular 1974 (Gen) 88 requires the Hospital's Director of Finance and EHealth ("Finance Director") to:
- approve the financial systems;
 - approve the duties of officers operating these systems; and
 - maintain a written description of such approved financial systems, including a list of specific duties
- 1.1.5 As a result, the Finance Director must approve all financial procedures. Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Finance Director must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Board's SOs.
- 1.1.6 Failure to comply with SFIs and SOs is a disciplinary matter that could result in dismissal.

1.2 Interpretation

- 1.2.1 Any expression to which a meaning is given in Health Service legislation, or in the Financial Directions made under the legislation, shall have the same meaning in these instructions.
- 1.2.2 Wherever the title Chief Executive, Finance Director, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.
- 1.2.3 Wherever the term "employee" is used, and where the context permits, it shall be deemed to include employees of third parties contracted to the Board when acting on behalf of the Board.

1.3 Responsibilities and Delegation

- 1.3.1 The Board exercises financial supervision and control by:
- a) Formulating the financial strategy with due regard to Remobilisation Plans
 - b) Monitoring performance against plans and budgets by regular reports at Board meetings
 - c) Requiring the submission and approval of budgets within resource limits
 - d) Defining and approving essential features in respect of procedures and financial systems
 - e) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.
- 1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the “Reservation of Powers to the Board” (Standing Orders Section 20 a)).
- 1.3.3 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Board.
- 1.3.4 The Chief Executive of the NHS in Scotland shall appoint an Accountable Officer, accountable to the Scottish Parliament for the proper use of public funds by the Board. The Chief Executive of The State Hospital is the designated Board’s Accountable Officer. The Chief Executive’s duties as Accountable Officer are set out in Section 2.
- 1.3.5 The Chief Executive is ultimately accountable to the Board, and as Accountable Officer for the Board, to the Scottish Parliament, for ensuring that the Board meets its obligation to perform its functions within the available resources. The Chief Executive has overall Executive responsibility for the Board’s activities, is responsible to the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Board’s system of internal control.
- 1.3.6 The Chief Executive shall be responsible for the implementation of the Board’s financial policies and for co-ordinating any corrective action necessary to further these policies, after taking account of advice given by the Finance Director on all such matters. The Finance Director shall be accountable to the Board for this advice.
- 1.3.7 The Chief Executive may delegate such of his/her functions as Accountable Officer as are appropriate and in accordance with these Standing Financial Instructions and Accountable Officer Memorandum.
- 1.3.8 The Chief Executive will be responsible for signing the ‘Statement of the Chief Executive’s Responsibilities as the Accountable Officer of the Health Board’ as part of the Board’s Annual Accounts.
- 1.3.9 The Chief Executive must ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.
- 1.3.10 The Finance Director is responsible for:
- a) Implementing the Board’s financial policies and for co-ordinating any corrective action necessary to further these policies
 - b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions

- c) Ensuring that sufficient records are maintained to show and explain the Board's transactions, in order to disclose, with reasonable accuracy, the financial position of the Board at any time

and, without prejudice to any other functions of directors and employees to the Board, the duties of the Finance Director include:

- d) Providing financial information to the Board and the Scottish Government Health and Social Care Directorate (SGHSCD)
- e) Setting the Board's accounting policies consistent with SGHSCD and Treasury guidance and generally accepted accounting practice
- f) Preparing and maintaining such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties.

1.3.11 All directors and employees, severally and collectively, are responsible for:

- a) The security of the property of the Board
- b) Avoiding loss
- c) Exercising economy and efficiency in the use of resources
- d) Conforming with the requirements of:
 - Standing Orders
 - Standing Financial Instructions
 - Scheme of Delegation
 - Finance Procedure Manual

1.3.12 No action should be taken in a manner devised to avoid any of the requirements of, or the financial limits specified in, these governance documents.

1.3.13 Any contractor or employee of a contractor, who is empowered by the Board to commit the Board to expenditure or who is authorised to obtain income, shall comply with these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.14 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Finance Director.

1.3.15 For any period of secondment of the Director of Workforce, responsibilities assigned to the Director of Workforce within these Standing Financial Instructions and the Scheme of Delegation will be delegated to Chief Executive.

2 RESPONSIBILITIES OF CHIEF EXECUTIVE AS ACCOUNTABLE OFFICER

2.1 Introduction

- 2.1.1 Under the terms of Sections 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accounting Officer for the Scottish Government has designated the Chief Executive of The State Hospitals Board for Scotland as Accountable Officer.
- 2.1.2 Accountable Officers must comply with the terms of the Memorandum to National Health Service Accountable Officers, and any updates issued to them by the Principal Accountable Officer for the Scottish Government.

2.2 General Responsibilities

- 2.2.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finances for The Board. The Accountable Officer must ensure that The State Hospitals Board for Scotland takes account of all relevant financial considerations, including any issues of propriety, regularity or value for money, in considering policy proposals relating to expenditure, or income.
- 2.2.2 It is incumbent upon the Accountable Officer to combine his/her duties as Accountable Officer with their duty to The Board, to whom he/she is responsible, and from whom he/she derives his/her authority. The Board is in turn responsible to the Scottish Parliament in respect of its policies, actions and conduct.
- 2.2.3 The Accountable Officer has a personal duty of signing the Annual Accounts of the Board for which he/she has responsibility. Consequently, he/she may also have the further duty of being a witness before the Audit Committee of the Scottish Parliament, and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.
- 2.2.4 The Accountable Officer must ensure that any arrangements for delegation promote good management and that he/she is supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services. He/she must ensure that staff are as conscientious in their approach to costs not borne directly by their component organisation (such as costs incurred by other public bodies, or financing costs, e.g. relating to banking and cash flow) as they would be were such costs directly borne.

2.3 Specific Responsibilities

- 2.3.1 The Accountable Officer must:
- Ensure that from the outset, proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes
 - Sign the Accounts and the associated Governance Statement assigned to him/her, and in doing so accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers
 - Ensure that proper financial procedures are followed, incorporating the principles of separation of duties and internal check, and that accounting records are maintained in a form suited to the requirements of the relevant Health Board Manual for Accounts
 - Ensure that the public funds for which he/she is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official

- Ensure that the assets for which he/she is responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate
- Ensure that, in the consideration of policy proposals relating to the resources for which he/she has responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and where necessary brought to the attention of the Board
- Ensure that any delegation of responsibility is accompanied by clear lines of control and accountability, together with reporting arrangements
- Ensure that effective management systems appropriate for the achievement of the organisation's objectives, including financial monitoring and control systems have been put in place
- Ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them
- Ensure that arrangements have been made to secure Best Value as set out in the Scottish Public Finance Manual
- Ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs, outcomes or performance in relation to these objectives
- Ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to organisations or individuals outside The State Hospitals Board for Scotland) including a critical scrutiny of output and value for money
- Ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively regarding regularity and propriety of expenditure

2.3.2 The Accountable Officer has a responsibility to ensure that the Board achieves high standards of regularity and propriety in the consumption of resources. Regularity involves compliance with relevant legislation (including the annual Budget Act), relevant guidance issued by the Scottish Ministers - in particular the Scottish Public Finance Manual - and any framework document (e.g. Management Statement / Financial Memorandum) setting out the accountability arrangements and other relevant matters. Propriety involves respecting the Parliament's intentions and conventions and adhering to values and behaviours appropriate to the public sector.

2.3.3 The Accountable Officer has a responsibility for ensuring compliance with parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be applied only to the extent and for the purposes authorised by Parliament in Budget Acts (or otherwise authorised by section 65 of the Scotland Act 1998). Parliament's attention must be drawn to losses or special payments by appropriate notation of the organisation's Accounts. In the case of expenditure approved under the Budget Act, any payments must be within the scope and amount specified in that Act.

2.3.4 In his/her stewardship of public funds all actions must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct. The Accountable Officer must not misuse his / her official position to further his / her private interests and care should be taken to avoid actual, potential, or perceived conflicts of interest.

2.4 Advice to the Body

2.4.1 In accordance with section 15(8) of the PFA Act the Accountable Officer has particular responsibility to ensure that, where he / she considers that any action that he / she is required to take is inconsistent with the proper performance of his / her duties as Accountable Officer, he / she obtain written authority from the body for which he / she is designated and to send a copy of this as soon as possible to the Auditor General. A copy of such written authority should also be sent to the Clerk to the Public Audit Committee.

The Accountable Officer should ensure that appropriate advice is tendered to the body on all matters of financial propriety and regularity and on the economic, efficient and effective use of resources. The Accountable Officer will need to determine how and in what terms such advice should be tendered, and whether in a particular case to make specific reference to his / her own duty as Accountable Officer to seek written authority and notify the Auditor General.

- 2.4.2 The Accountable Officer has particular responsibility to see that appropriate advice is tendered to the body on all matters of financial propriety and regularity and on the economic, efficient and effective use of resources. If he / she considers that the body is contemplating a course of action which is considered would infringe the requirements of financial regularity or propriety or that could not be defended as representing value for money within a framework of Best Value he / she should set out in writing the objection to the proposal and the reasons for this objection. If the body decides to proceed, he / she should seek written authority to take the action in question. In the case of a body sponsored by the Scottish Government the sponsor Directorate should be made aware of any such request in order that, where considered appropriate, it can inform the relevant Scottish Government Accountable Officer and Cabinet Secretary / Minister. Having received written authority he / she must comply with it, but should then, without undue delay, pass copies of the request for the written authority and the written authority itself to the Auditor General and the Clerk to the Public Audit Committee.
- 2.4.3 If because of the extreme urgency of the situation there is no time to submit advice in writing to the body in either of the eventualities referred to in paragraph 2.5.2 before the body takes a decision, the Accountable Officer must ensure that, if the body overrules the advice, both his / her advice and the body's instructions are recorded in writing immediately afterwards.
- 2.4.4 If the Accountable Officer is also a member of the Management Board of the body, he / she should ensure that his / her responsibilities as Accountable Officer do not conflict with those as a Board member. For example, if the body proposes action which as Accountable Officer he / she could not endorse and would therefore advise against he / she should, as a Board member, vote against such action, or ensure that opposition as a Board member as well as Accountable Officer is clearly recorded if no formal vote is taken. It will not be sufficient to protect his / her position as a Board member merely by abstaining from a decision which cannot be supported.

2.5 Appearance before the Public Audit Committee

- 2.5.1 Under section 23 of the PFA Act the Auditor General may initiate examinations into the economy, efficiency and effectiveness with which any part of the Scottish Administration, or certain other bodies, have used their resources in discharging their functions. The Accountable Officer may expect to be called upon to appear before the Public Audit Committee to give evidence on reports arising from any such examinations involving his / her body. The Accountable Officer will also be expected to answer the questions of the Committee concerning resources and accounts for which he / she is Accountable Officer and on related activities. He / she may be supported by other officials who may, if necessary, join in giving evidence or the Committee may agree to hear evidence from other officials in his / her absence.
- 2.5.2 He / she will be expected to furnish the Committee with explanations of any indications of weakness in the matters covered by paragraphs 2.3 above, to which their attention has been drawn by the Auditor General or about which they may wish to question him / her.
- 2.5.3 In practice, the Accountable Officer will have delegated authority widely, but cannot on that account disclaim responsibility. Nor, by convention, should he / she decline to answer questions where the events took place before his / her designation.

- 2.5.4 The Accountable Officer must make sure that any written evidence or evidence given when called as a witness before the Public Audit Committee is accurate. He / she should also ensure that he / she is adequately and accurately briefed on matters that are likely to arise at the hearing. He / she may ask the Committee for leave to supply information not within his / her immediate knowledge by means of a later note. Should it be discovered subsequently that the evidence provided to the Committee has contained errors, he / she should let this be made known to the Committee at the earliest possible moment.
- 2.5.5 In general, the rules and conventions governing appearances of officials before Committees of the Scottish Parliament apply, including the general convention that officials do not disclose the advice given to the body. Nevertheless, in a case where he / she was overruled by the body on a matter of propriety or regularity, his / her advice would be disclosed to the Committee. In a case where he / she were overruled by the body on the economic, efficient and effective use of resources the Auditor General will have made clear in the report to the Committee that he / she was overruled. He / she should, however, avoid disclosure of the precise terms of the advice given to the body or disassociation from the decision. Subject, where appropriate, to the body's agreement he / she should be ready to discuss the costs, benefits and risks of options considered and explain the reasoning for the decision taken. He / she may also be called on to satisfy the Committee that all relevant financial considerations were brought to the body's attention before the decision was taken.

2.6 Absence of Accountable Officer

- 2.6.1 The Accountable Officer should ensure that he / she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the body who can act on his / her behalf if required.
- 2.6.2 In the event of the Accountable Officer not being available the Director of Nursing & Operations shall deputise in any required capacity, as authorised to do so.
- 2.6.3 If it becomes clear to the body that he / she is so incapacitated that he / she will not be able to discharge these responsibilities over a period of four weeks or more, it should notify the Principal Accountable Officer of the NHS in Scotland so that he / she can appoint an Accountable Officer, pending return. The same applies if, exceptionally, he / she plans an absence of more than four weeks during which he / she cannot be contacted.
- 2.6.4 Where the Accountable Officer is unable by reason of incapacity or absence to sign the accounts in time for them to be submitted to the Auditor General the body may submit unsigned copies pending his / her return.

3 ALL LOCATIONS, ESTIMATES, PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 Preparation and Approval of the Financial Plan and Budgets

- 3.1.1 The Chief Executive will compile and submit to the Board for approval annually a strategic plan covering a three/ five year period (as specified by SGHSCD). This shall include financial targets and spending proposals and forecast limits of available resources. The annual strategic plan will contain:
- a) A statement of the strategies and significant assumptions on which the plan is based
 - b) Details of major changes in workforce, delivery of services or resources required to achieve the plan
 - c) Details of the performance management arrangements in place, including national and local targets.
- 3.1.2 The Finance Director will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board before the start of the financial year. Where it is not possible to agree a full budget, a roll forward budget will be approved prior to the start of the financial year, with a full budget approved by end June. Such budgets will:
- Be in accordance with the aims and objectives set out in the strategic plan
 - Accord with workload and workforce plans
 - Be produced following discussion with appropriate budget holders
 - Be prepared within the limits of available funds
 - Identify the assumptions used in their preparation and potential risks
 - Reflect SGHSCD indicative budgets
- 3.1.3 The Finance Director will monitor financial performance against budget and strategic plan, periodically review them, and report to the Board.
- 3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets, plans, estimates and forecasts to be compiled.

3.2 Budgetary Delegation

- 3.2.1 The Chief Executive may, within limits approved by the Board, delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:
- a) Amount of the budget
 - b) Purpose(s) of each budget heading
 - c) Individual and group responsibilities
 - d) Authority to exercise virement
 - e) Achievement of planned levels of service
 - f) The provision of regular reports.
- 3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board in the Scheme of Delegation.
- 3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.
- 3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.
- 3.2.5 Expenditure for which no provision has been made in approved plans and budgets and outwith delegated virement limits may only be incurred after authorisation by the Chief Executive or the Finance Director acting on their behalf, or the Board, dependant on the nature and level of expenditure.

3.3 Budgetary Control and Reporting

- 3.3.1 The Finance Director shall monitor financial performance against budget and plan, periodically review them, and report to the Board. There should be a locally agreed mechanism for the early identification and reporting of exceptional financial pressures that cannot be managed.
- 3.3.2 The Finance Director will devise and maintain systems of budgetary control. These will include:
- a) Financial reports to the Board at each meeting in a form approved by the Board containing:
 - Revenue resource and expenditure to date showing trends and forecast year-end position against budget
 - Performance against statutory targets
 - Capital project spend and projected outturn against plan
 - Explanations of any material variances from plan
 - Where necessary, details of any corrective action and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation
 - Changes in the resources available to the Board
 - Report on budgetary transfers.
 - b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible
 - c) Investigation and reporting of variances from financial, workload and workforce budgets
 - d) Monitoring of management action to correct variances
 - e) Arrangements for the authorisation of budget transfers.
- 3.3.3 Each Budget Holder is responsible for ensuring that:
- a) Any likely overspending or reduction of income which cannot be met by virement is not incurred without prior consent
 - b) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement
 - c) No permanent employees other than those provided for in the budgeted establishment as approved by the Board are appointed without the approval of the Senior Management Team and signed off by the Finance Director.
- 3.3.4 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.4 Cost Improvements and Income Generation

- 3.4.1 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the strategic plan and a balanced budget.

3.5 Capital Expenditure

- 3.5.1 The general rules applying to delegation SFI 3.2 and reporting SFI 3.3 also apply to capital expenditure. (The particular applications relating to capital expenditure are in SFI 7).

3.6 Financial Performance Returns

- 3.6.1 The Chief Executive is responsible for ensuring that the required financial performance returns are submitted to the SGHSCD.

4 ANNUAL ACCOUNTS AND REPORTS

- 4.1.1 The Board is responsible for ensuring proper accounting records are maintained which disclose with reasonable accuracy, at any time, the financial position of the Board and enable the Board to ensure that the accounts comply with the National Health Service (Scotland) Act 1978 and the requirements of the SGHSCD.
- 4.1.2 The Board, in regard to the preparation of accounts, is required to:
- a) Select suitable accounting policies and then apply them consistently
 - b) Make judgements and estimates that are reasonable and prudent
 - c) State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
 - d) Prepare the accounts on the going concern basis unless it is inappropriate to assume that the Board will continue to operate.
- 4.1.3 The Finance Director, on behalf of the Board, will:
- a) Prepare, for the Board, periodic and annual financial reports in accordance with the accounting policies and guidance given by the SGHSCD and the Treasury, the Board's accounting policies, and generally accepted accounting practice
 - b) Prepare and submit annual financial reports to the Scottish Ministers certified in accordance with current guidelines
 - c) Submit financial returns to the Scottish Ministers for each financial year in accordance with the timetable prescribed by the SGHSCD.
- 4.1.4 The following statements will be completed and attached to the annual accounts:
- a) Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Health Board
 - b) Statement of NHS Board Members' Responsibilities in Respect of the Accounts
 - c) A management commentary comprising of an Annual Report which includes a Performance Report and Accountability Report
 - d) Remuneration and Staff Report
 - e) Governance Statement
- 4.1.5 The Board's audited annual accounts must be presented to a public meeting, not later than 6 months after the Board's accounting date. The audited annual accounts shall not be presented until the Audit and Risk Committee has approved them in the first instance and then the Board and thereafter laid before the Scottish Parliament.
- 4.1.6 The Board will publish an annual report after the Annual Accounts have been laid before the Scottish Parliament in accordance with guidelines on local accountability, and present it at a public meeting, (MEL(1994) 80, Guidance to NHS Scotland, Preparation of Local NHS Annual Reports 2001-2002). The document will comply with the Boards Manual for Accounts.

5 BANK AND GOVERNMENT BANKING SERVICE (GBS)

5.1 General

- 5.1.1 The Finance Director is responsible for managing the Board's banking arrangements and for advising the Board on the provision of banking services and operation of accounts. This advice will take into account guidance/directions issued from time to time by the SGHSCD.
- 5.1.2 The Board will implement Project Bank Accounts (in construction contracts) where the project value is greater than the monetary limits detailed within Scottish Government guidance "Implementing Project Bank Accounts in Construction Contracts" dated 20 December 2016. This guidance applies to relevant bodies in scope of the Scottish Public Finance Manual (SPFM).
- 5.1.3 No employee shall hold Board monies in any Bank accounts outwith those approved by the Board. The Finance Director shall be notified of all funds held on behalf of the Board. This should be taken to include Exchequer Funds, Patients Private Funds and Project Bank Accounts.
- 5.1.4 Banking arrangements shall comply with current guidance as in MEL (2000)39, HDL (2001) 49 and subsequent guidance.

5.2 Bank and GBS

- 5.2.1 The Finance Director is responsible for:
 - a) Establishing bank account(s) for the Board's exchequer funds
 - b) Establishing separate bank accounts for the Board's non-exchequer funds (including Project Bank Accounts)
 - c) Ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made
 - d) Reporting to the Board all arrangements made with the Board's bankers for accounts to be overdrawn.

5.3 Banking Procedures

- 5.3.1 The Finance Director will prepare detailed instructions on the operation of bank accounts, which must include:
 - a) The conditions under which each account is to be operated
 - b) The limit to be applied to any overdraft
 - c) Those authorised to sign cheques or other orders drawn on the Board's bank accounts, and the limits of their authority.
- 5.3.2 The Finance Director must advise the Board's bankers in writing of the conditions under which each account will be operated, including the Board's resolution. No other officer than the Finance Director shall authorise the opening of an account in the name of The State Hospital, for which signed authority will be required by the Finance Director and one other executive director.
- 5.3.3 The Scottish Minister will be able to direct where Boards may invest temporary cash surpluses. This in practice will be restricted to GBS accounts with the effect of reducing overall exchequer borrowing. Temporary cash surpluses shall only be held in GBS account. Required amounts will be transferred to the commercial bank account as required to cover any salary or creditor payments. The amount of working cash held in commercial accounts should be limited to no more than £50,000. Any excess funds should be invested with the GBS accounts.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Finance Director is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Board shall follow the SGHSCD's guidance in setting prices for services.

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the SGHSCD or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

6.2.3 All employees must inform the Deputy Director of Finance promptly of money due arising from transactions which they initiate/deal with, including all contracts, service agreements, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Finance Director is responsible for the appropriate recovery action on all outstanding debts and overpayments.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayment when detected should be recovered.

6.3.4 The Finance Director shall establish procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

- a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable
- b) Ordering and securely controlling any such stationery
- c) Provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines and for absence cover
- d) Prescribing systems and procedures for handling cash and negotiable securities on behalf of the Board.

6.4.2 All officers whose duty it is to collect or hold cash shall be provided with a safe or with a lockable cash box, which will normally be deposited in a safe. The officer concerned shall hold only one key and all duplicates shall be lodged with the Finance department or other officer authorised by the Finance Director, and suitable receipts obtained. The loss of any key shall be reported immediately to the Finance Director. The Finance Director, on receipt of a satisfactory explanation, shall authorise the release of the duplicate key. The Finance Director shall arrange for all new safe keys to be dispatched directly to him/her from the manufacturers. The Finance Director shall be responsible for maintaining a register of authorised holders of safe keys.

- 6.4.3 The Finance Director shall prescribe the system for the transporting of cash and un-crossed pre-signed cheques and shall approve, where appropriate, the use of the services of a specialist security firm.
- 6.4.4 During the absence (e.g. on holiday) of the holder of a safe key or cash box key, the officer who acts his/her place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the transfer of responsibilities and the discharge document must be retained for inspection.
- 6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses. (See Section 15 – Disposals and Condemnations, Losses and Special Payments).
- 6.4.6 Official money shall not under any circumstances be used for the encashment of private cheques.
- 6.4.7 All cheques, postal orders, cash etc, shall be banked intact and promptly. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.
- 6.4.8 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Board is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Board from responsibility for any loss.
- 6.4.9 It is recommended that any large sums of cash collected for unofficial purposes (e.g. for retirements, leavers) should not be retained at ward / department level. Such funds should, if preferred, be considered for passing to the finance department for safe keeping. Once the collection is complete the cash can then be returned to the collector.

7 CAPITAL INVESTMENT, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

7.1 Capital Investment

7.1.1 The Chief Executive:

- a) Shall ensure that there is an adequate appraisal and approval process, detailed in the Finance Procedure Manual, in place for determining capital expenditure priorities and the effect of each proposal upon service plans. These should form part of the Boards' Property and Asset management strategy.
- b) Is responsible for ensuring that a Capital programme, showing the full, lifetime cost of each project, is brought to the Board for approval at the start of each financial year, in a format agreed by the Board
- c) Is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost
- d) Shall ensure that the capital investment is not undertaken without confirmation of Board support and the availability of resources to finance all revenue consequences, including capital charges.

7.1.2 For every capital expenditure proposal over £2,000,000 (£1,000,000 if IM&T project) the Chief Executive shall ensure:

- a) That a business case (in line with the guidance contained within the Scottish Capital Investment Manual) is produced, for the approval of the Board, setting out:
 - An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs
 - Appropriate project management and control arrangements
- b) That the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

7.1.3 For capital schemes where the contracts stipulate staged payments, the Chief Executive will issue procedures for their management.

7.1.4 The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure, including reporting to the Board.

7.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

7.1.6 The approval of the Chief Executive shall be required for any variations which exceed the lower of £25,000 or 10% of approved expenditure of any scheme.

7.1.7 The Chief Executive shall issue to the manager responsible for any scheme:

- a) Authority to proceed to tender
- b) Approval to accept a successful tender within established limits
- c) Guidance on relevant legislation, SGHSCD requirements, Board procedures etc.

7.1.8 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with Scottish Capital Investment Manual guidance and the Board's Standing Orders.

7.1.9 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

7.2 Asset Registers

- 7.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year – generally within the annual audit review. The minimum data set to be held within the registers shall be as specified in CEL (2010)³⁵ as issued by the SGHSCD.
- 7.2.2 Additions to the fixed asset register must be clearly identified and be validated by reference to:
- a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties
 - b) Stores, requisitions and wages records for own materials and labour including appropriate overheads
 - c) Lease agreements in respect of assets held under a finance lease and capitalised.
- 7.2.3 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).
- 7.2.4 The Finance Director shall approve procedures for reconciling balances on fixed asset accounts in ledgers against balances on fixed asset registers.
- 7.2.5 The value of each asset shall be revalued or indexed and depreciated in accordance with guidance issued by the SGHSCD.

7.3 Security of Assets

- 7.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.
- 7.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including any donated assets) must be approved by the Finance Director. This procedure shall make provision for:
- a) Recording managerial responsibility for each asset
 - b) Identification of additions and disposals
 - c) Identification of all repairs and maintenance expenses
 - d) Physical security of assets
 - e) The express prohibition of any unauthorised use or disposition of Board assets
 - f) Periodic verification of the existence of, condition of, and title to, assets recorded
 - g) Identification and reporting of all costs associated with the retention of an asset
 - h) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.
- 7.3.3 The Finance Director shall prepare procedural instructions on the security and checking and disposal of assets (including cash, cheques and negotiable instrument, and also including donated assets).
- 7.3.4 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Finance Director.
- 7.3.5 Each employee has a responsibility for the security of property of the Board and it is the responsibility of directors and senior employees in all disciplines to ensure appropriate routine security practices in relation to NHS property as may be determined by the Board are applied. Any breach of agreed security practices must be reported in accordance with instructions.

- 7.3.6 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating.
- 7.3.7 Any damage to the Board's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.
- 7.3.8 Registers shall be maintained by the responsible officer for:
- Equipment on loan;
 - Leased equipment.
- 7.3.9 Where practical, assets should be marked as Board property.

7.4 Sale of Property, Plant and Equipment,

- 7.4.1 There is a requirement to achieve best value for money when disposing of property, plant and equipment assets belonging to the Board. Competitive tendering should normally be undertaken in line with the requirements of SFI 10.3.
- 7.4.2 Competitive Tendering or Quotation procedures shall not apply to the disposal of:
- a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer
 - b) Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Board
 - c) Items to be disposed of with an estimated sale value of less than £5,000 this figure to be reviewed annually
 - d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract
 - e) Land or buildings concerning which SGHSCD guidance has been issued but subject to compliance with such guidance.
 - f) Assets that can be transferred to another NHS body at their Net Book value.
- 7.4.3 Managers must ensure that:
- a) All assets are be disposed of in accordance with MEL(1996)7 'Sale of surplus and obsolete goods and equipment'
 - b) The Finance Director is notified of the disposal of any such assets
 - c) All proceeds from the disposal of such assets are notified to the Finance Director.

8 SERVICE LEVEL AGREEMENTS (SLAs)

- 8.1.1 Service Level Agreements between two NHS organisations, for example by Health Boards with Boards for the supply of healthcare services, are subject to the provisions of the NHS and Community Care Act 1990. Such contracts do not give rise to legal rights or liabilities but a dispute may be referred to SGHSCD.
- 8.1.2 Service level agreements provided by the independent healthcare sector on behalf of the NHS are subject to the provisions of HDL (2005) 41. This letter sets out the arrangements that should apply for ensuring the quality of services and identifies that the Chief Executive should ensure the necessary contracting and clinical governance arrangements are put in place.
- 8.1.3 The Chief Executive is responsible for ensuring Service Level Agreements are agreed and in place before 1 April each year, following discussion between the relevant Boards. The following areas should be covered:
 - a) Costing and pricing of services
 - b) Tendering of services
 - c) Terms and conditions for funding
 - d) Monitoring of service provision, quality and performance.
- 8.1.4 Service Level Agreements for The State Hospital providing services to other Boards should be so devised as to minimise risk whilst maximising the Board's opportunity to generate income. Any pricing at marginal cost must be undertaken by the Finance Director and reported to the Board where material. Non-recurrent income should not be used for recurrent purposes without the authority in writing of the Chief Executive.

9 TERMS OF SERVICE AND PAYMENT OF EXECUTIVE DIRECTORS AND EMPLOYEES

9.1 Remuneration and Terms of Service

- 9.1.1 The Board has established a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting (MEL(94) 80).
- 9.1.2 The Board will remunerate the Chairperson and Non-Executive Directors in accordance with instructions issued by Scottish Ministers.
- 9.1.3 The Remuneration Committee will:
- a) Advise the Board about appropriate Remuneration and Terms of Service for the Chief Executive and other Executive Directors (and other senior employees), including:
 - All aspects of salary (including any performance related elements/bonuses)
 - Provisions for other benefits, including pensions and cars
 - Arrangements for termination of employment and other contractual terms.
 - b) Make such recommendations to the Board on the Remuneration and Terms of Service of Executive Directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Board – having proper regard to the Board's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate.
 - c) Monitor and evaluate the performance of individual Executive Directors (and other senior employees)
 - d) Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking into account such national guidance as is appropriate.
- 9.1.4 The Remuneration Committee shall report in writing to the Board the basis for its recommendations – generally in the form of an Annual Report. The Board shall use the report as the basis for its decisions, but remain accountable for taking decisions on the Remuneration and Terms of Service of Executive Directors. Minutes of the Board's meetings should record such decisions.
- 9.1.5 The Board will approve proposals presented by the Chief Executive for setting of Remuneration and Terms and Conditions of service for those employees not covered by the Committee.

9.2 Funded Establishment

- 9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment.
- 9.2.2 The funded establishment of any department may not be varied, after approval of the annual budget, without the approval of the Chief Executive through the Senior Management Team subject to section 3 of the Scheme of Delegation.

9.3 Staff Appointments

- 9.3.1 No director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or hire agency staff, or agree to changes in any aspect of remuneration:
- a) Unless given delegated authority to do so by the Chief Executive
 - b) Within the limit of his/her approved budget and funded establishment
 - c) In accordance with procedures approved by the Director of Workforce.
 - d) In accordance with the relevant pay scales / Terms and Conditions of service.
- 9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.
- 9.3.3 The budget impact of all staff appointments must have the authorisation of the Finance Director or his/her delegated officer, before appointment.

9.4 Contracts of Employment

- 9.4.1 The Director of Workforce will be responsible for:
- a) Ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation
 - b) Dealing with variations to, or termination of, contracts of employment.

9.5 Pay and Payroll Documentation

- 9.5.1 The Director of Workforce is responsible for ensuring that proper arrangements are in place for:
- a) The final determination of pay and expenses
 - b) Verification authorisation and documentation of payroll data
 - c) Verification and authorisation of expenses payments
 - d) Prescribing the form of appointment, notification of change and termination forms
 - e) Prescribing the form of completion of time records and other payroll notifications
 - f) Prescribing the form for claiming expenses
 - g) Ensuring the arrangements for the determination, verification and notification of pay and payroll data are supported by appropriate (contract) terms and conditions of service, adequate internal controls and audit review procedures.
- 9.5.2 Each Director and employee is responsible for complying with the systems in place in the Board for the prompt and accurate provision of information related to the verification of their personal entitlement to pay and expenses and for complying with appropriate Terms and Conditions of Service.
- 9.5.3 All payroll change forms must be authorised by the Finance Director.

9.6 Processing of Payroll

- 9.6.1 The Finance Director is responsible for:
- a) Specifying timetables for submission of properly authorised time records, other payroll notifications and authorised expense claims
 - b) Making payment on agreed dates
 - c) Agreeing method of payment to be by bank credit (BACS).

9.6.2 The Finance Director will issue instructions regarding:

- a) The timetable for receipt and preparation of payroll data and the payment of employees
- b) Maintenance of subsidiary records for superannuation, income tax, social security benefits, arrestments and other authorised deductions from pay
- c) Security and confidentiality of payroll information
- d) Checks to be applied to completed payroll after processing
- e) Authority to release payroll data under the provisions of the Data Protection Act
- f) Method of payment to employees will be bank credit (BACS)
- g) Procedures for payment by bank credit to employees
- h) Procedures for the recall before payment of bank credits
- i) The collection of payroll deductions and payment of these to appropriate bodies
- j) Pay advances and their recovery
- k) Maintenance of regular and independent reconciliation of pay control accounts
- l) Separation of duties of compiling payroll and checking of payroll after processing
- m) A system to ensure the recovery from employees or leavers of sums of money and/or property due by them to the Board
- n) Ensuring payroll processing is supported by adequate internal controls and audit review procedures.

9.6.3 Appropriately nominated managers have delegated responsibility for:

- a) Completing accurate roster records consistent with approved conditions of service, and other notifications in accordance with agreed timetables
- b) Completing roster records and other notifications in accordance with the Human Resources Director's instructions and in the form prescribed by the him/her
- c) Submitting commencement, change or termination forms in the prescribed form immediately upon knowing the effective date of the relevant date. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Human Resources Director must be informed immediately.

9.7 Settlement Agreements, Early Retirement and Redundancy

9.7.1 The Director of Workforce, jointly with the Finance Director is responsible for:

- a) Ensuring compliance with the guidance issued by the Health Workforce and Performance Directorate in the situations described above.
- b) Ensuring that detailed, accurate costings are produced showing the impact of any instances of early retirement/redundancy on the financial performance of the Board.

9.8 Relocation Expenses

9.8.1 The Director of Workforce is responsible for:

- a) Preparing a policy relating to the payment of removal expenses and presenting it to the Board for approval
- b) Maintaining detailed procedures for the implementation of this policy
- c) Ensuring that monitoring and tracking arrangements are in place for the payment of such expenses.

9.9 Non Salary Rewards

- 9.9.1 The Scottish Public Finance Manual sets out arrangements for establishment of non salary reward schemes, and provides the following examples:
- Cash bonuses
 - Amenities and recreational facilities
 - Gifts, vouchers, and entertainment offered as rewards under recognition schemes
 - Payment by the employer of its staffs' personal subscriptions to sports or leisure clubs
 - Rewards leading to donations to a charity or other external body
 - Provision of cars where they are needed for official purposes and are covered by an existing and agreed scheme which includes charging for any private use.
- 9.9.2 The Scottish Government Finance Pay Policy Team should be consulted prior to the implementation of any non-salary reward scheme to determine whether it will require approval under the Public Sector Pay Policy for Staff Pay Remits or Senior Appointments.
- 9.9.3 The tax implications for both employers and employees of the provision of all non-salary rewards – cash and non-cash – should be carefully considered. In considering such schemes, it may be appropriate for the Finance Director to seek expert PAYE advice.
- 9.9.4 When consulting about a proposed scheme, or advising employees of a scheme to be implemented, the Director of Workforce should ensure that mechanisms are in place to advise employees of the tax implications for recipients and how these are to be handled.

10 NON-PAY EXPENDITURE

10.1 Delegation of Authority

10.1.1 The Board will approve the total level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget holders.

10.1.2 The Finance Director will identify:

- a) Managers who are authorised to place requisitions for the supply of goods and services
- b) The maximum level of each requisition and the system for authorisation above that level.

10.1.3 The Finance Director shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

10.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always seek to obtain the best value for money for the Board through the application of these SFIs, and of all relevant Financial Operating Procedures. In so doing, the advice of the Board's Procurement Manager shall be sought.

10.2.2 National contracts agreed by National Procurement, should be used wherever possible, HDL (2006)39, updated by CEL 05(2012). The Accelerated Procurement initiative was established by the NHS Chief Executive Officers' Group in August 2010. The group recognised the essential nature of the engagement between procurement professionals and the wider Health Board teams to maximise the delivery of benefits for NHSScotland, and to ensure that appropriate professional input from across the service is provided to assist in Best Value outcomes for procurement activity. This work was developed further and is now controlled within the NHSScotland Procurement Steering Group. The key principles of this engagement are set out below:

- a) National, regional & local contracts: Where national, regional or local contracts exist (including framework arrangements) the overriding principle is that use of these contracts is mandatory. Only in exceptional circumstances and only with the authority of the Board's Procurement Manager or the Finance Director, based on existing schemes of delegation, shall goods or services be ordered out-with such contracts. Procurement leads will work with National Procurement and other national contracting organisations to ensure best value decisions are made, and that a record of exceptions is maintained for review.
- b) Engagement: Technical User Groups (TUGs) should be established by each Health Board for key projects with decision making powers from their Executive Board through a scheme of delegation. Each TUG will be responsible for supplier award and product selection decision making within their Board for local contracts and will provide representation to national CAP (Clinical/Commodity Advisory Group) panels for national contract activity. The decision of the TUG will be mandatory across the Board and will be made prior to development of national contract tendering activities.
- c) CAP Panel Membership: CAP panels will have a membership consistent with the principle of decision making based on the consensus of the majority of informed users. Boards should ensure that appropriate representation, based upon the clinical or commodity area concerned is released to and provided with the appropriate authority to input on behalf of a Board and/or clinical specialism.

- d) **Commitment Contracts:** The CAP and TUG groups will work to the principle of seeking to award Commitment based contracts. This means where possible a supplier(s) will be selected for an agreed volume of business by each Board and such volumes aggregated to provide a national commitment level.
Where commitment cannot be provided, CAP and TUG groups will support the principles of reduced variation and increased consistency, commensurate with clinical and operational requirements.
- e) **eCommerce Systems:** In support of governance and transparency each Board should adopt the Scottish Government national eCommerce solutions and associated business processes for all procurement activity. These solutions will include Public Contracts Scotland, Public Tenders Scotland, Collaborative Content Management and Pecos. Use of alternative or local systems for procurement activity must be approved by the Board's Procurement Manager or the Finance Director, based on existing schemes of delegation. Procurement leads will work with National Procurement and any other relevant bodies to ensure appropriate decisions are made.
- f) **Transparency:** All awards whether from existing framework contracts or local tender processes will be established following the principles of openness and transparency. This requires clear specifications of need and award criteria against which competing offers can be assessed. All members of evaluation panels must confirm that they have no conflict of interest in relation to the specific procurement activity. Any individual wishing to challenge an award decision must also confirm likewise. Any member of staff who confirms a conflict of interest will not be able to be involved in such panels or challenges.
- g) **No Purchase Order / No Payment:** Each Board must implement a policy where no payment shall be made to any supplier where there is no pre-let purchase order. Only if a separately agreed payment mechanism has been pre-arranged should direct payments be made. Each supplier should be formally notified of this and the limit of the Board's liability if they proceed with supply without such order cover.

10.2.3 The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

10.2.4 The Finance Director will:

- a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in SFI 10.3 and reviewed regularly
- b) Prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds
- c) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:
 - A list of directors/employees (including specimens of their signatures) authorised to order goods/certify invoices and the limits of that authority.
 - Certification that:
 - ✓ Goods have been duly received, examined and are in accordance with specification and the prices are correct
 - ✓ Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct
 - ✓ In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined

- ✓ Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained
 - ✓ The setting of thresholds for matching invoices to orders and good received notes – above which additional budget holder authorisation is required
 - ✓ The account is arithmetically correct
 - ✓ The account is in order for payment
- A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
 - Instructions to employees regarding the handling and payment of accounts within the Finance Department
- d) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).

10.2.5 Prepayments are only permitted where exceptional circumstances apply. In such instances:

- Prepayments are only permitted where the financial advantages outweigh the disadvantages and the intention is not to circumvent cash limits.
- The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Board, if the supplier is at some time during the course of the prepayment agreement, unable to meet his commitments. The report must include a statement of support from the Procurement Manager for the proposed prepayment agreement.
- The Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed.
- The budget manager/holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or the Chief Executive if problems are encountered.
- Regardless of the arrangements for paying suppliers, the Finance Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for payment.

10.2.6 Official Orders must:

- a) Be consecutively numbered
- b) Be in a format approved by the Finance Director
- c) State the Board's terms and conditions of trade
- d) Only be issued to, and used by, those duly authorised by the Chief Executive.

10.2.7 Managers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

- a) All contracts, leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made
- b) Contracts above specified thresholds are advertised and awarded in accordance with WTO GPA rules on public procurement and comply with the Public Contracts (Scotland) Regulations 2015 and the Procurement Reform Act Scotland 2014
- c) Officers are also expected to use their discretion in obtaining more than the minimum number of quotations if they have doubts about the competitiveness of those obtained
- d) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the SGHD – MEL (1994)⁴

- e) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:
 - Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars; conventional hospitality, such as lunches in the course of working visits
 - Any officer who receives an offer shall notify his/her manager as soon as practicable. The manager will consult with the Finance Director (and/or Chief Executive) on what action is to be taken
 - Visits at suppliers' expense to inspect equipment etc. must not be undertaken without the prior approval of the Chief Executive
- f) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive
- g) All goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash
- h) Verbal orders must only be issued very exceptionally – by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”
- i) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds
- j) Goods are not taken on trial or loan in circumstances that could commit the Board to a future uncompetitive purchase
- k) Advice is sought from the appropriate supplies advisor, and the Finance Director (and/or the Chief Executive) is consulted if this advice is not acceptable
- l) Changes to the list of directors/employees authorised to certify invoices are notified to, and agreed with, the Finance Director
- m) Purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Finance Director
- n) Purchases via Purchasing Cards are in accordance with instructions issued by the Finance Director
- o) Petty cash records are maintained in a form as determined by the Finance Director.

10.3 Tendering Procedures

- 10.3.1 The procedure for making all contracts by or on behalf of the Board shall comply with these Standing Financial Instructions.
- 10.3.2 Public Contracts (Scotland) Regulations 2015 and the Procurement Reform Act Scotland 2014 procedures for awarding all forms of contracts shall have effect as if incorporated in Standing Orders and Standing Financial Instructions.
- 10.3.3 The Board shall comply as far as is practicable with the requirements of the “Scottish Capital Investment Manual”. In the case of management consultancy contracts the Board shall comply as far as is practicable with SGHSCD guidance “The Use of Management Consultants by Scottish Health Authorities” (MEL (1994) 4).
- 10.3.4 Where the estimated value of the contract is £50,000 or greater (exclusive of VAT), a regulated tender process will be carried out. Where the estimated value of the contract is between £5,000 and £50,000 a quotation process will be carried out and both processes will cover:
 - The supply of all goods, materials and manufactured articles not available to the Board through national contracts
 - For the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the SGHSCD)
 - For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens)
 - For disposals of assets.

- 10.3.5 The Chief Executive and Finance Director may dispense with the requirements for competitive tendering or quotations if they jointly agree that it is not possible or desirable to undertake or obtain having regard for all the circumstances. Such decisions and their reasons must be recorded. Formal tendering procedures may be waived with the approval of the Chief Executive and Finance Director where:
- a) The time scale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
 - b) Specialist expertise is required and is available from only one source; or
 - c) The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or
 - d) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
 - e) The Product has been used within the hospital or other secure units and meets a security need. You must provide evidence of other similar products and the reason why these will not suit. (statement from the Director of Security, Estates and Resilience is required)or
 - f) As provided for in the Scottish Capital Investment Manual.
 - g) The overall value of the contract exceeds £10,000 + VAT.
- 10.3.6 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.
- 10.3.7 Where it is decided that competitive tendering is not applicable and should be waived by virtue of the above, the fact of the waiver and the reasons must be documented and reported by the Chief Executive to the Board in a formal meeting and recorded in a register kept for that purpose.
- 10.3.8 Except where 10.3.5 or a requirement under 10.3.2, applies, the Board shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate. This would normally comprise no less than three, firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.
- 10.3.9 The Board shall ensure that normally the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Finance Director it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive. Suppliers shall normally be chosen in rotation from the list unless the approval of the Chief Executive or nominated officer is given.
- 10.3.10 Tendering procedures are set out in a separate Procurement Policy for Tendering and Contracting.
- 10.3.11 Quotations are required where formal tendering procedures are waived under 10.3.5 a) or c) and where the intended expenditure or income exceeds, or is reasonably expected to exceed £5,000.
- 10.3.12 Where quotations are required under 10.3.4 they should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Board.
- 10.3.13 Quotations should be in writing unless the Chief Executive or nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

- 10.3.14 All quotations should be treated as confidential and should be retained for inspection.
- 10.3.15 The Chief Executive or nominated officer should evaluate the quotations and select the one which gives the best value for money. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record.
- 10.3.16 Non-competitive quotations in writing may be obtained for the following purposes:
- a) The supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations
 - b) The goods/services are required urgently; and
 - c) Where tenders or quotations are not required, because expenditure is below £5,000, the Board shall procure goods and services in accordance with procurement procedures prepared by the Finance Director.

10.4 Contracts

- 10.4.1 The Board may only enter into contracts within its statutory powers and shall comply with:
- a) Standing Orders
 - b) Standing Financial Instructions
 - c) WTO GPA Directives and other statutory provisions
 - d) Any relevant directions including the Scottish Capital Investment Manual and guidance on the Use of Management Consultants (MEL(1994)4)
 - e) Such of the NHS Standard Contract Conditions as are applicable
 - f) Public Contracts (Scotland) Regulations 2015
 - g) Procurement Reform Act Scotland 2014
- 10.4.2 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.
- 10.4.3 In all contracts made the Board shall endeavour to obtain best value for money. The Chief Executive shall formally nominate an officer who shall oversee and manage each contract on behalf of the Board.
- 10.4.4 All contracts entered into by the Board shall contain clauses, standard examples of which are detailed in the Procurement Policy, empowering the Board to:
- a) Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to Board staff
 - b) Recover all losses in full or enforce specific performance where goods or services are not delivered in line with contract terms.
- 10.4.5 Contracts involving "Funds Held on behalf of the Board" shall be made individually to a specific named fund and shall comply with the requirements of the Charities Acts and regulations.
- 10.4.6 The Finance Director shall ensure that the arrangements for financial control and the financial and technical audit of building and engineering contracts and property transactions comply with guidance contained within The Property Transaction Handbook CEL (2011)08 and SCIM CEL (2009)19.

10.5 Grants and Similar Payments

- 10.5.1 Any grants or similar payments to local authorities and voluntary organisations or other bodies shall comply with procedures laid down by the Finance Director which shall be in accordance with the relevant Acts.
- 10.5.2 The financial limits for officers' approval of grants or similar payments are set out in the Scheme of Delegation.

10.6 In-house Services

- 10.6.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.
- 10.6.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:
 - a) Service specification group, comprising the Chief Executive or nominated officer(s) and specialist(s)
 - b) In-house tender group, comprising representatives of the in-house team, a nominee of the Chief Executive and technical support
 - c) Evaluation group, comprising normally a specialist officer, a procurement officer and a Finance Director representative. For services having a likely annual expenditure exceeding £250,000, a Non-Executive Director should be a member of the evaluation group.
- 10.6.3 All groups should work independently of each other but individual officers may be a member of more than one group. No member of the in-house tender group may, however, participate in the evaluation of tenders.
- 10.6.4 The evaluation group shall make recommendations to the Board.
- 10.6.5 The Chief Executive shall nominate an officer to oversee and manage the contract.

11 STORES AND RECEIPT OF GOODS

- 11.1.1 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Procurement Manager by the Chief Executive. The day-to-day responsibility may be delegated by him/her to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Finance Director. The control of Pharmaceutical stocks shall be the responsibility of a nominated pharmaceutical officer; the control of fuel oil and bio-fuel of a designated facilities manager.
- 11.1.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the nominated managers.
- 11.1.3 Wherever practicable, stocks should be marked as health service property.
- 11.1.4 The Finance Director shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.
- 11.1.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.
- 11.1.6 The nominated managers shall be responsible for a system approved by the Finance Director for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Finance Director any evidence of significant overstocking and of any negligence or malpractice (see also 15, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.
- 11.1.7 Stock levels should be kept to a minimum consistent with operational efficiency.
- 11.1.8 Stocktaking arrangements shall be agreed with the Finance Director and there shall be a physical check covering all items in store at least once a year.
- 11.1.9 Those stores designated by the Finance Director as comprising more than seven days of normal use should be:
 - a) Subjected to annual or continuous stock-take
 - b) Valued at the lower of cost and net realisable value.

12 RISK MANAGEMENT AND INSURANCE

- 12.1.1 The Chief Executive shall ensure that the Board has a programme of risk management which will be approved and monitored by the Board.
- 12.1.2 The programme of risk management shall include:
- a) A process for identifying and quantifying risks and potential liabilities
 - b) Engendering among all levels of staff a positive attitude towards the identification and control of risk
 - c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk
 - d) Contingency plans to offset the impact of adverse events, including a business continuity plan
 - e) Audit arrangements including; incident reporting and review, internal audit, clinical audit, health and safety review
 - f) Arrangements to review and update the risk management programme
 - g) Development of a financial risk management strategy to cope with possible in-year variations to the initially set budgets.
- 12.1.3 The existence, integration and evaluation of the above elements will provide a basis for the Audit and Risk Committee to provide appropriate assurance to the Directors that the necessary controls are in place to allow the Directors to sign the Governance Statement in keeping with Corporate Governance in the NHS.
- 12.1.4 The Finance Director shall ensure that appropriate insurance arrangements exist in accordance with the risk management programme.

13 INFORMATION TECHNOLOGY

- 13.1.1 The Finance Director is responsible for the accuracy and security of the computerised financial data of the Board and shall:
- a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Board's data, programs and computer hardware for which she/ he is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR).
 - b) Ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system
 - c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment
 - d) Ensure that the Board is compliant with information regulation and legislation
 - e) Ensure that electronic signatures are only used with the written approval of the Finance Director
 - f) Ensure that adequate controls exist for all acquisition/disposal of computer equipment
 - g) Ensure that an adequate audit trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out
 - h) Ensure that contingency planning, including business continuity, is undertaken and that adequate contingency arrangements are in place.
- 13.1.2 The Finance Director shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.
- 13.1.3 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Health Boards /Boards in the area wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:
- a) Details of the outline design of the system
 - b) Contract details and/or standard contract conditions
 - c) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.
- These should form part of the national e-Health platform and be procured using framework agreements as set out in section 10.2.2, unless not suitable for the organisations due to cost or functionality.
- 13.1.4 The Finance Director shall ensure that for contracts for computer services for financial applications with another body, the Board periodically seek assurances that adequate controls are in operation, such as service audits.
- 13.1.5 Where computer systems have an impact on corporate financial systems the Finance Director shall satisfy him/herself that:
- a) Systems acquisition, development and maintenance are in line with corporate policies such as the eHealth Strategy
 - b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that an audit trail exists
 - c) Systems are appropriate for future business need as well as the present
 - d) Finance Directorate staff have access to such data
 - e) Such computer audit reviews as are considered necessary are being carried out.

- 13.1.6 The Associate Medical Director shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of patient confidential information held on computer files after taking account of the Data Protection Act 1998 and General Data Protection Regulations (EU) 2016/679 (GDPR). The appointed Information Governance and Data Security Officer will provide the same assurances over all other non patient data.
- 13.1.7 The Finance Director shall devise and implement any necessary procedures to comply with the Freedom of Information (Scotland) Act 2002.

14 AUDIT

14.1 Audit and Risk Committee

14.1.1 In accordance with Standing Orders the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference, which will consider:

- a) Internal control and corporate governance, including ensuring that relevant controls are in place and that appropriate assurances can be provided to allow the directors to sign the required statements
- b) Internal audit
- c) External audit
- d) Standing orders and standing financial instructions
- e) Accounting policies
- f) Annual accounts (including the schedules of losses and compensations).

14.1.2 Where the Audit and Risk Committee is satisfied there is evidence of ultra vires transactions, evidence of improper acts, or any other issue, the Chair of the Audit and Risk Committee should raise the matter at a meeting of the Board or convene an emergency Board meeting if required. Exceptionally, the matter may need to be referred to the SGHSCD.

14.1.3 It is the responsibility of the Audit and Risk Committee with the guidance of the Finance Director to ensure that both an effective and cost effective internal audit service is provided. The Finance Director will retender Internal Audit services at least every five years. The Review panel will include the Chairman of the Audit and Risk Committee, the Chief Executive and the Finance Director and may also include other members of the Audit and Risk Committee. Tendering will be done on the basis of Technical ability, a Qualitative assessment and affordability.

14.2 Director of Finance and eHealth (“Finance Director”)

14.2.1 The Finance Director is responsible for:

- a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control, including the establishment of an effective internal audit function
- b) Ensuring that Internal Audit is adequate and meets the NHS mandatory audit standards
- c) With regard to the Governance Statement, arranging for the provision of the necessary compliance evidence which would:
 - Identify and disclose where there is a significant control weakness
 - Show where a control has been introduced during the financial year;
- d) Developing and documenting an effective Fraud, Theft and Other Financial Irregularity Policy, and
- e) Investigating cases of fraud, misappropriation or other irregularities, in consultation with the Chief Internal Auditor, Counter Fraud Service and the Police, where appropriate and shall notify the Chief Executive and Audit and Risk Committee
- f) Ensuring that the Chief Internal Auditor prepares a detailed operational plan each financial year for approval by the Audit and Risk Committee
- g) Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit and Risk Committee, for the consideration of the Audit and Risk Committee and the Board. The report must cover:
 - A clear statement on the effectiveness of internal control
 - Major internal control weaknesses discovered
 - Progress on the implementation of internal audit recommendations
 - Progress against plan over the previous year.

14.2.2 The Finance Director or designated auditors are entitled without necessarily giving prior notice to require and receive:

- a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature
- b) Access at all reasonable times to any land, premises or employees of the Board
- c) The production of any cash, stores or other property of the Board under an employee's control
- d) Explanations concerning any matter under investigation.

14.3 Internal Audit

14.3.1 The role, objectives and scope of Internal Audit are set out in the mandatory Public Sector Internal Audit Standards.

14.3.2 Internal Audit will review, appraise and report upon:

- a) The extent of compliance with and the financial effect of relevant established policies, plans and procedures
- b) The adequacy and application of financial and other related management controls, including internal financial controls
- c) The suitability of financial and other related management data
- d) The extent to which the Board's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - Fraud and other offences
 - Poor risk assessment
 - Waste, extravagance, inefficient administration
 - Poor value for money or other causes.

14.3.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

14.3.4 The Chief Internal Auditor, or appointed representative, will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chairperson and Chief Executive of the Board.

14.3.5 The Chief Internal Auditor shall be accountable to the Finance Director. The reporting and follow-up systems for internal audit shall be agreed between the Finance Director, the Audit and Risk Committee and the Chief Internal Auditor. The agreement shall be in writing and shall comply with the guidance on reporting contained in the Public Sector Internal Audit Standards. The reporting and follow-up systems shall be reviewed at least every 3 years.

14.3.6 The Chief Internal Auditor shall issue reports in accordance with the Internal Audit reporting mechanism agreed by the Audit and Risk Committee. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation of the objectivity of the audit, the Chief Internal Auditor shall seek the advice of the Chairperson of the Board.

14.4 External Audit

- 14.4.1 The external auditor is concerned with providing an independent assurance of the Board's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000.
- 14.4.2 The external auditor has a general duty to satisfy him/herself that:
- a) The Board's accounts have been properly prepared in accordance with directions given under s86(1) of the National Health Service (Scotland) Act 1978
 - b) Proper accounting practices have been observed in preparation of the accounts
 - c) The Board has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources
 - d) The Internal Audit function is adequate.
- 14.4.3 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:
- a) Whether the statement of accounts presents a true and fair view of the financial position of the Board
 - b) The Board's main financial systems
 - c) The arrangements in place at the Board for prevention and detection of fraud and corruption
 - d) Aspects of the performance of particular services and activities
 - e) The Board's management arrangements to secure economy, efficiency and effectiveness in the use of resources.
- 14.4.4 The Board's Audit and Risk Committee provides a forum through which Non-Executive Directors can secure an independent view of any major activity within the appointed auditor's remit. The Audit and Risk Committee has a responsibility to ensure that the Board receives a cost-effective service and that co-operation with senior managers and Internal Audit is appropriate.

15 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

15.1 Disposals and Condemnations

- 15.1.1 The Finance Director shall maintain detailed procedures for the disposal of assets (excluding land) including condemnations, and ensure that these are notified to managers.
- 15.1.2 When it is decided to dispose of an asset, the head of department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate.
- 15.1.3 All unserviceable articles shall be:
- a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director
 - b) Recorded by the relevant officer, in a form approved by the Finance Director, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.
 - c) The relevant officer shall ensure that any article disposed of, is done so in accordance with appropriate guidance or regulations.
 - d) The relevant officer shall satisfy him/herself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.
- 15.1.4 The Director of Security Estates and Resilience will ensure that the Board complies with the Property Transactions Handbook and will ensure that detailed procedures are in place for the disposal of land.

15.2 Losses and Special Payments

- 15.2.1 The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
- 15.2.2 Special payments are defined in more detail in the Scottish Public Finance Manual. The main types which may be relevant to the State Hospital are:
- A compensation payment is one made in respect of unfair dismissal in respect of personal injuries, traffic accidents, damage to property etc, suffered by staff or by others.
 - Special severance payments are paid to employees beyond and above normal statutory or contractual requirements when leaving employment in public service whether they resign, are dismissed or reach an agreed termination of contract. See the section of the SPFM on Severance, Early Retirement and Redundancy Terms.
 - Ex gratia payments are payments made where there is no legal obligation to pay. There must always, however, be good public policy grounds for making such payments. Into this category will fall some out of court settlements, such as cases where the pursuer has no legal case but the Board wants to stop the litigation because it is costly in time and resources. It would not however include cases where the settlement is a negotiated price to settle a potentially higher legal liability. Other examples of ex gratia payments would be payments as compensation for distress or loss arising from a perceived failure of the Board but where there was no legal obligation to pay.
- 15.2.3 Within limits delegated to it by the SGHSCD (CEL 10 (2010)), the Board, following the recommendation of the Audit and Risk Committee, shall review the Summary of Losses and Special Payments which shall be prepared by the Finance Director in the form laid down in the Health Board Manual for Accounts, SFR 18.

	No of Cases	£	Delegated Limit
Theft / Arson / Wilful Damage			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Buildings & Fixtures			20,000
Other			10,000
Fraud, Embezzlement & other irregularities (inc. attempted fraud)			
Cash			10,000
Stores/procurement			20,000
Equipment			10,000
Contracts			10,000
Payroll			10,000
Other			10,000
Nugatory & Fruitless Payments			10,000
Claims Abandoned:			
(a) Private Accommodation			10,000
(b) Road Traffic Acts			20,000
(c) Other			10,000
Stores Losses:			
Incidents of the Service			
- Fire			20,000
- Flood			20,000
- Accident			20,000
Deterioration in Store			20,000
Stocktaking Discrepancies			20,000
Other Causes			20,000
Losses of Furniture & Equipment and Bedding & Linen in circulation:			
Incidents of the Service – Fire			10,000
- Flood			10,000
- Accident			10,000
Disclosed at physical check			10,000
Other Causes			10,000
Compensation Payments - legal obligation			
Clinical			250,000
Non-clinical			100,000
Ex-gratia payments:			
Extra-contractual Payments			10,000
Compensation Payments - ex-gratia - Clinical			250,000
Compensation Payments - ex-gratia - Non Clinical			100,000
Compensation Payments - ex-gratia - Financial Loss			25,000
Other Payments			2,500
Damage to Buildings and Fixtures:			
Incidents of the Service – Fire			
- Fire			20,000
- Flood			20,000
- Accident			20,000
- Other Causes			20,000
Extra-Statutory & Extra-regulatory Payments			0
Gifts in cash or kind			10,000
Other Losses			10,000

- 15.2.4 The Finance Director shall be authorised to take any necessary steps to safeguard the Board's interests in bankruptcies and company liquidations.
- 15.2.5 For any loss, the Finance Director should consider whether any insurance claim can be made.
- 15.2.6 The Board shall delegate to the Chief Executive and the Finance Director, acting jointly, its responsibility for the approval of losses and authorisation of special payments for such categories or values of losses as within limits to the Board by the SGHSCD.
- 15.2.7 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded – which shall be reviewed on an annual basis.
- 15.2.8 No losses or special payments exceeding delegated limits (CEL 10 (2010)) shall be written off or made without the prior approval of the SGHSCD.

15.3 Theft, Fraud, Embezzlement, Corruption and Other Financial Irregularities

- 15.3.1 The Finance Director must prepare a 'fraud response plan', incorporating the requirements of HDL (2004) 23, updated by CEL(2009)18, that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.
- 15.3.2 The Finance Director will be the nominated contact for the National Fraud Initiative (NFI) and will authorise the release of the required data for this purpose. The Finance Director may delegate the NFI investigation and reporting requirements, to suitable representatives. The Finance Director will ensure that all staff receive the required notifications that their information will be used for this purpose.
- 15.3.3 The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with Scottish Government Health Department Circular No HDL(2002)88 This procedure also applies to any non-public funds.
- 15.3.4 The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash, has been stolen.
- 15.3.5 It is the designated officer's responsibility to inform as he/she deems appropriate the police, the Counter Fraud Services (CFS), the appropriate director, the Appointed Auditor and Internal Auditor where such an occurrence is suspected.
- 15.3.6 Where any officer of the Board has grounds to suspect that any of the above activities has occurred, his or her local manager should be notified without delay. Local managers should in turn immediately notify the Board's Finance Director, who should ensure consultation with the CFS, normally by the Fraud Liaison Officer. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.
- 15.3.7 If, in exceptional circumstances, the Finance Director and the Fraud Liaison Officer are unavailable the local manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter the Director of Finance should be advised of the situation.
- 15.3.8 Where preliminary investigations suggest that prima facie grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with, the Board. At all stages the Finance Director and the Fraud Liaison Officer will be kept informed of developments on such cases. All referrals to the CFS must also be copied to the Appointed Auditor.

15.3.9 The Chief Executive has also the responsibility to designate an officer within the Board as Counter Fraud Champion. The role is a strategic one, and focuses on spearheading change in culture and attitudes towards NHS fraud. Full background to this role is included within CEL 3 (2008). As such the role of Champion will complement the role of the Fraud Liaison Officer and includes responsibility for:

- Raising the profile of counter fraud initiatives and publicity
- Ensuring recommendations from investigation reports by NHSScotland Counter Fraud Services (CFS) are implemented
- Monitor implementation of CFS recommendations and ensure compliance with them
- Set clear guidelines and measures for monitoring the effectiveness of implementation.

15.4 Remedial action

15.4.1 As with all categories of loss, once the circumstances of a case are known the Finance Director will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

15.5 Reporting to the SGHSCD

15.5.1 Under Enhanced Reporting of NHS Fraud & Attempted Fraud CEL (2010)¹⁰ an annual return SFR18 must be completed, as part of the annual account process, to report all cases of Fraud to the SGHSCD. There may be occasions where the nature or scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases, the SGHSCD must be notified of the main circumstance of the case at the same time as an approach is made to the CFS. However all significant or unusual incidents involving patients' funds or endowments should be reported to the SGHSCD.

15.6 Responses to Press Enquiries

15.6.1 Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

15.7 Counter Fraud Services (CFS) – Access to Data

15.7.1 CFS work closely with the Board and may at times require access to evidence relating to ongoing investigations. Scottish Government Health & Social Care Directorate endorse that Boards should support the important role played by CFS and that any CFS staff acting on the Finance Director's behalf should be allowed access to the following:

- All records, documents and correspondence relating to relevant transactions
- At all reasonable times, access to any premises or land of The State Hospital
- The production or identification by any employee of the Board, cash, stores or other property under the employee's control

16 PATIENTS' PROPERTY

- 16.1.1 The Board has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients.
- 16.1.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that the Board will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.
- 16.1.3 The Director of Security Estates and Resilience must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.
- 16.1.4 Where SGHSCD instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Finance Director.
- 16.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained. Any payment by the Hospital towards funeral expenses should be approved by the Finance Director.
- 16.1.6 Staff should be informed, on appointment, formally in writing by the Human Resources Director and by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 16.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.
- 16.1.8 The Finance Director shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Health Board Accounts Manual. This abstract shall be audited independently and presented to the Audit and Risk Committee annually.
- 16.1.9 In general staff are not allowed to receive benefit from any patient's Will. If staff become aware of an intention to include themselves in a Will, staff should discourage such action. This should be reported to the appropriate manager. Anyone receiving a bequest should report this to their line manager to determine further action. Except in cases of the direst emergency, staff should not be involved in witnessing or otherwise in the making of a patient's Will. Any reference of such matters by a patient to a member of staff should immediately be communicated to Advocacy or the Board management, who may arrange for a local solicitor's services to be made available to the patient, if that is wished.
- 16.1.10 In order to comply with the Gambling Act 2005, patients are not allowed to gamble or place bets. Clinical staff should therefore not approve any requests from patients to withdraw funds for this purpose.

17 RETENTION OF DOCUMENTS

- 17.1.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in SHM 58/60, NHS MEL (1993)152 “Guidance for the Retention and Destruction of Health Records” and HDL (2006) 28 “The Management, Retention and Disposal of Administrative Records”, The Scottish Government records management: NHS code of practice (Scotland) version 2.1: 11 January 2012.
- 17.1.2 The documents held in archives shall be capable of retrieval by authorised persons.
- 17.1.3 Documents held under the above guidance shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

18 STANDARDS OF BUSINESS CONDUCT

18.1 General Responsibility

18.1.1 It shall be the responsibility of the Chief Executive to:

- Ensure that the Scottish Government Health and Social Care Directorate guidelines on standards of business conduct for NHS staff (MEL (1994) 48) are brought to the attention of all staff, and effectively implemented
- Develop local policies and the processes to implement them, in consultation with staff and local staff representatives
- Ensure that such policies are kept up to date.

18.1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000 provides a code of conduct for members of The State Hospitals Board for Scotland. This code was incorporated into Board Standing Orders in May 2003. The principles that apply to gifts and hospitality set out in Standing Orders (Section 3) apply equally to all staff.

18.2 Acceptance of Gifts and Hospitality

18.2.1 The acceptance of gifts, hospitality or consideration of any kind from contractors and other suppliers of goods or services as an inducement or reward is not permitted under the Corruption Acts 1906 and 1916. In the event of a contractor or other supplier of goods or services making such an offer to any officer, either for their personal benefit or the “benefit” of the Board, the guidance given in HSG(93)5 and NHS Circular HDL (2003) 62 (or subsequent guidance issued by the Scottish Government Health and Social Care Department) must be followed. Initially, the matter must be reported to an individual’s line manager, or the relevant Director. Acceptance, or refusal, of gifts or hospitality must be entered in a Register of Hospitality and Interests, which will be maintained by the Finance Director. The register will also record details of hospitality provided by the Board’s employees:

- a) Articles of a low intrinsic value, such as business diaries or calendars, need not be refused
- b) Care should also be taken in accepting hospitality such as lunches and dinners, corporate hospitality events etc. All such offers should be reported to the officers line manager before accepting.
- c) Visits at suppliers expense to inspect equipment etc should not be undertaken without the prior approval of the Chief Executive and in the case of the Chief Executive by the prior approval of the Chairman. Costs associated with such visits will be borne by The State Hospital.
- d) If officers are involved in the acquisition of goods and services they should adhere to the ethical code of the Institute of Purchasing and Supply.
- e) Officers should ensure that the acceptance of commercial sponsorship will not influence or jeopardise purchasing decisions.

18.3 Private Transactions

18.3.1 Where offers of goods or services do not involve inducement or reward, employees should still not accept gifts from commercial sources other than inexpensive articles such as calendars or diaries. If any such gifts should arrive unsolicited, the advice of the Finance Director should be sought.

18.4 Declaration of Interest

18.4.1 Employees having official dealings with contractors and other suppliers of goods or services should avoid transacting any kind of private business with them by means other than normal commercial channels. No favour or preference as regards price or otherwise which is not generally available should be sought or accepted.

- 18.4.2 In accordance with Standing Order 5, the Chief Executive shall be advised of declared pecuniary interests of Directors or senior staff for recording in the Register of Hospitality and Interests.
- 18.4.3 The Finance Director is responsible for putting in place arrangements for staff to declare interests. In accordance with Data Protection principles, access is strictly controlled on a need to know basis. The only department likely to be passed this information would be the Procurement Department where there may be concern about the possibility of entering into contracts with organisations which could conflict with registered interests.

Annex 1 Minimum Financial Controls

(extract from guidance on preparation of Statement of Internal Control March 2010)

Corporate Governance	
The Control Environment	
Public Finance & Accountability (Scotland) Act 2000 HDL(2003)11	Code of Corporate Governance
SSI(2001)301/2 MEL(1994)80	Standing Orders
MEL(1994)80, Annex 4 MEL(1992)35	Scheme of Reservation and Delegation
Appointed Officer Memorandum SSI(2001) 301/2	Accountable Officer Responsibilities
MEL(1994)80, MEL(1996)42 HDL(2002)25, SGHD Audit Committee Handbook	Audit and Risk Committee
HDL(2002)11, MEL(1996)42	Internal Audit function
Section 2 of the National Health Service Reform (Scotland) Act 2004 HDL(2002)11	Structures of assurance including CHPS
The Community Care (Joint Working etc.) (Scotland) Regulations 2002 CCD5/2005 CCD11/2002 Governance for Joint Services (Paper by Audit Scotland, Scottish Government & COSLA)	Partnerships including Joint Futures
Identification and Evaluation of Risks and Objectives	
HDL(2006)12 HDL(2004)46	Local Development Plan and regional planning
MEL(1994)15, MEL(1999)14, MEL(1994)80	Risk Management
Control Processes	
	Compliance with laws and regulations

Monitoring and Corrective Action	
MEL(1994)80, Annex 5	Performance reporting
MEL(1994)80, Annex 9	Policies, procedures and control frameworks
Best Value in Public Services – Secondary Guidance to Accountable Officers	Best Value
Clinical Governance	
MEL(1998)75, MEL(1998)29, MEL(2000)29, HDL(2005)41	Clinical Governance Committee
HIS Standards	Health Improvement Scotland Reports
Staff Governance	
HDL(2004)39, HDL(2005)52 Staff Governance Standard	Staff Governance Committee
HDL(2006)54, HDL(2006)23 HDL(2002)64, MEL(1994)80, Annex 1	Remuneration Committee
KSF/Agenda for Change guidance	Performance management and development
Financial Governance	
SI(1994)No. 468	Financial reporting
MEL(1994)80 NHS 1974(GEN)88	Standing Financial Instructions
MEL(1994)48 Standards Commission	Standards of Business Conduct Model Code of Conduct
HDL(2005)5 MEL(1994)48 RIPSA CEL11(2013)	Fraud Theft & Corruption Policy and Response Plan
NHS 1974(GEN)88	Budgetary control system
SI(94) No 468, MEL(1994)80, Annex 9 HDL(2001)49	Financial Procedures
MEL(1992)35 &59 ,MEL(1998)9	Acquisition, use, disposal and safeguarding of assets

MEL(1992)18 HDL(2002)87, MEL(1996)48, SCIM	Capital investment control and project management
MEL(1992)8 MEL(1992)9	Property transactions procedures Delegation of authority: land transactions
Annual Accounts Manual Capital Accounting Manual SPFM	Financial accounting and annual accounts presentation Capital accounting policy and guidance Financial policies and guidance for Scottish central government bodies
Schedule 6, part 11, section 6(1) 1990 Health Act Accountable Officer Memorandum	Arrangements to ensure resources are used effectively, efficiently and economically
Scottish Government IFRS Technical Application Notes	Application of International Financial Reporting Standards from 2009/10 and the International Financial Reporting Manual issued by HM Treasury
Health Workforce & Performance Directorate Guidance 13 March 2015	Settlement Agreements
Information Governance	
MEL(1994)64 HDL(2005)46 NHSScotland eHealth Strategy Board guidance	IM&T strategy
HDL(2006)41 MEL(1992)14 MEL(1992)45 NHS Information System Security Manual issued under MEL(1994)75	Information Security Policy
NHS Scotland Information Governance Standards	Information Governance Toolkit and annual improvement plan

THE STATE HOSPITALS BOARD FOR SCOTLAND
SCHEME OF DELEGATION
 VERSION 20 – MARCH 2026

Version Control Log

Version	Date	Description
1	July 2005	Approved By Board
2	May 2006	Annual Review presented to Audit Committee.
2.1	5 June 2006	Approved by the Board on 22 June 06.
3.0	11 June 2007	Approved by the Board on 21 June 2007.
3.1	24 April 2008	Approved by the Board on 19 June 2008.
4.0	30 April 2009	Presented to Audit Committee on 30 April 2009. Detailed Scheme – No change Financial limits 13.6 – Constraint text “subject to appointment of bankers by Board” removed 14.3 (d) – “Annually” added to Virement of Budget “per event over £25,000 and up to £100,000” Several instances referring to SEHD updated to SGHD.
4.1	16 July 2009	Approved by the Board 18 June 2009
4.2	24 September 2009	Changed to reflect portfolio changes. Approved by Audit Committee 24 September 2009.
4.3	April 11	Changes proposed to board
	June 11	Changes approved by the board
4.4	April 12	Changes approved by the board
5	April 13	Changes to SFI references to agree to SFI’s Approved by Audit Committee on 25 April 2013
5.1	April 13	Approved by Board 2 May 2013
6	April 14	Changes to SO references to agree to SO’s. Changes to responsibilities to reflect portfolio changes and changes in staff. Financial limits amended to reflect limits in Pecos system 14.8 a) Capital value changed from £1.800 to £2,400 14.8 b) eHealth capital value added – value up to £4,000 and value up to £24,000 Approved by Audit Committee 24 April 2014. Approved by Board 26 June 2014.
7	April 15	Amended PFPI to Equality & Involvement Added Achievement of savings to 14.3 Management of Budgets Changes to 16.1.3 re change in responsibility of patients’ property. Approved by Audit Committee 2 April 2015 after changes to reflect that Remuneration Committee is no longer a sub committee.
8	March 16	Changes to responsibilities to reflect portfolio changes re L&D PO approval 14.7 – added in Procurement Team Leader Asset disposals 14.10 – removed Security Director limit up to £10k and replaced with Finance Director. Added 1uthorized deputy.
8.1	June 16	Financial limit for waiver of tenders 14.9 increased from £3k to £5k. Approved by Audit Committee and Board 23 June 2016.

Version	Date	Description
9	March 17	Changed Nursing Director to Director of Nursing & AHP and removed reference to General Manager. Approved by Audit Committee 23 March 2017 Approved by Board 4 May 2017
10	March 18	Section 3 & 13.5 – change financial monitoring forms to Financial Performance Returns. Clinical Effectiveness Strategy 6.2 replaced with Quality Assurance and Improvement Strategy. IM&T Security 11.8 – change title of 2uthorized deputy to Information Governance and Data Security Officer. Approved by Audit Committee 5 April 2018
11	June 18	Section 14.7 – Pay Revenue Expenditure – Requisitioning / Ordering of Goods and Services 14.7c – change to >£15k - <£20k 14.7d – change to >£10k - <£15k 14.7e – change to >£5k - <£10k 14.7f – change to >£1k - <£5k Approved by Audit Committee 28 June 2018
12	March, May 2019	Sections 3.1, 7.2 – changed title from Involvement and Equality Lead to Person Centred Improvement Lead Section 8.1 – corrected delegated authority from Director of Nursing and AHPs to Medical Director Approved by Audit Committee 28 March 2019 Approved by Board 20 June 2019
13	March 2020	Amended for updated job titles. 14.8 d) inclusion of Programme Director approval levels for contract variations. Approved by Audit Committee 26 March 2020 Approved by Board 18 June 2020
14	December 2020	Amended approvals for clarity re batch processing and BACS
15	March 2021	Amended for updated job titles. Amended terminology re Remobilisation Plan (formerly Annual Operating Plan) Allocation of Risk responsibility to Security Directorate (section 5.2) Approved by Audit Committee 25 March 2021 Approved by Board 17 June 2021
16	March 2022	Amended sections 14.7, 14.9 for changes to procurement job titles and updated tender levels to comply with current legislation in line with SG Procurement Journey Process. Approved by Audit Committee 17 March 2022 Approved by Board 23 June 2022
17	April 2023	Amended section 14.9 to clarify inclusion of SLAs Removed historic reference to sealing of documents Approved by Audit Committee 6 April 2023 Approved by Board 27 April 2023
18	April 2024	Insertion of new clause 14.1 re approval of expenditure in excess of SG annual allocation Updated Director titles (Nursing & Operations, Workforce, Security Estates and Resilience) Approved by Audit and Risk Committee 21 March 2024 Approved by Board 25 April 2024

Version	Date	Description
19	March 2025	Approved by Audit and Risk Committee 27 March 2025 Approved by Board 24 April 2025
20	March 2026	Amended committee titles where updates required Corporate Governance para 2.1; Planning & Performance paras 4.2, 4.3; Clinical Governance paras 6.4, 6.5 delegations updated Approved by Audit and Risk Committee 19 March 2026 For approval by the Board 16 April 2026

1. DELEGATION OF POWERS

1.1 Delegation to Committees

Under Standing Order (SO) B20, the Board may determine that certain of its powers shall be exercised by committees. Under SO D27 each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board) as the Board shall decide. In accordance with SO D28d committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

Under the SO D27c the committees established by the Board are:

Clinical Governance Committee
Staff Governance Committee
Audit and Risk Committee
Remuneration Committee

2. SCHEME OF DELEGATION TO OFFICERS

2.1 Role of the Chief Executive

All powers to the Board which have not been retained as reserved by the Board or delegated to a committee or sub-committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to other Directors and Officers. This scheme will be reviewed annually in March of each year.

The Chief Executive is accountable to the Board and as Accountable Officer is also accountable to the Principal Accountable Officer of the NHS in Scotland and the Scottish Parliament for ensuring that the Board meets its obligation to perform its functions within available financial resources.

The Chief Executive shall have overall executive responsibility for the Hospital's activities and shall be responsible to the Board for ensuring that its financial obligations and targets are met and shall have overall responsibility for the Board's system of internal financial control.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accountable Officer the Chief Executive is accountable to the Principal Accountable Officer of the Scottish Government Health and Social Care Directorate (SGHSCD) for the funds entrusted to the Board.

2.2 Caution over the Use of Delegated Powers

Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a manner that in their judgement was likely to be a cause for public concern.

2.3 Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows the "top level" of delegation within the Board. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Board.

2.4 Absence of Directors and Officers to Whom Powers have been Delegated

In the absence of a Director or Officer to whom powers have been delegated those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent powers delegated to him/her shall be exercised in accordance with the Accountable Officer Memorandum.

Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive ("CE"), the Director of Finance and EHealth ("FD" / "Finance Director") and other Directors. These responsibilities are summarised below.

Certain matters need to be covered in the Scheme of Delegation that are not covered by SFIs or SOs as they do not specify the responsible Officer.

This Scheme of Delegation covers only matters delegated by the Board to Directors and certain other specific matters referred to in SFIs. Each Director is responsible for the delegation within their sphere of responsibility. They should produce a Scheme of Delegation covering their area of responsibility and in particular the Scheme of Delegation should include how their budget responsibility and procedures for approval of expenditure are delegated.

3. SCHEME OF DELEGATION ARISING FROM STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

SO Reference	Delegated to	Duties Delegated
1.6	CE	Maintenance of Register of Board Members Interests

SFI Reference	Delegated to	Duties Delegated
1.1.5	FD	Approval of all financial procedures.
1.3.9	CE	To ensure all employees and directors, present and future, are notified of and understand Standing Financial Instructions.
1.3.10	FD	Responsible for implementing the Board's financial policies and co-ordinating corrective action and ensuring detailed financial procedures and systems are prepared and documented.
1.3.10	FD	Maintaining an effective system of internal financial control
1.3.10	FD	Ensuring that sufficient records are maintained to show and explain the Board's transactions
1.3.14	All Directors and Employees	Ensuring that the form in which financial records are kept and the manner in which directors and employees discharge their duties is to the satisfaction of the Director of Finance and eHealth.
3.1.1	CE	Submit to the Board an annual strategic plan (currently "Annual Delivery Plan" - formerly "Remobilisation Plan" 2021-2023 and "Annual Operational Plan" to 2020) covering 3-year period.
3.1.2 & 3.1.3	FD	Submit budgets to Board and monitor performance against budget and strategic plan.
3.2	CE	Delegate management of budgets to budget holders.
3.3	FD	Devise and maintain systems of budgetary control.
3.3	FD	Deliver adequate training on an ongoing basis to budget holders to enable them to manage effectively.
3.4	CE	Identifying and implementing cost improvements and income generation initiatives.
3.6	CE	Ensuring that the required financial performance returns are submitted to the SGHSCD.
4	FD	Prepare annual accounts, financial returns and supporting papers
5.1	FD	Managing the Board's banking arrangements
6.1	FD	Designing, maintaining and ensuring compliance with income systems.
7.1	CE	Capital programme investment process, and scheme of delegation for capital investment management.
7.1.4	FD	Procedures for the regular reporting of expenditure and commitment, including reporting to the Board.

SFI Reference	Delegated to	Duties Delegated
7.1.9	FD	Procedures for financial management of capital investment.
7.2	CE	Maintenance of asset registers.
7.2.4	FD	Procedures for reconciling balances on ledgers to fixed asset registers.
7.3	CE	Overall responsibility for fixed assets.
7.3.2	FD	Asset control procedures.
8	CE	Agreeing service agreements for provision of patient services.
9.1	Workforce Director	Application of pay and expenses rates within arrangements approved by Remuneration Committee and Scottish Government circulars and guidance.
9.2	CE	Variation of funded establishment from annual budget.
9.3	CE	Delegation of authority to engage, re-engage, regrade employees, hire agency staff, or agree changes in remuneration.
9.4	Workforce Director	Contracts of employment.
9.5	HR Director	Pay and Payroll documentation.
9.6	FD	Processing of payroll.
9.7	Workforce Director / FD	Early retirement and redundancy policy and procedures.
9.8	Workforce Director	Removal expenses policy and procedures.
10.1.1	CE	Determine, and set out, level of delegation of non-pay expenditure to budget managers.
10.1.2 & 10.1.3	FD	Identify managers who are authorised to place requisitions including maximum levels and set out procedures on the seeking of professional advice
10.2	FD	Procedures for seeking advice on supply of goods and services.
10.2.3	FD	Prompt payment of accounts.
10.2.4	FD	Advise the Board regarding setting thresholds for quotations or tenders.
10.2.4	FD	Designing a system of verification for all non-pay amounts payable.
10.2.6	CE	Authorise who may use and be issued with official orders.
10.3.5	CE / FD	Dispensing with need for competitive tendering or quotations.
10.5	FD	Procedures for payment of grants to local authorities and voluntary organisations.
10.6	CE	Best value achieved for all services provided under contract or in-house.
11.1.1	CE	Identify person with overall responsibility for control for stores.
11.1.3	FD	Procedures and systems to regulate the stores.
11.1.7 & 11.1.8	FD	Stocktaking arrangements.
12.1.1	CE	Risk management programme including Health and Safety.

SFI Reference	Delegated to	Duties Delegated
12.1.4	FD	Insurance arrangements.
13.1.1	FD	Responsible for accuracy and security of computerised financial data.
13.1.2	FD	Development of new financial systems and amendments to existing systems.
13.1.4 & 13.1.5	FD	Contracts for computer services for financial applications
13.1.6	Associate MD	Procedures to comply with the Data Protection Act.
13.1.7	FD	Procedures to comply with the Freedom of Information Act.
14.2.1	FD	Developing and implementing Fraud, Theft and Irregularity Policy.
14.2.1	FD	Investigate fraud or other irregularity in consultation with Chief Internal Auditor and Counter Fraud Services.
14.3	FD	Arrangements to report on effectiveness of internal control.
14.3	FD	Arrangements for internal audit.
14.3	Chief Internal Auditor (CIA)	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
15.1	FD	Procedures for disposal of assets including condemnations.
15.1.4	Security Director	Procedures for disposal of land including compliance with Property Transactions Handbook.
15.2	FD	Maintain procedures for recording and accounting for losses and special payments; maintaining a register.
15.2.8	CE & FD	Approval of losses and authorisation of special payments within limits set by SGHSCD.
15.3	FD	Preparing a "Fraud Response Plan"
15.3.4	CE	Designating a Fraud Liaison Officer.
15.3	Fraud Liaison Officer	Notifying police, Counter Fraud Service, appropriate Director, appointed Auditor and Internal Audit in respect of theft.
15.3	Counter Fraud Services	Investigating instances of <i>prima facie</i> grounds for believing a criminal offence has been committed.
16.1.2	CE	Ensure patients or guardians informed of extent of Board's liability or responsibility for patients property brought into Health Service property.
16.1.3	Security Director	Provide detailed written instructions on collection, custody, investment, recording, safekeeping and disposal of patients' property.
16.1.5	FD	Approval of payment towards costs of funeral expenses.
16.1.6	Workforce Director	Advise staff on appointment of their responsibilities and duties in respect of the administration of patients' property.

SFI Reference	Delegated to	Duties Delegated
16.1.8	FD	Preparing an abstract of receipts and payments for patients' funds, for presentation to the Audit and Risk Committee annually; with independent audit.
17.1.1	CE	Retention of document procedures.
18.1	CE	Standards of Business Conduct policy.
18.2	FD	Maintain a Register of Gifts and Hospitality.
18.4	CE	Maintain Register of Board members interests
18.4	FD	Maintain a Register of staff members interests

THE STATE HOSPITALS BOARD FOR SCOTLAND SCHEME OF DELEGATION

1. Organisational Scope / Profile

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
1.1 Preparation and Maintenance of Service Directory	Chief Executive	Director of Nursing & Operations ("Director of Nursing")	N/A	CG & RM Standards

2. Corporate Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
2.1 Maintenance of Register of Board Member Interests	Chief Executive	Head of Corporate Governance	N/A	Standing Orders A4
2.2 Scheme of Delegation Responsibility for preparation and update of Scheme	Chief Executive	Director of Finance & eHealth ("Finance Director")	N/A	CG & RM standards, SG standards, Governance Statement
2.4 Distribution of all relevant new legislation, regulations, good practice and case law	Chief Executive	N/A	N/A	CG & RM standards

3. Communications

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
3.1 Preparation of Communications Strategy - Overall communications framework	Chief Executive	Head of Communications	N/A	-
3.1 Preparation of Communications Strategy - Internal (staff)	Chief Executive	Head of Communications	N/A	SG Standards
3.1 Preparation of Communications Strategy - External	Chief Executive	Head of Communications	N/A	CG & RM Standards
3.1 Preparation of Communications Strategy - Patients and Carers	Director of Nursing	Person Centred Improvement Lead	N/A	CG & RM Standards

4. Planning and Performance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
4.1 Preparation and Implementation of the Delivery Plan	Chief Executive	Finance Director	as per supporting Financial Plan	SGHSCD letter CG & RM standards
4.2 Preparation of Corporate Objectives, Targets, Measures	Chief Executive	Head of Corporate Governance (Objectives); Head of Corporate Planning, Performance & Quality (Targets, Measures)	as above	SGHSCD letter CG & RM standards
4.3 Performance management systems	Chief Executive	Head of Corporate Planning, Performance & Quality	N/A	CG & RM standards
4.4 Service Level Agreements with other Health Boards	Chief Executive	Finance Director	all	CG & RM standards
4.5 Partnership Agreements	Chief Executive	N/A	all	-

5. Risk Management

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
5.1 Preparation of Risk Management Strategy	Chief Executive	Director of Security, Estates and Resilience ("Security Director")	N/A	CG & RM standards Statement of Internal Control
5.2 Policies and Procedures - Risk Management	Security Director	Risk Manager	N/A	CG & RM standards
5.2 Policies and Procedures - Child Protection	Director of Nursing	N/A	N/A	-
5.2 Policies and Procedures - Prescribing	Associate Medical Director	N/A	N/A	HDL(2007)12 Safer management of controlled drugs - Accountable Officer status delegated to Associate Medical Director
5.2 Policies and Procedures - Health and Safety	Chief Executive	Security Director	N/A	HSG 65 (Health & Safety Executive) and associated regulations
5.3 Emergency and Continuity Planning	Security Director	N/A	N/A	CG & RM standards
5.4 Insurance Arrangements	Finance Director	Head of Procurement	N/A	SFI 12

6. Clinical Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
6.1 Clinical Governance Strategy	Medical Director	N/A	within existing resources	CG & RM standards
6.2 Quality Assurance and Improvement Strategy	Medical Director	N/A	within existing resources	CG & RM standards
6.3 Research Governance - Compliance with research governance standards	Associate Medical Director	N/A	N/A	CG & RM Standards Research Governance Standards
6.3 Research Governance - Approval of Research and Development Studies including associated clinical trials and indemnity agreements for commercial studies	Associate Medical Director	N/A	N/A	Research Governance Standards
6.4 Legal Claims - Clinical negligence (negotiated settlements)	Finance Director	Head of Corporate Governance	< £25k	Scottish Government approval is required for all claims in excess of £100,000
6.4 Legal Claims - Personal injury claims involving negligence where legal advice has been obtained and guidance applied	Finance Director	Head of Corporate Governance	< £25k	Scottish Government approval is required for all claims in excess of £100,000
6.4 Legal Claims - All other claims	Chief Executive	Finance Director	> £25k	Scottish Government approval is required for all claims in excess of £100,000
6.5 Complaints - Responding to complaints	Chief Executive	Deputy Chief Executive	N/A	Complaints guidance
6.5 Complaints - Maintenance of complaints procedures and reporting	Chief Executive	Head of Corporate Governance	N/A	Complaints guidance
6.6 Knowledge Services	Director of Nursing	N/A	within existing resources	CG & HIS standards

7. Equality & Involvement

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
7.1 Designated Director for Equality & Involvement	Director of Nursing	N/A	N/A	CG & RM standards Equality & Involvement Self-Assessment
7.2 Policies and Procedures - Equality/Diversity (Human Rights, Race, Disability, Gender, etc)	Director of Nursing	N/A	N/A	CG & RM standards Equality & Involvement Self-Assessment
7.2 Policies and Procedures - Advocacy	Director of Nursing	N/A	N/A	CG & RM standards Equality & Involvement Self-Assessment
7.2 Policies and Procedures - Carers	Director of Nursing	Person Centred Improvement Lead	N/A	CG & RM standards Equality & Involvement Self-Assessment
7.2 Policies and Procedures - Volunteering	Director of Nursing	Person Centred Improvement Lead	N/A	CG & RM standards Equality & Involvement Self-Assessment
7.2 Policies and Procedures - Spiritual and Pastoral Care	Director of Nursing	Person Centred Improvement Lead	N/A	CG & RM standards Equality & Involvement Self-Assessment
7.2 Policies and Procedures - Patient and Carer Information and Communications	Director of Nursing	Person Centred Improvement Lead	N/A	CG & RM standards Equality & Involvement Self-Assessment

8. Access, transfer, referral, discharge

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
8.1 Monitoring of Waiting Times - Psychological Therapies	Medical Director	N/A	N/A	Delivery Plan
8.1 Monitoring of Waiting Times - Patient Activity and Recreational Services	Director of Nursing	N/A	N/A	Delivery Plan
8.2 Public Information on access to services	Director of Nursing	N/A	N/A	CG & RM Standards
8.3 Access Policy	Medical Director	N/A	N/A	CG & RM Standards
8.4 Discharge Strategy and Policy	Medical Director	Associate Medical Director	N/A	CG & RM Standards
8.5 Clinical Supervision Policy	Medical Director & Director of Nursing	N/A	N/A	CG & RM Standards
8.6 Consent Policy	Medical Director	N/A	N/A	CG & RM Standards

9. Healthcare Associated Infection

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
9.1 Compliance and adherence to national standards in healthcare acquired infection	Director of Nursing	N/A	Within available resources	Infection Control Standards SGHSCD guidance
9.2 Compliance and adherence to national standards in decontamination	Security Director	N/A	N/A	SGHSCD guidance
9.2 Compliance and adherence to national standards in cleaning	Security Director	N/A	N/A	SGHSCD guidance

10. Health Promotion and Education

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
10.1 Health Education and Health Promotion Activities	Director of Nursing	N/A	as per financial plan	CG & RM Standards
10.2 Public Health Information dissemination	Director of Nursing	N/A	N/A	CG & RM Standards

11. Information Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
11.1 Information Management Systems & Strategy	Finance Director	Head of eHealth	within programme plan	CG & RM Standards National eHealth Strategy
11.2 Clinical Responsibility for eHealth Strategy	Medical Director	Associate Medical Director	N/A	CG & RM Standards
11.3 Information Governance Framework	Finance Director	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.4 Data Protection Act - patient related data	Caldicott Guardian	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.4 Data Protection Act - staff related data	Director of Workforce	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.5 Freedom of Information Act	Finance Director	Head of eHealth	N/A	CG & RM Standards Information Governance Standards
11.6 Caldicott Guardian	Medical Director	Associate Medical Director	N/A	CG & RM Standards Information Governance Standards
11.7 Records Management - clinical records	Caldicott Guardian	Health Records Manager	N/A	CG & RM Standards
11.7 Records Management - non clinical records	Finance Director	Health Records Manager	N/A	Information Governance Standards

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
11.8 Information Management & Technology Security	Finance Director	eHealth Security Officer	N/A	CG & RM Standards Information Governance Standards
11.9 Data Quality	Finance Director	Health Records Manager	N/A	CG & RM Standards Information Governance Standards

12. Staff Governance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.1 Staff Governance Standards - Implementation of Staff Governance Standards action plan	Director of Workforce	N/A	N/A	Staff Governance Standards
12.1 Staff Governance Standards - HR policies and procedures	Director of Workforce	N/A	Within existing resources	PIN guidelines
12.2 Pay Modernisation Benefits Realisation Plans	Director of Workforce	N/A	N/A	SGHSCD guidance
12.3 Workforce Planning	Director of Workforce	N/A	N/A	GHSCD guidance
12.4 Contracts of employment	Director of Workforce	N/A	N/A	Staff Governance Standards PIN guidelines
12.5 Systems for Professional registration and CPD	Medical Director & Director of Nursing	N/A	N/A	CG & RM Standards
12.6 Learning and Development Plans	Director of Workforce	N/A	N/A	Staff Governance Standards Development Plan
12.7 Whistleblowing Policy	Director of Workforce	N/A	N/A	PIN guidelines Counter Fraud Service Partnership Agreement
12.8 Disciplinary Action and Appeal a) Decision to dismiss	Any Director in consultation with Director of Workforce	N/A	N/A	-

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.8 Disciplinary Action and Appeal b) Appeal against disciplinary action short of dismissal	Manager of Disciplinary decision maker	N/A	N/A	Subject to no involvement in disciplinary action
12.8 Disciplinary Action and Appeal c) Appeal against disciplinary action short of dismissal (action taken by Director)	Chief Executive	N/A	N/A	-
12.8 Disciplinary Action and Appeal d) Appeal against disciplinary action short of dismissal (action taken by Chief Executive)	Staff Governance Committee	N/A	N/A	-
12.8 Disciplinary Action and Appeal e) Appeal against dismissal	Chief Executive	N/A	N/A	-
12.8 Disciplinary Action and Appeal f) Appeal against disciplinary action in respect of Directors	Remuneration Committee	N/A	N/A	-
12.8 Disciplinary Action and Appeal g) Appeal against disciplinary action in respect of the Chief Executive	Full Board or special Committee with delegated authority	N/A	N/A	Subject to members not having been involved in disciplinary action
12.9 Senior Employees Remuneration Remuneration and performance of Directors and Senior Managers	Remuneration Committee	N/A	N/A	SGHSCD guidance

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
12.8 Disciplinary Action and Appeal a) Decision to dismiss	Any Director in consultation with Director of Workforce	N/A	N/A	-
12.8 Disciplinary Action and Appeal b) Appeal against disciplinary action short of dismissal	Manager of Disciplinary decision maker	N/A	N/A	Subject to no involvement in disciplinary action
12.8 Disciplinary Action and Appeal c) Appeal against disciplinary action short of dismissal (action taken by Director)	Chief Executive	N/A	N/A	-
12.8 Disciplinary Action and Appeal d) Appeal against disciplinary action short of dismissal (action taken by Chief Executive)	Staff Governance Committee	N/A	N/A	-
12.8 Disciplinary Action and Appeal e) Appeal against dismissal	Chief Executive	N/A	N/A	-
12.8 Disciplinary Action and Appeal f) Appeal against disciplinary action in respect of Directors	Remuneration Committee	N/A	N/A	-
12.8 Disciplinary Action and Appeal g) Appeal against disciplinary action in respect of the Chief Executive	Full Board or special Committee with delegated authority	N/A	N/A	Subject to members not having been involved in disciplinary action
12.9 Senior Employees Remuneration Remuneration and performance of Directors and Senior Managers	Remuneration Committee	N/A	N/A	SGHSCD guidance

13. Financial controls (subject to compliance with Standing Orders and Standing Financial Instructions)

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
13.1 System for funding decisions and business planning	Finance Director	N/A	N/A	-
13.2 Preparation of Financial Plans	Finance Director	Deputy Director of Finance	Allocation Letter	-
13.3 Preparation of budgets	Finance Director	Deputy Director of Finance	Per Financial Plan	-
13.4 Financial Systems and Operating Procedures	Finance Director	Deputy Director of Finance	N/A	-
13.5 Financial Performance Reporting System	Finance Director	Deputy Director of Finance	N/A	-
13.6 Maintenance / Operation of Bank Accounts	Finance Director	Deputy Director of Finance	N/A	-
13.7 Annual Accounts signatories	Chairperson, Chief Executive, Finance Director	N/A	N/A	In accordance with Scottish Accounts Manual
13.8 Audit Certificate	Appointed Auditors	N/A	N/A	In accordance with Scottish Accounts Manual
13.9 Systems for administration of patients' funds	Finance Director	Deputy Director of Finance	N/A	-
13.10 Fraud, Theft and Irregularity Policy	Finance Director	Fraud Liaison Officer	N/A	-

14. Financial limits (subject to compliance with Standing Orders and Standing Financial Instructions)

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.1 Authority to commit expenditure in excess of SG annual budget allocation	Board	Chief Executive	-	-
14.2 Authority to commit expenditure for which no provision has been made in approved plans/ budgets	Chief Executive Finance Director	Finance Director	£100k £25k	-
14.3 Virement of Budget within approved Resource Limit for items where no provision has been made in approved plans/ budgets	Chief Executive	Finance Director	£100k	-
14.4 Management of Budgets Responsibility for keeping expenditure within budgets a) at individual budget level (pay and non-pay)	Nominated budget-holders	Named Deputies	Budget notified	-
14.4 Management of Budgets Responsibility for keeping expenditure within budgets b) at service level	Directors	Named Deputies	Budget notified	-
14.4 Management of Budgets Responsibility for keeping expenditure within budgets c) for reserves and contingencies	Finance Director	Dep'y Director of Finance	-	-
14.4 Management of Budgets Responsibility for keeping expenditure within budgets d) achievement of savings	Directors, Chief Executive	Named Deputies	Savings notified	-

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.4 Management of Budgets Responsibility for keeping expenditure within budgets e) Virement of Budget between Directors - per event up to £25,000	Directors	Named Deputies	< £25k	Subject to maximum virement limit of Chief Executive
14.4 Management of Budgets Responsibility for keeping expenditure within budgets e) Virement of Budget between Directors - per event over £25,000 and up to £100,000 annually	Chief Executive	Finance Director	> £25k < £100k	Subject to maximum virement limit of Chief Executive
14.4 Management of Budgets Responsibility for keeping expenditure within budgets f) Virement of Budget between Directors - non recurring	Finance Director	N/A	< £100k	Subject to maximum virement limit of Chief Executive
14.4 Management of Budgets Responsibility for keeping expenditure within budgets f) Virement of Budget between Directors - recurring	Chief Executive	N/A	< £100k	Subject to maximum virement limit of Chief Executive
14.5 Engagement of staff not on establishment All staff (i.e. bank/agency/locums) a) where aggregate commitment in any one year is less than £5,000	Directors	Finance Director	< £5k	Subject to maximum virement limit of Chief Executive
14.5 Engagement of staff not on establishment All staff (i.e. bank/agency/locums) b) where aggregate commitment in any one year is more than £5,000 but less than £25,000	Finance Director	Chief Executive	> £5k < £25k	Subject to maximum virement limit of Chief Executive
14.5 Engagement of staff not on establishment All staff (i.e. bank/agency/locums) c) where aggregate commitment in any one year is more than £25,000	Chief Executive	N/A	> £25k	Subject to maximum virement limit of Chief Executive

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.6 Setting of Fees and Charges	Finance Director	N/A	N/A	-
14.7 Agreement/ Licences a) Granting and termination of leases with annual rent less than £25,000	Finance Director	N/A	< £25k	-
14.7 Agreement/ Licences b) Granting and termination of leases with annual rent more than £25,000	CE and FD jointly	N/A	> £25k	-
14.7 Agreement/ Licences c) Preparation & signature of all tenancy licences for all staff subject to Board policy on accommodation	Finance Director	N/A	N/A	-
14.7 Agreement/ Licences d) Extensions to existing leases	Chief Executive and Finance Director jointly	N/A	N/A	-
14.7 Agreement/ Licences e) Letting of premises to outside organisations	Chief Executive	N/A	N/A	-
14.7 Agreement/ Licences f) Approval of rent based on professional assessment	Finance Director	N/A	N/A	-
14.8 Non-Pay Revenue Expenditure – Requisitioning / Ordering of Goods and Services a) Value over £100,000	Board	N/A	>£100k	Subject to containment within overall Board resources

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.8 Non-Pay Revenue Expenditure – Requisitioning / Ordering of Goods and Services b) Annual Value over £20,000 and up to £100,000	Chief Executive and Head of Procurement (PO only)	Finance Director, Deputy Chief Exec, Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)	>£20k < £100k	Subject to containment within overall Board resources
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services c) Annual Value over £15,000 and up to £20,000	Finance Director and Head of Procurement (PO only)	Chief Exec, Deputy Chief Exec, Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)	>£15k < £20k	Subject to containment within overall Board resources
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services d) Annual Value over £10,000 and up to £15,000	Budget Director	Finance Director, Chief Exec, Deputy Chief Exec	>£10k < £15k	Subject to containment within overall delegated funds for Directorate
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services d) Annual Value over £10,000 and up to £15,000	Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance, Finance Director (PO only)	>£10k < £15k	Subject to containment within overall delegated funds for Directorate
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services e) Annual Value over £5,000 and up to £10,000	Budget Manager	Budget Director	>£5k < £10k	Subject to containment within overall delegated funds for budget manager
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services e) Annual Value over £5,000 and up to £10,000	Head of Procurement (PO only)	Procurement Team Leader, Deputy Director of Finance (PO only)	>£5k < £10k	Subject to containment within overall delegated funds for Directorate
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services f) Annual Value over £1,000 and up to £5,000	Budget holder	Budget Manager	>£1k < £5	Subject to containment within overall delegated funds for budget holder

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services f) Annual Value over £1,000 and up to £5,000	Head of Procurement (PO only)	Procurement Team Leader (PO only) and Deputy Director of Finance (PO only)	>£1k < £5	Subject to containment within overall delegated funds for Directorate
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services g) Annual Value up to £1,000	Budget holder	Budget Manager	< £1k	Subject to containment within overall delegated funds for budget holder
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services g) Annual Value up to £1,000	Head of Procurement (PO only)	Procurement Team Leader (PO only) and Deputy Director of Finance (PO only)	< £1k	Subject to containment within overall delegated funds for budget holder
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services h) Orders exceeding a 12-month period over £50,000 and up to £100,000	Chief Executive	Deputy Chief Exec, Finance Director	> £50k < £100k	Subject to containment within overall Board resources
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services i) Orders exceeding a 12-month period and up to £50,000	Finance Director	Chief Executive	< £50k	Subject to containment within overall Board resources
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services j) Subsequent variations to contract	Finance Director	Chief Executive	N/A	Subject to containment within delegated limits and within budget
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services k) Specific exceptions to above limits – Utilities – up to £25,000	Estates Manager	Estates Co-ordinator, Security Director	< £25k	Subject to containment within budget

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services k) Specific exceptions to above limits - Laundry - up to £5,000	Estates Manager	Estates Co-ordinator	< £25k	-
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services k) Specific exceptions to above limits - Decontamination – up to £3,000	Estates Manager	Estates Co-ordinator	< £25k	-
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services k) Specific exceptions to above limits - Shop Trading Account – up to £5,000	Designated budget holders	N/A	< £5k	Countersigned by Procurement Manager (PO only)
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services l) Consolidated orders up to £10,000	Head of Procurement	Procurement Team Leader	< £10k	Subject to individual items authorised as above
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services m) Invoice matching queries	Head of Procurement / Deputy Director of Finance	Senior Management Accountant	<£100 or 10% whichever is lower	Above this level re-authorisation by the budget holder is required
14.8 Non-Pay Revenue Expenditure - Requisitioning/ Ordering of Goods and Services n) Approval of removal expenses packages	Chief Executive	Deputy Chief Executive	<£8k	Taxable Threshold. In exceptional circumstances a higher level may be considered, reasons to be documented
14.9 Capital schemes a) Non-IM&T capital schemes - approval and authorisation to proceed -value over £ 2,000,000	Board and SGHSCD jointly	N/A	> £2.0m	HDL (2005) 16
14.9 Capital schemes a) Non-IM&T capital schemes - approval and authorisation to proceed - value between £ 500,000 and £ 2,000,000	Chief Executive and Board jointly	N/A	> £0.5m < £2.0m	Internal business case required for £ 1.0m

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.9 Capital schemes a) Non-IM&T capital schemes - approval and authorisation to proceed - value up to £ 500,000	Chief Executive	Deputy Chief Executive	< £0.5m	-
14.9 Capital schemes a) Non-IM&T capital schemes - approval and authorisation to proceed - value up to £ 10,000	Finance Director	N/A	<£0.01m	-
b) eHealth capital schemes - approval and authorisation to proceed -value over £ 1,000,000	Board and SGHSCD jointly	N/A	> £1.0m	HDL (2005) 16
b) eHealth capital schemes - approval and authorisation to proceed - value between £100,000 and £ 1,000,000	Chief Executive and Board jointly	N/A	> £0.1m < £1.0m	Internal business case required for £ 0.5m
b) eHealth capital schemes - approval and authorisation to proceed - value up to £100,000	Chief Executive	Deputy Chief Executive	< £0.1m	-
b) eHealth capital schemes - approval and authorisation to proceed - value up to £20,000	Finance Director	N/A	N/A	-
b) eHealth capital schemes - approval and authorisation to proceed - value up to £5,000	Head of eHealth	N/A	N/A	Subject to containment within approved budget
c) Selection of professional advisors	Chief Executive	N/A	N/A	Subject to containment within approved budget

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
d) Approval of variations to contract -value up to £ 100,000	Chief Executive	Deputy Chief Executive	> £25k < £100k	-
d) Approval of variations to contract - value up to £ 25,000 or 10% of approved expenditure of any scheme whichever is the lower	Security Director or Finance Director	N/A	< £25k	or 10% of approved spend whichever is lower
d) Approval of variations to contract - value up to £ 5,000 on up to 5 occasions between contract Project Board meetings	Programme Director	N/A	< £5k	or 10% of approved spend whichever is lower
d) Approval of variations to contract value up to £ 1,000 on up to 5 occasions between contract Project Board meetings	Deputy Programme Director	N/A	< £1k	or 10% of approved spend whichever is lower
14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures a) Quotations Three minimum quotations for goods/services for spend over £5,000 and up to £50,000	Head of Procurement	N/A	>£5k < £50k	Refer to Route 1 SG Procurement Journey Process
14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures b) Tenders Regulated tender process over £ £50,000 and up to £100,000	Finance Director	N/A	> £50k < £100k	Refer to Route 2 SG Procurement Journey Process
14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures b) Tenders Regulated tender process over £100,000	Chief Executive	N/A	>£100k	Refer to Route 3 SG Procurement Journey Process if value over £138,760 (incl. Vat)
14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures c) Waiving of quotations & tenders over £10,000	Chief Executive & Finance Director	N/A	N/A	-

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures d) Arrangements for opening tenders	Head of Procurement	N/A	N/A	All Tenders are now electronic uploaded to PCS or PCS-T
14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures e) Procurement Strategy Approval for Regulated Tenders Contract value up to £250,000	Director of Finance	N/A	N/A	Approval to proceed with tender process
14.10 Quotation, Tendering, Contract and Service Level Agreement Procedures e) Procurement Strategy Approval for Regulated Tenders Contract value up to £250,000 Contract value over £250,000	Chief Executive	N/A	N/A	Approval to proceed with tender process
14.11 Condemning & Disposal of Assets (excluding heritable property) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively - with current /estimated purchase price up to £50,000	Finance Director	Deputy Director of Finance	< £50k	-
14.11 Condemning & Disposal of Assets (excluding heritable property) Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively - with current/estimated purchase price over £50,000	Chief Executive	N/A	> £50k	-
14.12 Condemnations, Losses and Special Payments a) Compensation Payments made under legal obligation - ex gratia - over £100,000	Board	N/A	> £100k	Requires SGHSCD approval

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.12 Condemnations, Losses and Special Payments a) Compensation Payments made under legal obligation - ex gratia - between £25,000 and £100,000	Chief Executive	Deputy Chief Executive	>£25k < £100k	-
14.12 Condemnations, Losses and Special Payments a) Compensation Payments made under legal obligation - ex gratia - up to £25,000	Finance Director	N/A	< £25k	-
14.12 Condemnations, Losses and Special Payments b) Other ex-gratia payments - other payments - over £5,000	Board	N/A	> £ 5k	Requires SGHSCD approval
14.12 Condemnations, Losses and Special Payments b) Other ex-gratia payments - other payments - up to £5,000	Chief Executive	N/A	< £5k	-
14.12 Condemnations, Losses and Special Payments c) Stores/stock losses due to - theft, fraud, arson ; incidents of the service; or disclosed at check - over £20,000	Board	N/A	> £20k	Requires SGHSCD approval
14.12 Condemnations, Losses and Special Payments c) Stores/stock losses due to - theft, fraud, arson ; incidents of the service; or disclosed at check - up to £20,000	Finance Director & Chief Executive	N/A	< £20k	-
14.12 Condemnations, Losses and Special Payments - d) Routine stores write on / write off disclosed at check - up to £100	Deputy Director of Finance	N/A	< £100	-

Area of Responsibility / Duties Delegated	Delegated To	Authorised Deputy	Financial Value £'m	Constraints/Reference
14.12 Condemnations, Losses and Special Payments d) Routine stores write on / write off disclosed at check - over £100	Finance Director	N/A	> £100	-
14.12 Condemnations, Losses and Special Payments e) Losses of cash due to theft, fraud, overpayment and others - over £5,000	Board	N/A	> £5k	Requires SGHSCD approval
14.12 Condemnations, Losses and Special Payments e) Losses of cash due to theft, fraud, overpayment and others - up to £5,000	Finance Director & Chief Executive	N/A	< £5k	-
14.12 Condemnations, Losses and Special Payments f) Abandoned Claims - over £5,000	Board	N/A	> £5k	Requires SGHSCD approval
14.12 Condemnations, Losses and Special Payments f) Abandoned Claims - up to £5,000	Finance Director & Chief Executive	N/A	< £5k	-
14.12 Condemnations, Losses and Special Payments g) Damage to buildings - over £20,000	Board	N/A	> £20k	Requires SGHSCD approval
4.12 Condemnations, Losses and Special Payments g) Damage to buildings - up to £20,000	Finance Director & Chief Executive	N/A	< £20k	-

DELEGATION TO INDIVIDUAL OFFICERS TO BE APPROVED BY FINANCE DIRECTOR

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026

Agenda Reference No: Item No: 16b

Sponsoring Director: Chief Executive Officer

Author(s): Head of Corporate Governance

Title of Report: Board Standing Orders and Code of Conduct

Purpose of Report: For Decision

1 SITUATION

As part of the annual review of standing documentation, the Audit and Risk Committee reviewed the Board's Standing Orders as well as the Members' Code of Conduct at the meeting held on 19 March 2026.

2 BACKGROUND

The Audit and Risk Committee conducted this review on the basis the assessment outlined, so that it could then make a recommendation to the Board.

3 ASSESSMENT

The Board Standing Orders were fully updated in 2020 in line with NHS national guidance and prescribed formatting, and review has not highlighted any areas that require change. There are no further amendments proposed at a national level at this stage.

The Model Code of Conduct is based on the principles of Section 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000. The Code has been issued by Scottish Ministers, with the approval of the Scottish Parliament, as required by the Act. It is intended to set out the conduct expected of those who serve on Bords of public bodies in Scotland. The wording has been adopted directly and approved as the State Hospital's Code of Conduct, co-aligning with other public bodies including other NHS Boards. There are no proposed changes to the code at this point.

The Audit and Risk Committee agreed to the above, recommending that the Board provides its approval.

4 RECOMMENDATION

The Board is asked to approve the review of the Standing Orders and Members' Code of Conduct, on the basis of there being no requirement for change as outlined.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Ensures that the Board's standing orders and members' code of conduct are up to date in respect of regulatory guidance.
Corporate Objectives Please note which objective is linked to this paper	These are the standing orders and code of conduct for the business of the Board itself, which exist to ensure that the aims of the Corporate Objectives are both progressed and monitored, and assurance taken across the entire remit of the Board.
Workforce Implications	None identified as part of this report.
Financial Implications	None identified as part of this report.
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Required as part of annual review of standing documentation
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	No impacts identified
Equality Impact Assessment	No significant risks identified
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/a
Data Protection Impact Assessment (DPIA) See IG 16. 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. No privacy implications

STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF THE STATE HOSPITALS BOARD FOR SCOTLAND

1 General

- 1.1 These Standing Orders for regulation of the conduct and proceedings of **The State Hospitals Board for Scotland**, for the Board and its Committees, are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

The NHS Scotland Blueprint for Good Governance (issued through [DL 2019\) 02](#)) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (<https://learn.nes.nhs.scot/17367/board-development>)

- 1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.
- 1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.
- 1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.
- 1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

- 1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of The State Hospitals Board for Scotland. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This

individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

- 1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.
- 1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).
- 1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.
- 1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.
- 1.11 The Board's Board Secretary shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2 Chair

- 2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

- 3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. A member who is an employee of a Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.
- 3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.
- 3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason), the

Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the Interim Chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

- 4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates.
- 4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.
- 4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.
- 4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.
- 4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.
- 4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.
 - a. With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally, only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

- 4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

- 4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.
- 4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken. Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has withdrawn. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

- 5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.
- 5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.
- 5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.
- 5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

- 5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.
- 5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.
- 5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.
- 5.8 Paragraph 5.7 will not apply where a member's, or an associate of their's, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However, members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.
- 5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.
- 5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.
- 5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

- 5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

- 5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.
- 5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2. For Board meetings only, the Chair may propose within the notice of the meeting “items for approval” and “items for discussion”. The items for approval are not discussed at the meeting, but rather the members agree that the content and recommendations of the papers for such items are accepted, and that the minutes of the meeting should reflect this. The Board must approve the proposal as to which items should be in the “items for approval” section of the agenda. Any member (for any reason) may request that any item or items be removed from the “items for approval” section. If such a request is received, the Chair shall either move the item to the “items for discussion” section, or remove it from the agenda altogether.

Decision-Making

- 5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.
- 5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.
- 5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.
- 5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.
- 5.19 Where the Chair concludes that there is not a consensus on the Board’s position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.
- 5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.
- 5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

- 5.22 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board's Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

- a) Standing Orders
- b) The establishment and terms of reference of all its committees, and appointment of committee members
- c) Organisational Values
- d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
- e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)
- f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
- g) Risk Management Policy.
- h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
- i) Standing Financial Instructions and a Scheme of Delegation.
- j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly, the Board cannot publish the report of the external auditors of their annual accounts in this period.)
- k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the [Scottish Capital Investment Manual](#).

- l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
 - m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)
- 6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.
- 6.4 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

- 7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions
<http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx>
and the Scheme of Delegation
<http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx>
- 7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.
- 7.3 The Board and its officers must comply with the [NHS Scotland Property Transactions Handbook](#), and this is cross-referenced in the Scheme of Delegation.
- 7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

- 8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.
- 8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.
- 8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

- 9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish.
(<https://learn.nes.nhs.scot/17367/board-development>)
- 9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required and shall review the terms within 2 years of their approval if there has not been a review.
- 9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed
- 9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.
- 9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members includes some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However, if the committee elects to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.
- 9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.
- 9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of The State Hospitals Board for Scotland and is not to be counted when determining the committee's quorum.

MODEL CODE OF CONDUCT

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Section 1: Introduction To The Model Code Of Conduct

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the [Ethical Standards in Public Life etc. \(Scotland\) Act 2000 \(the “Act”\)](#).

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in [Section 2](#) and set out how the provisions of the Code should be interpreted and applied in practice.

My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body’s rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland (“Standards Commission”) and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

Enforcement

1.10 [Part 2 of the Act](#) sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at [Annex A](#).

Section 2: Key Principles Of The Model Code Of Conduct

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty

I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

Selflessness

I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity

I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity

I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship

I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

Openness

I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty

I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership

I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

Respect

I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

Section 3: General Conduct

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

- a) a one-off incident,
- b) part of a cumulative course of conduct; or
- c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

- a) my public body, its committees; and
- b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

Remuneration, Allowances and Expenses

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services (“gift or hospitality”) that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

- a) a minor item or token of modest intrinsic value offered on an infrequent basis;
- b) a gift being offered to my public body;
- c) hospitality which would reasonably be associated with my duties as a board member; or
- d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body’s Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the [Bribery Act 2010](#), which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of Public Body Resources

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

- a) imprudently (without thinking about the implications or consequences);
- b) unlawfully;
- c) for any political activities or matters relating to these; or
- d) improperly.

Dealing with my Public Body and Preferential Treatment

3.28 I will not use, or attempt to use, my position or influence as a board member to:

- a) improperly confer on or secure for myself, or others, an advantage;
- b) avoid a disadvantage for myself, or create a disadvantage for others or
- c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at [Section 5](#), I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

Section 4: Registration Of Interests

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

- a) employed;
- b) self-employed;
- c) the holder of an office;
- d) a director of an undertaking;
- e) a partner in a firm;
- f) appointed or nominated by my public body to another body; or
- g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, "Other Roles".

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph [6.7](#) of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.19 below) have made a contract with my public body:

- a) under which goods or services are to be provided, or works are to be executed; and
- b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body. I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.19 I have a registerable interest where:

- a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
- b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.20 I understand the requirements of paragraphs [3.13 to 3.21](#) regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non-Financial Interests

4.21 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Category Nine: Close Family Members

4.22 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

Section 5: Declaration Of Interests

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body, unless:

- a) The matter being considered by my public body is quasi-judicial or regulatory; or
- b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

Section 6: Lobbying And Access

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies.

I must distinguish between:

- a) any role I have in dealing with enquiries from the public;
- b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
- c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the [Lobbying \(Scotland\) Act 2016](#).

6.8 I will not accept any paid work:

- a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.
- b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

Annex A: Breaches Of The Code

Introduction

1. [The Ethical Standards in Public Life etc. \(Scotland\) Act 2000](#) (“the Act”) provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.
2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.
3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the [Standards Commission for Scotland](#) (“Standards Commission”) and the post of [Commissioner for Ethical Standards in Public Life in Scotland](#) (“ESC”).
4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body’s Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.
5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.
7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

- Do nothing;
 - Direct the ESC to carry out further investigations; or
 - Hold a Hearing.
9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:
- **Censure:** A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
 - **Suspension:** This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
 - **Disqualification:** Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:
- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
 - That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21

and the procedures it will follow in doing so, should any such a report be received from the ESC can be found [here](#).

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

Annex B: Definitions

"Bullying" is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

"Code" is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

"Confidential Information" includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

"Employee" includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body's premises.

"Gifts" a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

"Harassment" is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

“Hospitality” includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

“Relevant Date” Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the 5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

“Public body” means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

“Remuneration” includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

“Securities” a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

“Undertaking” means:

- a) a body corporate or partnership; or
- b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	16 April 2026
Agenda Reference No:	Item No: 17
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Communications
Title of Report:	Communications Annual Report 2026/27
Purpose of Report:	For Noting

1 SITUATION

The Head of Communications is required to produce an annual report covering Communications Service performance from 1 April 2025 to 31 March 2026, in line with the Communications Strategy 2025/30.

The Communications Annual Report 2025/26 provides the Board with assurance on the effectiveness, governance and delivery of internal and external communications activity across the reporting period)

2 BACKGROUND

Effective communication is critical to the Board's ability to meet its statutory duties, corporate objectives, and values, particularly within a complex, highly regulated and high-profile environment.

The Communications Service supports the organisation through a wide range of functions, including internal / external communications, media management, statutory reporting, digital communications, accessibility compliance, and stakeholder engagement.

The annual report is a key governance and assurance mechanism, enabling the Board to assess whether communications activity remains compliant, effective, well-governed, and aligned to organisational and national priorities.

3 ASSESSMENT

The Communications Service performed to a high and consistent standard throughout 2025/26, delivering all core communications functions and meeting all statutory, governance and quality requirements.

Despite operating with reduced staffing capacity for part of the year, the Service maintained delivery across all priority areas, supported the Board and Executive Team effectively, and managed risk appropriately. Capacity was restored in October 2025, enabling renewed focus on development, resilience, and future-proofing.

Key areas of assurance include:

- **Governance and compliance** - All relevant legislative and policy requirements were met, including accessibility, data protection, equality, and whistleblowing.
- **Internal communications and staff engagement** - Core internal channels continued to perform well and remain valued by staff. A formal review of the Board Bulletin confirmed it remains an effective mechanism for communicating Board business, with benchmarking demonstrating alignment with NHS Scotland practice.
- **External communications and Hospital profile** - External communications activity supported transparency, recruitment, and public confidence. Social media activity was substantial and purposeful, with strong engagement and clear evidence that people-focused, authentic content delivers the greatest impact.
- **Media management** - Media activity was managed effectively, with prompt responses to all enquiries, strengthened media lines for On-Call Directors, and clear escalation and governance arrangements in place.
- **Capacity, capability, and improvement** - Investment in accessibility expertise, digital skills and AI-enabled working improved efficiency, quality, and resilience. All Key Performance Indicators were met or appropriately closed, and Quality Assurance and Quality Improvement objectives were delivered or managed transparently where carried forward.

No significant concerns have been identified. Where activity was paused or deferred, this was due to known capacity pressures and was appropriately risk-assessed and managed.

4 RECOMMENDATION

The Board is asked to note the Communications Annual Report 2025/26 and the assurance it provides on the effectiveness, governance, and delivery of communications across the organisation.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	Communications activity supports the Communications Strategy 2025/30, the Annual Delivery Plan, and delivery of the Board's ambitions.
Corporate Objectives Please note which objective is linked to this paper	The Communications Service supports all four corporate objectives equally: Better Care, Better Health, Better Value and Better Workforce
Workforce Implications	Service delivery is dependent on maintaining a full Communications team establishment; capacity pressures during part of the year were managed with full staffing restored in October 2025.
Financial Implications	Communications activity was delivered within existing budgets. Staffing decisions supported financial sustainability while maintaining core service delivery, with no additional financial pressures identified.
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Sponsorship and governance route: Head of Communications and the Chief Executive.
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks were identified. Capacity pressures during part of the year were recognised and appropriately managed, with mitigating actions in place.
Assessment of Impact on Stakeholder Experience	Communications activity supports positive stakeholder experience through transparent, timely and accessible engagement.
Equality Impact Assessment	Communications activity is supported by existing Equality Impact Assessments, ensuring inclusive and accessible engagement across all communication channels.
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).	Communications activity supports the Fairer Scotland Duty by promoting inclusive, accessible, and transparent communication, helping to reduce barriers to understanding and engagement for all stakeholders
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).	3. There are privacy implications, full DPIA included Numerous DPIAs are in place to support communications activity. No Communications-originated reportable data protection breaches occurred during 2025/26

COMMUNICATIONS SERVICE ANNUAL REPORT 2025/26



ENABLING RESILIENCE AND GROWTH

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1 EXECUTIVE SUMMARY

This Annual Report provides assurance to the Board on the effectiveness, governance, and performance of the Communications Service during the period 1 April 2025 to 31 March 2026. Throughout the year, the Communications Service operated in a complex and highly regulated environment, supporting the Board, Executive Team, and services to meet statutory, governance and organisational objectives. All core communications functions were delivered in line with legislative requirements, corporate priorities, and the Communications Strategy 2025/30.

1.1 Key Achievements And Assurance

1.1.1 Governance and Compliance

Full compliance was achieved across all relevant communications-related legislation, including accessibility, data protection, and equality. The organisation successfully passed its website accessibility audit, with remaining remediation work completed in Q4 2025/26. No Communications-originated reportable data protection breaches occurred during the year.

1.1.2 Strategic and Corporate Contribution

Communications remained embedded in governance and planning activity, contributing to the Annual Delivery Plan, Medium-Term Plan, Board Development sessions and major organisational initiatives. The Service supported key workforce programmes, statutory reporting, crisis preparedness and national engagement, providing professional advice and assurance at all levels.

1.1.3 Internal Communications and Staff Engagement

Core internal channels remained effective and well-valued. Weekly and special staff bulletins were produced consistently, supported by targeted campaigns and publications across professional groups and services. A formal review of the Board Bulletin confirmed it remains an effective mechanism for communicating Board business, with no actions identified.

Benchmarking with other NHS Scotland Boards provided further assurance that current practice is appropriate and aligned with national norms.

1.1.4 External Communications and Public / Political Confidence

The Hospital's external communications activity supported transparency, recruitment, public / political confidence, and stakeholder understanding. Social media activity was substantial and purposeful, with 700–750 posts published during the year. Facebook performance demonstrated strong organic reach and engagement, achieving 2.18 million views and 12,000 interactions, with evidence showing that authentic, people-focused content delivers the greatest impact. Media activity was managed effectively, with clear escalation, governance, and improved media lines for On-Call Directors.

1.1.5 Capacity, Capability and Resilience

Despite operating with reduced staffing for part of the year, the Service maintained delivery across all core areas. Recruitment to the Communications Assistant post in October 2025 restored capacity and enabled renewed focus on development, innovation, and sustainability. Significant investment was made in accessibility expertise, digital capability, and Artificial Intelligence (AI)-enabled working, thus improving efficiency, quality, and resilience.

1.1.6 Quality Assurance and Continuous Improvement

All Key Performance Indicators were met or appropriately closed, and Quality Assurance and Quality Improvement objectives were progressed or delivered as planned. Where activity was paused or carried forward, this was clearly risk-assessed, documented, and managed. The maturity of processes, guidance and controls provides assurance that communications activity is well governed and consistently applied.

1.1.7 Looking Ahead

The Communications Service enters 2026/27 with restored capacity, a new Communications Strategy in place, and a clear focus on embedding accessibility, expanding audio-visual capability, supporting digital transformation, and continuing to strengthen organisational resilience. The Service remains well positioned to support the Board's strategic ambitions while maintaining high standards of governance, professionalism, and public trust.

2 CORE PURPOSE

Communication is at the heart of everything we do. Within the State Hospital, the core purpose relates to all aspects of communications both internally and externally, from consultancy / advice and guidance to the provision of electronic communications, audio-visual production including video, dealing with the media, social media, the production of corporate publications, and stakeholder engagement. Specifically, the Head of Communications acts as a communications link between the Hospital and stakeholders including staff, the local community, general public, professional bodies, and local and national government, and drives forward improvements in communication. This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change.

Given the nature and organisational arrangements of the Board, patients are uniquely viewed as internal communication stakeholders in addition to Non-Executive Directors, Volunteers, the Chaplaincy Team, Patients' Advocacy Service, and staff. Carers, the public and the media are included within external communication arrangements, which differs from the Communications function of other Boards. The State Hospital's public (patients) are with us for an average of 6.5 years, and some very much longer, and therefore are classed as internal stakeholders. The public are potential patients of territorial Boards and are viewed by them as external stakeholders. These Boards will therefore undertake direct engagement with their public in relation to health, wellbeing and services provided.

The two services predominately delivering internal and external communications within the State Hospital are the Communications Service and the Person Centred Improvement Team (PCIT). These two services work very closely together with the PCIT having specific responsibility for patient, carer, and volunteer communication. Combined key results areas include Stakeholder Communications (Internal and External including staff, patients, carers, and volunteers), Public Relations (Relationship Management), Crisis Management, Public Affairs (Media and Political), and Marketing Communications.

This annual report covers the work of the Communications Service from 1 April 2025 to 31 March 2026. Communication activity with patients, carers, and volunteers during 2025/26 is captured in the PCIT 12-month update reports. Additionally, stakeholder stories (presenting feedback from patients, carers, and volunteers directly to the Board) are a key feature of the Board's agenda.

Trust and confidence of our stakeholders can only be achieved through maintaining the highest levels of transparency. The work of the Communications Service in particular helps drive our public profile locally, nationally, and globally through different channels by communicating with all stakeholders in a timely, accurate and consistent fashion. This in turn generates confidence, which ultimately supports the Board's vision and corporate objectives.

Within Communications, we believe that our values (mirroring those of the State Hospital and NHS Scotland) and our ethical way of working form the bedrock of our culture, guiding how we work with one another and our stakeholders.

3 LEGAL AND POLICY CONTEXT FOR COMMUNICATIONS

Communications is delivered in line with the State Hospital's Communications Strategy 2025/30, which supports the Hospital to achieve its vision and strategic objectives, respond to crisis situations, and meet its legal obligations:

3.1 Data Protection and Privacy Legislation

- *UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018*: Governs handling of personal data, ensuring secure, lawful, and transparent processing in all communications involving patient or staff information.
- *Privacy and Electronic Communications Regulations (PECR)*: Regulates electronic marketing (emails, texts), confidentiality of communications, and the use of cookies.

3.2 Freedom of Information Legislation

- *Freedom of Information (Scotland) Act 2002*: Requires public bodies to respond to information requests, unless exemptions apply, supporting transparency in communications.

3.3 Equality and Non-Discrimination Legislation

- *Equality Act 2010*: Prohibits discrimination and promotes accessibility, ensuring inclusive communication for all protected groups.
- *Fairer Scotland Duty (2018)*: Obligates public bodies to consider socioeconomic inequality when developing policies, services, and communications.

3.4 Healthcare-Specific Legislation plus Standards and Expectations

- *Carers (Scotland) Act 2016*: Mandates that carers are informed about their rights and available support.
- *Health & Care (Staffing) (Scotland) Act 2019*: Ensures safe staffing levels, indirectly supporting communications around workforce transparency.
- *Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016*: Covers statutory Duty of Candour and regulates treatment standards and nicotine products.
- *Mental Health (Care and Treatment) (Scotland) Act 2003 / 2015*: Framework for patient rights and treatment, with implications for sensitive and rights-respecting communication.
- *Patient Rights (Scotland) Act 2011*: Supports person-centred communication, ensuring patients are informed and involved in decisions.
- *Public Services Reform (Scotland) Act 2010*: Improves transparency, efficiency, and accountability across public services.
- *National Staff Governance Standard (4th edition, 2012)*: Promotes staff wellbeing, inclusion, and engagement in communications.

- *NHS Scotland Workforce Vision (Everyone Matters), 2013*: Supports a motivated, person-centred workforce, emphasising effective staff communication.

3.5 Whistleblowing and Ethical Conduct Legislation

- *Duty of Candour Procedure (Scotland) Regulations 2018*: Requires openness and honesty following adverse events.
- *Public Interest Disclosure Act 1998 (PIDA)*: Protects whistleblowers who report wrongdoing, ensuring fair treatment and protection from retaliation.
- *NHS Scotland Whistleblowing Standards (2021)*: Establish the national standard process for raising concerns within NHS Scotland, including roles, timelines, and routes to the Independent National Whistleblowing Officer (INWO); complements PIDA protections.

3.6 Marketing and Advertising Standards

- *CAP Code (UK Code of Non-Broadcast Advertising and Direct & Promotional Marketing)*: Sets clear rules for fairness, transparency, and non-deceptive promotional materials.
- *Consumer Protection from Unfair Trading Regulations 2008*: Prohibits misleading or aggressive communications and marketing tactics.

3.7 Human Rights and Communications Ethics

- *Human Rights Act 1998*: Upholds individual rights, including respect for privacy and freedom of expression in public communications.

3.8 Health-Specific Communication Frameworks – Strategy / Guidance

- *NHS Scotland Communication and Engagement Strategy 2020–2024*: Provides a framework for meaningful engagement with patients, staff, and stakeholders. May now be superseded or integrated within broader NHS strategic frameworks; used here as contextual guidance.
- *Healthcare Improvement Scotland – "What Matters To You?" (2016)*: Encourages listening and patient-centred dialogue in care conversations.
- *Leading Quality Health and Care for Scotland (2023–2028)*: Strategic vision to embed quality improvement and leadership in care delivery.
- *NHS Recovery Plan (2021–2026)*: Sets direction for post-pandemic transformation, digital innovation, and service resilience—relevant to evolving communications.
- *Scotland's Digital Health and Care Strategy (2021 Update)*: Supports digital-first approaches to patient and staff engagement.

3.9 State Hospital Annual Delivery Plans

Focus remains primarily on performance, high-level finance, and workforce; drawing together key planning assumptions which reflect local priorities.

4 ASSURANCES AT A GLANCE (2025/26)

- *Data protection*: No Communications originated reportable breaches. All DPIAs were reviewed and updated. Communications Asset Register forms were completed during Q4 2025/26 and will be checked / signed-off in April 2026.
- *Accessibility*: Cabinet Office re-audit passed (Mar 2025), and outstanding PDF remediation work completed Q4 2025/26.
- *FOI*: Response performance referenced in Information Governance Annual Report 2025/26 with Communications support remaining active.

- *Equality / Fairer Scotland Duty*: All EQLAs reviewed and updated.
- *Whistleblowing / Duty of Candour*: Standards signposted across staff channels with specific Speak Up Week promotion.

5 COLLABORATIVE WORKING

An essential element of the Communications Service is commitment to effective and consistent collaboration across all directorates and teams. Its independence from other functions, services, and directorates underpins organisational confidence, opens dialogue, and promotes strong connections - principles that have been developed and refined over many years.

Within the State Hospital, it is vital that staff recognise the Communications Service as a function that serves all disciplines equitably and is strategically positioned to do so. This is achieved through a cohesive internal network, characterised by strong, multi-directional links, with communications at the centre of engagement and exchange.

The Service also maintains well-established collaborative relationships with the Scottish Government Mental Health Team, Scottish Government Communications colleagues, NHS Board Communications peers, the Mental Welfare Commission, and other key partners.

6 STRENGTHENING OUR TEAM AND INVESTING IN FUTURE CAPACITY

During 2025/26, the Communications Service continued to build resilience, capability, and capacity as it progressed toward a fully staffed establishment of three posts: Head of Communications, Communications Specialist, and a part-time Communications Assistant appointed in October 2025.

Operating with two staff for the first half of the year inevitably placed pressure on the Service, particularly as the team managed a backlog of activity following the previous year's intensive focus on accessibility compliance. Recruitment to the Communications Assistant post attracted over 100 applicants and required significant time and resource. Since appointment, a comprehensive induction and development programme has been led by the Head of Communications. While this represented a substantial short-term investment, it is already delivering clear value and will further strengthen capacity in 2026/27.

With the team restored to full complement, focus shifted to enhancing skills and expanding capability in areas aligned to current and emerging organisational needs. The Communications Specialist successfully completed the New to Forensics programme, strengthening understanding of the specialist context in which the State Hospital operates, and undertook training to become a Peer Support Worker. The team also celebrated the Communications Specialist being shortlisted as a finalist in the Staff Excellence Awards for the second consecutive year.

Significant organisational expertise was developed in accessibility, supported by extensive self-directed learning undertaken by both the Head of Communications and Communications Specialist. As a result, in year the Service completed outstanding tasks from the Cabinet Office Accessibility Audit, ending a prolonged period of increased workload associated with evolving legislative requirements. This provided assurance to the organisation while enabling the team to rebalance capacity.

To support consistent implementation across the organisation, the Communications Service developed a new accessibility guide '*Governance Framework for Corporate Documentation and Accessibility*', which was piloted through the Corporate Management Team from June 2025 and is scheduled for formal rollout across the organisation in April / May 2026.

All members of the team completed Co-pilot training and have embedded the use of AI into daily workflows, improving the speed, quality and efficiency of drafting, editing, and research.

Digital capability was further strengthened through enhanced design skills, including PowerPoint animation, expanded use of Canva for visual storytelling and short-form video content, attendance at AI innovation workshops, and the transition to OneDrive.

The potential introduction of Instagram as an additional social media platform was explored during the year. Following research and analysis, it was determined that the platform was not an appropriate fit for the State Hospital, given its highly visual, informal, and lifestyle-focused nature. This evidence-based decision ensured resources remained focused on the most effective and appropriate communication channels.

In addition, Ninja Forms were introduced to the website, enhancing functionality and improving the secure and efficient collection of information, e.g. Visitor, Volunteer and Feedback forms.

The Service continued to strengthen resilience and consistency through the development of internal guidance. Fifteen new guides were produced covering areas such as Microsoft Teams, social media, website management, YouTube, MyCompliance, Photoshop, starters and leavers, the Communications Handbook, asset management, PowerPoint animation, and audio-visual standards. No new SOPs were required, reflecting the maturity of existing processes.

With capacity now restored, video skills development (previously paused due to workload pressures) can progress in 2026/27. The Communications Assistant brings strong graphic design and video production expertise, enabling the Service to expand creative output and further modernise digital communications. Short videos, graphics, avatars, and animations were produced in year to enhance promotional activity, particularly across social media. Exploration of emerging AI technologies, including video generation and synthetic voice creation, is also underway, offering opportunities to increase effectiveness while reducing production time.

Looking ahead, the Communications Service will continue to invest in both individual capability and collective team development. By embedding shared learning, strengthening new ways of working and fostering a culture of collaboration, creativity and continuous improvement, the Service is well positioned to meet increasing organisational demands and to contribute even more effectively to the State Hospital's strategic ambitions.

7 KEY PERFORMANCE INDICATORS (KPIs)

Established KPIs relate to the core Communications Service as detailed below:

No	KPI	Source	Timescale	Status / Outcome
01	To produce a Communications Annual Report and present this to the Board.	Board	Annually (April)	Continues to be met
02	To produce the Board's Annual Report.	Board	By 31 October each year	Continues to be met The State Hospital's Annual Report 2024/25 was produced in October 2025. The 2025/26 Annual Report will be produced in 2026/27.
03	To produce at least 44 weekly bulletins for staff.	CEO	Annually	Complete Fifty-two were produced.
04	To produce special bulletins as a support to staff.	CEO	Annually	Complete Thirty-eight were produced.
05	To produce Staff Newsletter 'Vision' twice a year as a minimum.	CEO	Annually	Complete Seven normal editions were produced: July, September, November & December 2025, and February 2026. Special editions supported Psychology Professions Week in November 2025 and the Staff Excellence Awards in March 2026.
06	To deliver on 100% of all appropriate requests for Talks to the Community.	General Public	Annually	Complete There were no requests in year.
07	To respond promptly to all Media Enquiries.	Media	Annually	Continues to be met Eleven Media Enquiries were received and responded to promptly. These related to: • 1 x Women's Service & Autism (April 2025). • 1 x Massage Chairs and Sports Equipment Costs (April 2025). • 1 x Women's Service (April 2025). • 2 x Documentary (May & November 2025). • 3 x Weight Loss Jab (1 x September and 2 x October 2025). • 1 x Alleged new male patient (October 2025). • 1 x Staff member in court (November 2025). • 1 x Former patient (December 2025).

No	KPI	Source	Timescale	Status / Outcome
08	Complete the 'Well Informed' section of the Staff Governance Self-Assessment Monitoring Tool.	Staff Governance Standard	Annually	N/A - As per previous years, there has been no requirement for this. As such, this KPI will now be removed.
09	To attend at least four of the six State Hospital Board Meetings.	Board	Ongoing	Continues to be met both via Teams and in-person.
10	Ensure Board business is published on the Website including the Board Schedule of Meetings, Public Notices, Agendas, Minutes, Papers, Standing Documentation, Board Biographies, State Hospital Annual Reports & Accounts etc.	Board	Ongoing	Continues to be met Additionally, after each Board Meeting a review of all Board papers takes place to identify information / communication for the staff bulletin, staff newsletter 'Vision,' Intranet, Website, Media, and Social Media as appropriate.
11	To attend 90% of NHS Scotland Strategic Communications Network Meetings.	NHS Scotland	Annually	Continues to be met All meetings were held on Teams during the year.
12	To ensure representation at the annual NHS Scotland Event.	NHS Scotland	Annually in June	N/A As the event has been held virtually in recent years, there is no longer a need for Communications to host a stand on behalf of the State Hospital. This KPI will now be removed.

The table below details activity in 2025/26 not covered by KPIs:

No	Workstream	Lead	Outcome	Key Result Area
01	Media Releases / Statements	Head of Comms	Two media releases were issued during the year: <i>State Hospital Wins RCN Scotland Award (June 2025)</i> recognising the Dementia Care Project. The announcement received positive media coverage, and our accompanying social media post generated strong engagement with more than 2,000 views on Facebook. <i>Return of Women's Service to the State Hospital (June 2025)</i> also attracting positive media attention. Engagement on Facebook was particularly high, with the post receiving over 3,500 views. No Media Statements were issued in year.	Media Relations
02	Media Features	Head of Comms	There were no Media Features published during the year.	Media Relations
03 NEW for 2025/26	Media Coverage	Head of Comms	The State Hospital featured in twenty-four media articles during 2025/26 for which no media enquiries were received. The majority related to patient Court cases.	Media Relations

No	Workstream	Lead	Outcome	Key Result Area
04	Suspected Media Leaks	Head of Comms	A Datix report was submitted in April 2025 regarding a suspected information leak to the media concerning the Women's Service.	Media Relations
05	FOI Enquiries	FOI Lead	The number of FOI Enquiries is captured within the Information Governance Annual Report 2025/26.	Public Relations
06	Academic Published Articles	Research & Development Manager	The Research Committee Annual Report 2025/26 notes all published journal articles and the delivery of presentations.	Public Relations
07	Leadership Walkrounds	-	These recommenced in 2025/26 and are reported on directly to the Board. Going forward, they will no longer be included within this report.	Staff Relations

8 QUALITY ASSURANCE (QA) OBJECTIVES

The table below details progress against QA objectives set for 2025/26:

8.1 Internal Communications

No	QA Objective	Source	Lead	Timescale	Status
01	Provide professional advice and direction to the Board, line managers and all teams.	Comms Strategy	Head of Comms	Ongoing	Continues to be met This enables the influencing and shaping of communication planning and strategy at all levels, ensuring good communications practice is firmly embedded in everyday service development, delivery, and change.
02	Support the Board and Organisational Management Team (OMT) through dedicated staff bulletins covering each meeting.	Board / OMT	Comms	Ongoing	Continues to be met Six Board bulletins and twelve OMT bulletins were produced.
03	Review and update of State Hospital publications / information sheets.	Comms Strategy	Comms	Ongoing	Continues to be met A Publications Database is well established, enabling the effective review and update of materials during the year.
04	Review and update of State Hospital Banner Stands following rebrand.	Head of Comms	Comms	-	On hold Awaiting possible rebranding.

No	QA Objective	Source	Lead	Timescale	Status
05	Produce bulletins, newsletters, posters, publications, and other communications to advise staff of what is happening in the Hospital and the wider NHS.	Comms Strategy	Comms	Ongoing	Continues to be met
06	Periodic review of Board Photo Boards and update as necessary.	Board	Comms	Ongoing	Continues to be met
07	Review and update of Comms Audio Visual Photo Consent Forms.	Comms Strategy	Head of Comms / Information Governance	Ongoing	Complete A review took place in October 2025. Following advice from the Data Protection Officer, Consent Forms are now only used for external purposes, e.g. media, social media, and the State Hospital annual report.
08	Review of Board bulletin in respect of staff views.	Board Chair	Head of Comms	By Mar 26	New for 2025/26 Complete Survey developed and launched on 27 November with a closing date of 18 December 2025 (three-week engagement). A report on the findings has been prepared for the Board Chair. The findings were positive, requiring no change to current practice.
09	Establish how other Boards report on Board Meetings.	Board Chair	Head of Comms	By Mar 26	New for 2025/26 Complete Message placed in Strategic Communications Group Teams chat. This group comprises Directors / Heads of Communications from all Boards. A report on the findings has been prepared for the Board Chair. Responses show that State Hospital practice is aligned with national practice, therefore no action is required.

No	QA Objective	Source	Lead	Timescale	Status
10	Review of Communications Service resources and structure in July 2027.	CEO	Head of Comms	July 2027	New for 2027/28 On track

8.2 External Communications

No	QA Objective	Source	Lead	Timescale	Status
11	Through effective communications, foster public and political confidence in the care and services provided to protect and enhance understanding of the Hospital.	Comms Strategy	Comms	Ongoing	Continues to be met In the main through official reporting / governance, our website, media, and social media.
12	Keep the Scottish Government up to date on all matters relating to media activity and any correspondence with patients and families and / or carers which may require government officials and / or Ministers to become involved.	Annual Review	Head of Comms	Ongoing	Continues to be met
13	Inform Non-Executives and other identified staff of major events which are likely to attract Media interest.	Board	Head of Comms	Ongoing	Continues to be met
14	Undertake quarterly reviews of website content and maintain website action plan. In addition, produce statistical report via Google Analytics.	Comms Strategy	Comms Specialist	Quarterly Annually	Continues to be met
15	Undertake an annual review and update of the content on the ONELAN screens located in the Hospital's main Reception area and Visitor Waiting area.	Comms Strategy	Comms Specialist	Annually	Continues to be met Content is accurate and up to date.

No	QA Objective	Source	Lead	Timescale	Status
16	Undertake annual reviews and updates of the State Hospital's Speakers' Directory and general presentation slides.	Comms Strategy	Head of Comms	Annually	Continues to be met This update includes feedback from community talks.
17	Bi-annual review of Media Training requirements for Directors and other identified staff.	Comms Strategy	Chief Executive / Head of Comms	Autumn 2026	On track A paper was submitted to the Corporate Management Team in July 2025 with a view to training being delivered around Autumn 2026.
18	Familiarisation with 'Dealing with the Media' Guidance for State Hospital Spokespeople.	Comms Strategy	On-Call Directors / CEO	Ongoing	Continues to be met Note - This should be read in conjunction with the State Hospital's approved 'Media Lines for On-Call Directors' which have been prepared to assist those responding to media enquiries.
19	Maximise key messages about the Hospital's work, role and the services provided thus raising awareness of the Hospital's image, profile, and potential with external audiences locally, nationally, and internationally.	Comms Strategy	Comms	Ongoing	Continues to be met This is driven through our social media channels as a means of stakeholder education.
20	Manage the Communications Service eControl Book.	Health & Safety	Head of Comms	Ongoing	Continues to be met The 2025/26 Activity Planner supports the entire process, ensuring effective maintenance in year.
21	Review of 'all user' email permissions.	eHealth Sub Group	Head of Comms / Infrastructure Operations & IT Security Manager	Every two years	Continues to be met A review was undertaken in January 2026.
22	Review and ensure all videos on the State Hospital YouTube channel are compliant with accessibility legislation (WRAG 2.2) in respect of transcription, subtitles, and scene setting	Comms Strategy	Comms	By March 2027	New for 2026/27 On track At the end of 2025/26 work commenced on transcripts and subtitles.

No	QA Objective	Source	Lead	Timescale	Status
23	Conduct an interim review and update (if required) of the Communications Strategy, policies, and procedures.	Comms Strategy	Head of Comms	Annually	Continues to be met Communications Strategy for 2025/30 developed. Media Policy remains up-to-date.

8.3 Strategy / Policy

No	QI Objective	Source	Lead	Timescale	Status
24	Regular review and update of the Pandemic Influenza Communications Strategy.	Infection Control Committee	Senior Nurse for Infection Control / Head of Comms	Ongoing	Continues to be met Strategy for 2025/30 produced and approved by the Infection Control Committee in June 2025. Will be superseded by national guidance in around two years' time.
25	Undertake Equality Impact Assessments (EQIAs) for Communications.	Equality Act	Head of Comms	As required	Continues to be met There are five EQIAs in place to support communications work.
26	Undertake Data Protection Impact Assessments (DPIAs) for Communications.	GDPR	Head of Comms	Ongoing	Continues to be met. There are five active DPIAs in place.
27	Following the forthcoming handover of the Intranet from eHealth to Communications, review and update the Intranet Maintenance & Development Policy and associated Equality Impact Assessment (EQIA) to reflect changeover.	Comms Strategy / Equality Act	Head of Comms	Summer 2027	New for 2026/27 On hold. Sharepoint Online (new Intranet) is on hold at national level.

No	QI Objective	Source	Lead	Timescale	Status
28	Review and update of Corporate Document Standards in line with Accessibility legislation.	Records Services	Head of Comms	By end 2026	New for 2025/26 Complete. <i>Governance Framework for Corporate Documentation and Accessibility</i> was developed in May 2025 and piloted from June 2025 via the Corporate Management Team with a view to implementing Hospital-wide from April / May 2026. This may be further developed in due course to include Records Management best practice.

9 QUALITY IMPROVEMENT (QI) OBJECTIVES

The following table shows performance against QI objectives set for 2025/26:

9.1 Internal Communications

No	QI Objective	Source	Lead	Timescale	Status
01	Redevelop the Intranet. The current Sharepoint site (now at end of life) will be replaced with the new 'Sharepoint Online' version which is being led nationally for all Boards by National Services Scotland (NSS).	National	Comms / eHealth	-	Ongoing The project remains on hold nationally pending resources, governance approvals, and other necessary requirements to ensure successful implementation across NHS Scotland.
02	Develop the State Hospital Photo Library.	Head of Comms	Comms	-	Continues to be met Photos of the new Women's Service were added in year. Photos of the new huts / enhanced Anima & Pet Therapy Centre will be added in 2026/27.
03	Continue to undertake staff engagement exercises to support corporate objectives.	Comms Strategy	Project Lead / Designated Individual	Ongoing	Continues to be met

No	QI Objective	Source	Lead	Timescale	Status
04	Support ad-hoc key events via dedicated staff bulletins / Vision / campaigns as appropriate.	Project Lead	Project Lead / Comms	Ongoing	Continues to be met For example, visits and recruitment fairs.
05	Promote the work of Healthy Working Lives (HWL).	OD Strategy	OD Manager / Comms Specialist	Ongoing	Continues to be met Achieved both internally and externally.
06	Raise staff awareness of the Hospital's sustainability work to meet net zero target.	Sustainability & Climate Change Group	Head of Estates / Comms Specialist	Ongoing	Continues to be met Extra effort is given to promote Climate Week.
07	Support the 'Excellence Awards' and staff 'Long Service Awards.'	OD Strategy	OD / Comms	Annually	Continues to be met Communications is a member of both the oversight group and working group responsible for organising and managing these events.
08	Support Speak Up week	National	HR / Comms	Annually around Sep / Oct	Complete Comms supported through video, email, bulletins, and social media.
09	Annual redesign of the Weekly Staff Bulletin and Special Bulletin.	Board	Comms	Annually	Continues to be met New design launched 1 April each year.
10	Review and further develop Communications Guides for Communications staff.	Head of Comms	Comms	-	Continues to be met Twenty guides were developed to help staff navigate and deliver the wide range of activities within the Comms remit.
11	Review and further develop Standard Operating Procedures (SOPs).	Head of Comms	Comms	-	Continues to be met
12	Support HR initiatives.	HR	Comms	Ongoing	Continues to be met Support was provided in respect of several areas including Recruitment (processes, pathways, and job adverts), career fairs, new starts, National Demonstrator Programme and New Student Placements.

No	QI Objective	Source	Lead	Timescale	Status
13	Support Patient Initiatives.	Skye Centre Activity Centres	Comms	Ongoing	Continues to be met Support is provided in respect of the Koestler Awards, Sports Week, Learning Awards, Halloween, and other activities.
14	Support Occupational Therapy (OT) Week.	OT	Head of Comms	Each November	Ongoing. Campaign included social media posts and photos. All of this was positively received.
15	Support Allied Health Professions	Lead AHP	Comms Assistant	Each November	Our first ever video was produced to support AHP Day in November 2025. This received over 4000 views.
16	Support IT Security Initiatives.	eHealth	Head of Comms / Infrastructure Operations and IT Security Manager	Each November	Ongoing. Campaigns include phishing and cyber security.
17	Build capacity for workload ensuring full complement of staff is in place.	Board	Head of Comms	-	New for 2025/26 Complete Communications Assistant appointed in October 2026.
18	Strengthen digital innovation for the organisation via AI.	Comms Strategy	Comms Assistant	-	New for 2026/27 Platforms for AI video creation, AI text-to-speech, AI voice generation, and AI video generation to be explored.
19	Explore Microsoft Sway for staff communications.	Head of Comms	Comms Specialist	-	Ongoing. This is currently being piloted for staff newsletters and may offer additional benefits once SharePoint Online is implemented as our new Intranet.

No	QI Objective	Source	Lead	Timescale	Status
20	Develop Asset Register for Communications.	GDPR	Head of Comms	Spring 2026	Ongoing Circa 50 Records Services forms have been completed in respect of Communications files. These are in the process of being checked prior to being submitted to Records Services. The work should fully complete in April 2026.

9.2 External Communications

No	QI Objective	Source	Lead	Timescale	Status
21	Issue Media Releases surrounding good news stories, ensuring the safety and security of patients, staff and visitors is not compromised.	Comms Strategy	Comms	-	Continues to be met
22	Continue to invite visitors to the Hospital to learn about our work. Visitors include MSPs, Health Board Chairs and senior officials as well as other stakeholders.	Board	CEO / Directors	Ongoing	Continues to be met Visits are captured in the Chief Executive's Report to the Board and are covered in the staff newsletter 'Vision' as appropriate.
23	Maintain links with other agencies and forensic services through the Forensic Network.	Comms Strategy	CEO / Medical Director / Other Professions	Ongoing	Continues to be met
24	Improve communications with partners about the Hospital's work, aims and successes, and look for opportunities to work collaboratively.	Comms Strategy	Head of Comms	Ongoing	Continues to be met Good relationships maintained with Scottish Government, Mental Welfare Commission and NHS Boards.
25	Review Memorandum of Understanding (MoU) with the NHS Golden Jubilee as a means of strengthening Communications resilience within both Boards.	National Boards Collaborative	Head of Comms / Chief Executive	March 2026	Continues to be met MoU with the NHS Golden Jubilee remains in place. It was reviewed and updated in March 2026.

No	QI Objective	Source	Lead	Timescale	Status
26	Undertake Video Training and practice sessions to enhance familiarisation.	Comms Strategy	Comms	Ongoing	On hold during the year Workload pressures did not allow this to progress in year.
27	Explore 'Social Media for Businesses' and ensure two-factor authentication is enabled.	eHealth	Infrastructure Operations & IT Security Manager	-	Partly complete Two-factor authentication for Facebook is still being explored by IT. This risk is managed via admin-role restrictions and strong password policy.
28	Explore opportunity for the State Hospital to put a case forward for a State Hospital variant of the NHS Scotland logo that more clearly identifies the State Hospital as an NHS Scotland organisation.	Corporate Management Team (CMT)	Head of Comms	-	Progressing We continue to liaise with our Scottish Government Sponsorship Team regarding this.
29	Share Stakeholder Stories via the website.	CMT	Head of Comms	-	Continues to be met
30	Support the recruitment of Volunteer Roles through the website and social media.	PCIT	Head of Comms	Ongoing	Continues to be met
31	Produce narrative that covers process from admission to discharge, referring to reason for admission to the State Hospital.	Comms Strategy	Comms Specialist + ID Service RMO	By October 2026	Carried over from 2024/25 On track
32	Create narrative around detention / restriction orders and review process / rights to appeal.	Comms Strategy	Comms Specialist + ID Service RMO	By October 2026	Carried over from 2024/25 On track
33	Explore Instagram.	Comms Strategy	Comms	By October 2026	Complete Instagram was explored and not considered an appropriate channel for the State Hospital due to the platform's strong focus on visual, informal, and lifestyle-led content.

No	QI Objective	Source	Lead	Timescale	Status
34	Produce a series of short educational videos that can be placed on the State Hospital website, YouTube, and other social media channels.	Comms Strategy	Comms	Ongoing	New for 2025/26 A few short videos were produced for Social Media to test the water in this area. The first video produced in year was on patient art followed by an AHP video in November 2025 and Christmas / New Year videos. These were all favourably received with around 2000-3000 views each.
35	Create 'Meet the Board' Video.	Staff Governance Committee / HR	Comms	March 2026	New for 2025/26 Comms has asked the Committee to clarify the purpose of this video and respective audience. Response awaited.

9.3 Collaborative Working

No	QI Objective	Source	Lead	Timescale	Status
36	Participate in State Hospital development sessions aimed at informing our Annual Delivery Plans and Medium-Term Plans.	Head of Corporate Planning, Performance and Quality / OD Manager	Head of Comms	Ongoing	Continues to be met The Head of Communications attended the various planned events during the year and developed a three-year delivery plan for the Communications Service.

10 EVALUATION OF EFFECTIVENESS

All core Communications objectives, corporate objectives, and legislative requirements were met in 2025/26. The following are examples of positive outcomes evidencing effectiveness achieved during the year.

10.1 Internal Communications

10.1.1 Corporate Responsibility

The Communications Service met its corporate responsibilities by actively contributing to key strategic planning and governance activity throughout the year. This included attendance at, and contribution to, a number of high-level events that informed the development of the Annual Delivery Plan (ADP) and Medium-Term Plan (MDP), including Leadership and Organisational Development sessions, Board Development sessions, the ADP Planning Day, and a dedicated session on the Supreme Court Ruling. In addition, the team supported the Board's Annual Review, participated in multiple Job Evaluation panels, and undertook all required communications activity to support compliance with the Reduced Working Week (RWW). This ensured that organisational priorities, statutory requirements, and workforce impacts were clearly communicated and appropriately supported.

10.1.2 Staff Engagement

The 2025 iMatter Survey achieved a response rate of 64%, compared to 72% in 2024/25. The Board's Employee Engagement Index (EEI) was 74, marginally lower than the previous year (75), providing continued insight into staff experience and engagement.

A formal review of the Board Bulletin was undertaken to assess its effectiveness as an internal communications tool. Findings demonstrated that the Bulletin remains well-valued and effective, with overwhelmingly positive feedback from staff across professional groups. Respondents consistently highlighted its usefulness in keeping them informed about Board activity, organisational priorities, and key decisions. Importantly, no actions were identified as necessary, providing assurance that the current approach to communicating Board business is appropriate, effective, and meeting staff needs.

In parallel, benchmarking was undertaken to review how other NHS Scotland Boards communicate Board business to staff. This confirmed that the State Hospital's approach aligns well with national practice, including the publication of Board papers and provision of staff-facing summaries, and that no changes were required.

10.1.3 Staff Support

Throughout the year, the Communications team supported staff across the Hospital through a wide range of targeted campaigns, events, and publications, responding to both corporate priorities and service-level needs. This included support to Social Work colleagues to mark Patients' Rights Day and the development of an accessible, child-friendly version of the Corporate Parenting Plan 2026/27. Also making documents accessible for Heads of Service pending organisational rollout.

Support to Human Resources included recruitment advertising, staff Welcome Packs, Speak-Up Week, and Equality, Diversity and Rights activity. Newsletters were produced for Pharmacy and Security using the new Sway online format, and Psychology was supported through the development of hub-specific posters and a dedicated edition of Vision for Psychological Professions Week.

Allied Health Professions activity included extensive promotional and educational content across digital and onsite platforms, including video content, Occupational Therapy information sheets for both Women's and Men's services, and graphics to support the Physical Health Strategy.

Further support was provided to a range of organisational initiatives including TSH3030, Patient Learning Awards, sports initiatives, Staff Excellence Awards, Long Service Awards, Koestler Awards, and the promotion of RCN Award finalists and winners. Communications activity also supported volunteer recruitment, the development of the Women's Service, Essential Relational Aspects of Care, recruitment campaigns, the Seminar Series, and policy promotion.

10.1.4 Support to Groups and Committees

The Communications Service plays an active role in supporting multi-disciplinary groups and committees, ensuring effective communication, accessibility compliance, and alignment with organisational objectives.

The Head of Communications is a member of a range of internal and national groups, including the NHS Scotland Strategic Communications Group, NHS Scotland Accessibility Group, the Board, Corporate Management Team, Organisational Management Team, Gold Command (when stood up), and several governance and workforce-related groups. While not a formal member of the Policy Approval Group, the team provided extensive support to ensure policy compliance with accessibility legislation.

The Communications Specialist contributed to key operational and workforce groups, including Climate Change and Sustainability, Daytime Confinement Oversight, Healthy Working Lives, Staff Recognition, and Workforce Wellbeing and Organisational Development. This embedded communications expertise across strategic and operational decision-making.

10.1.5 Publications

Demand for printed and digital materials remained steady, demonstrating that publications continue to be fit for purpose and valued by services. A review of the Publications Database was undertaken in year, with content updated or made obsolete as appropriate. As at March 2026, the database comprised 74 information sheets, 13 banner stands and 30 departmental initiatives, providing assurance that published materials are current, relevant, and well-governed.

10.1.6 Staff Bulletin and Internal Channels

Workshops, events, and training promoted via the Staff Bulletin were consistently well attended, evidencing that the Bulletin remains an effective and trusted channel for staff engagement.

Dedicated bulletins were produced following Board and Organisational Management Team meetings, alongside a variety of themed and time-critical bulletins covering topics such as iMatter, Nursing Practice Development, Once for Scotland policies, the New Patient Timetable, Obesity, NHS Scotland events, pensions, Speak Up Week, Care Programme Approach (CPA) guidance, Reduced Working Week (RWW) engagement, and guidance relating to the Scottish Parliamentary Election in May 2026.

Despite the need for redevelopment, the Intranet continued to play a vital role as the primary internal communications platform. The Communications Service page was reviewed and updated during the year. The 'All User Email Request' function was heavily utilised, accounting for over 90% of requests, and remained an effective mechanism for urgent or time-sensitive communications not suitable for inclusion in the Staff Bulletin.

10.2 External Communications

10.2.1 Website

Achieving compliance with Website Accessibility legislation represented a significant milestone. While preparatory work was undertaken earlier in the year, the majority of activity took place towards the end of 2024/25 and continued into 2025/26, reflecting the scale and complexity of the work involved.

10.2.2 Social Media

During the year, the Communications team published 463 social media posts on each of its three social media platforms, circa 1500 in total. This activity supported a wide range of organisational priorities, including recruitment campaigns, statutory public notices, awareness days and weeks, staff recognition, wellbeing initiatives, and wider organisational updates. On many occasions, multiple posts were published on the same day to meet statutory requirements and to maximise engagement and recruitment reach.

Overall, this equates to an average of nine posts per week (or 39 posts per month) on each channel, with all content directly linked to the work, people, and priorities of the State Hospital.

10.2.3 Spotlight on Facebook

Facebook remains our most popular social media channel and has therefore been selected to provide a snapshot of performance data.

During the reporting period, the Hospital's Facebook content achieved 2.18 million views, all generated organically, alongside 12,000 content interactions (reactions, comments, and shares). This demonstrates sustained interest in our content and strong engagement without the use of paid promotion.

Standard corporate content performs consistently well, with Board Public Notices typically achieving around 1,500 views and job advertisements averaging between 2,000 and 4,000 views. However, a small number of posts significantly exceeded these benchmarks. The top eight viewed posts during the year achieved between 31,000 and 81,000 views per post, alongside strong levels of interaction:

- When a patient wouldn't communicate (our RCN Learning Disability Award finalist) – over 81.5K views / over 250 interactions.
- Congratulations to our Staff Nurse (additional post in respect of RCN Learning Disability Award finalist) – over 72.8K views / almost 350 interactions.
- Honouring Lives Lost, Acknowledging Lives (in remembrance of the State Hospital incident) – over 67.5K views / over 500 interactions.
- Nursing Assistant job advertisement – over 57.7K views / over 120 interactions.
- Long Service Awards - over 37.6K views / over 250 interactions.
- Staff Care and Wellbeing Officer job advertisement – over 33.1K views / over 50 interactions.
- Staff Excellence Awards – over 32.1K views / over 180 interactions.

- Welcome to (staff member) who is the fifth generation of family to work at the State Hospital – over 35.5K views / over 90 interactions.

Collectively, these posts attracted hundreds of reactions, comments, and shares, significantly outperforming average post reach and engagement.

Analysis of the highest-performing content indicates that posts with a strong human focus consistently generate the greatest reach and engagement. In particular:

- People-focused stories (including staff recognition, welcomes and achievements) resonate strongly with audiences.
- Photographs featuring staff markedly increase visibility and interaction, supporting wider organic reach.
- Narrative content that explains why something matters (such as patient care experiences, remembrance, or staff contribution) encourages meaningful engagement rather than passive viewing.
- Recruitment posts that highlight people, purpose and team culture perform significantly better than standard vacancy notices.

This reinforces the value of using social media not solely as a channel for corporate messaging, but also as a means of showcasing the people, values, and work of the Hospital.

However, developing this type of content can present challenges for the Communications Service. In practice, some staff choose not to engage with social media and therefore decline to appear in posts or to have their work promoted through these platforms. These views are fully respected and taken into account when planning and delivering social media activity.

The Communications Service will continue to work positively and proactively to encourage participation where appropriate. Experience to date shows that staff who have chosen to engage have done so without any negative impact; feedback and engagement have been overwhelmingly positive. While lower levels of participation can limit the pace at which the profile of the State Hospital can be raised, Communications will continue to build confidence and support the Board's ambitions around strengthening public and political confidence.

In summary, the performance of these posts demonstrates that audiences engage most strongly with authentic, human-centred content reflecting real experiences and achievements. This insight will continue to inform content planning, ensuring that social media activity supports recruitment, promotes public / political confidence, and staff recognition objectives while maintaining appropriate governance and tone.

10.2.4 The Media

Information relating to media enquiries, releases and statements, features, coverage, and suspected media leaks is captured earlier in this report. Media lines for On-Call Directors were reviewed and strengthened during the year. Media training for Directors and On-Call staff is planned for 2026/27.

10.2.5 Email

The general State Hospital mailbox (tsh.info@nhs.scot) continued to receive a steady flow of enquiries, demonstrating its effectiveness as a key public contact point. All enquiries were responded to promptly and appropriately.

10.2.6 Visits

Hosting visits to the Hospital continued to support engagement with external audiences, showcase our work, and facilitate the sharing of best practice and networking opportunities. Information on visits was reported through the Chief Executive's Report at each Board meeting, with key visits also being featured in the staff newsletter Vision. In addition, the Communications Team hosted a peer visit from the Mental Welfare Commission for Scotland.

10.2.7 Feedback from NHS Scotland Chairs' Meeting and Chief Executives' Meeting

The Chair provides feedback from the NHS Scotland Chairs' Meeting at each Board meeting, keeping the Board informed of national developments, including updates on targets and priorities. Similarly, the Chief Executive shares insights from national Chief Executive meetings.

11 SUMMARY / CONCLUSION

11.1 Staffing

In year, all mandatory training was up to date, staff objectives were developed and reviewed, staff appraisals were undertaken, and Personal Development Plans (PDP) were in place.

11.2 Performance – Target and Objectives

The Communications Service consistently excelled in delivering high-quality, comprehensive communications to stakeholders, ensuring that key objectives were met with efficiency and professionalism. In addition, others responsible for communication across the organisation continued to successfully achieve their goals, contributing to the overall effectiveness of collaborative efforts.

All core communications functions (encompassing key performance indicators, quality assurance, and quality improvement objectives) were fully delivered. The service not only met all legislative requirements but also achieved financial targets and identified savings, demonstrating strong fiscal responsibility.

These achievements were made while adhering to the core values and principles that the Board sponsors, and that are promoted throughout NHS Scotland. The commitment to these values ensured that standards were met, fostering continued success and furthering the impact of our work.

11.3 Service Delivery

The Communications Service maintained a highly proactive approach throughout the year, consistently delivering timely, high-quality work across all areas. This commitment to excellence ensured that each project was carefully managed and tracked through well-maintained action plans.

All communications strategies and policies were regularly reviewed and kept up to date, ensuring their ongoing effectiveness. Supporting documentation was meticulously maintained, with planned reviews scheduled for those documents nearing their end of life. A notable achievement was the development of the Communications Strategy for 2025/30, which builds on the successes of the 2020/25 strategy, further strengthening our communications framework for the future.

Focus remains on continuously developing the Communications Service to enable the most efficient and impactful use of resources. A key component of this development is building capacity for the future, with a particular emphasis on team building, enhancing resilience, succession planning, and fostering sustainable growth.

Equally important is the need to stay current with and embrace digital technologies and advancements, ensuring that communication channels remain innovative and effective in meeting the needs of stakeholders. During the year members of the Communications Service attended various internal and external workshops, seminars, and training in support of this.

Our strategic approach will ensure that the Communications Service is well-equipped to meet the demands of tomorrow while maintaining its high standards of excellence today.

12 LOOK BACK / LOOK FORWARD

Areas of focus in 2025/26 as identified in last year's annual report are shown below together with an update:

- Implement Sharepoint online (new Intranet) – On hold nationally.
- Develop a Communications Information Asset Register – Work will be fully complete and signed off in April 2026.
- Develop audio-visual materials, in particular video – Ongoing.
- Complete the State Hospital Rebranding – On hold in light of new Forensic Board for Scotland however discussions are taking place with our Scottish Government Sponsorship Team to maintain awareness.
- Recruit, support, and develop the Communications Assistant – Complete and ongoing.
- Continue to develop the Communications Service to enable the most efficient and impactful use of resources – Ongoing.
- Embrace the evolving landscape of digital technology including AI – Ongoing.

Areas of focus in 2026/27 include:

- Team and service development.
- Production of audio-visual materials.
- Completing work to ensure compliance with accessibility legislation (WRAG 2.2) in respect of transcription, subtitles, and scene setting.
- Embedding of accessibility compliance across the organisation.
- Completing the Communications Asset Register.
- Implementing Sharepoint online (new Intranet) when we get the green light nationally.
- Pursuing State Hospital rebranding.

Caroline McCarron Chart.PR MICPR
Head of Communications
1 April 2026

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	16 April 2026
Agenda Reference No:	Item No: 18
Sponsoring Director:	Chief Executive
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 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 (SG) 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 (CMT) 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 2 April 2026.

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 – OUTREACH WOMEN’S SERVICE

Since the last update to the board, consultation to develop the Women’s Outreach Service has continued to focus on the following workstreams:

Training

There have been further Continuous Professional Development presentations on 4th March and 1st April with high levels of attendance from the majority of services who work with women at risk of harm. Topics to date include ‘Women with Autism’ and ‘Reproductive Hormones and Mental Health’. A further CPD session is planned with the Women’s Court which operates in Glasgow.

NHS – Stakeholder Engagement

Multi-disciplinary colleagues from medium, low and intellectual disability services joined the CPT for a ‘stakeholders’ day’ on 3rd February 2026.

The CPT outlined the drivers for the outreach service and provided a summary of discussions to date. Colleagues in medium and low secure services provided presentations on their female population and challenges faced which was followed by an open discussion on how to operationalise a purposeful outreach service.

The event has received positive feedback with consensus on what would be helpful for services working with women, with the acknowledgement that the needs of services and professionals varied across the country and between services.

Scottish Prison Service

The CPT continue to engage with colleagues in HMP Stirling including those in management roles and officers working in Wintergreen and the SRU (Segregation and Reintegration Unit).

SPS staff have spoken about the high levels of need within their service and the diverse clinical presentations (e.g. autism, personality disorder, dementia and psychosis) and the challenges faced working with women without a clinical background.

In discussion, it was highlighted the need for further training on the types of mental disorder and practical recommendations staff can implement.

Data Gathering

The CPT continues to gather qualitative and quantitative data from colleagues across the forensic network. A joint survey is being undertaken along with the Risk Management Authority and has been sent to a range of professionals who work with women. This data will assist in the formulation of the final proposal for the outreach service.

Next Steps

The next steps for the CPT are as follows:

- develop a full proposal for the service that incorporates feedback from the survey and stakeholder events.
- pilot the provision of a limited number of case discussions to incorporate the learning and outcomes into the proposal.
- continue to arrange the webinars and establish a regular clinical discussion group with colleagues from forensic mental health inpatient settings.

3.3 PHASE 2 UPDATE

Feasibility Study

The CPT in conjunction with Thomson Gray have refreshed the 'Schedule of Accommodation' based on a twelve-bedded service. The feasibility report initially approved for a newly built six-bedded service has been refreshed and expert opinion is that Option 3 still provides best value for money. The size of the service has increased from 1534 m2 to 2897 m2 and this would change the estimated cost, with an increase indicated. The draft report outlines that the proposal can be accommodated on the land currently utilised by the management centre although further configuration of the design is required that supports a biophilic approach.

Strategic Assessment

A significant amount of engagement work has taken place to progress completion of the 'Strategic Assessment' through the WPOB and the CMT. The intention is that the CPT will prepare the final report for approval at the State Hospital Board meeting in June 2026.

3.4 FINANCIAL UPDATE

Interim Service

The allocation of £3.1m for the Interim Service has an anticipated underspend of £550k at year end. The significant level of staff being borrowed from other wards is being funded from the hospital's baseline budget. The additional overtime for staff recruited directly to the service is included in the overall spend to date which is £2,287k. Confirmation from SG on the funding allocation for 2026/7 is awaited.

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 current remaining allocation is £39k. There are further invoices awaited from Thomson Gray for £20k therefore the remaining allocation will be returned to SG as it cannot be carried forward into the next financial year.

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 Risk Management Strategy and allows the WPOB to escalate any risk to the Corporate Risk Register if required.

There are currently no High or Very 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.
- Health Service Executive, Ireland – Portlaine Facility
- NHS Nottingham – Rampton

The communications plan has been updated accordingly.

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 2026/27 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	The development of the service will reduce current inequalities and gaps in service provision.

inequalities when planning what they do).	
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).	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD

Date of Meeting:	16 April 2026
Agenda Reference No:	Item No: 19
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

The project is approaching a close, with completion planned for 5 May. A survey of the electrical supply quality has now been undertaken, and a report is expected in the week ending 17 April. Some other works have been moved to the two-year Defects and Liability period following completion. Further information regarding this is provided at 3b and 3c. A verbal update will be provided.)

2 BACKGROUND

As previously reported, governance arrangements have been tailored to match the stage of the project and the amount of outstanding works. The Project Oversight Board plans to meet monthly and the last meeting took place on 4 December 2025. The next meeting is to be scheduled once the electrical supply report is received. Weekly operational meetings continue.

3 ASSESSMENT

Description of progress / assessed risks / implications for workforce / finance / requirement for engagement or consultation / outstanding issues to be addressed. Assess against performance measures where appropriate.

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 completion is the 5 of May. The projected final cost overspend is contained in Finance – Project Cost below.

b) Project Timescales

Revision 76 is the most recently accepted programme. The programme projects completion on 5 May and includes a three-week period to implement a solution to the electrical supply problems. Depending on agreement regarding the nature and duration of the potential solution the works may be considered suitable for moving into the Defects and Liability period.

Works remaining to be addressed are:

- Works to take place in the Defects and Liability period following completion. These include:
 - F2K camera issues known to the Board, scheduled for the six months following contractual completion
 - Works to investigate and address water ingress to cable ducts. This work is planned to take place during spring / summer.
- Two outstanding tasks that require either completion, or an agreement how they will be addressed during the Defects and Liability period, before Contractual Completion can be awarded:
 - Operation and Maintenance Manuals
A small quantity of work is required and they should be complete by the time of the Board meeting.
 - Cameras affected by power fluctuations at generator tests
An independent review has been undertaken that examined the power supply to and from the power supply units in the affected camera poles to establish, if possible, the likely cause. The review completed on 1st April and a report of the findings is expected in mid April. As above, depending on the content of the report there may be a need for additional works.

c) Progress

Completion is imminent subject to the outcome of the electrical investigations. Communication continues between the State Hospital Chief Executive and the Securitas UK General Manager as required.

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 £1,165k. This has increased by 47k since the February 2026 report to the Board. The overspend is entirely composed of TSH costs for Lead Advisors, management and escort staff. This month's increase includes a backdated sum to address the annual change to Framework Consultant rates imposed by Scottish Government.

Other than the contractual retention the remaining amount due to Securitas is currently a small negative.

The key project outline at 02 April 2026 is:

Project Start Date:	April 2020
Planned Completion Date:	May 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 02/04/26:	£9,957,269
Total costs to date (exc. VAT & retention) at 02/04/26:	£9,938,284
Total costs to end of project (Exc. VAT & retention)	£ 18,985

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 02 April 2026 is:

Securitas	£ 7.299m
Thomson Gray	£ 1.356m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 1.205m
Miscellaneous	£ 0.002m
Income	<u>-£ 0.124m</u>
Total	£ 9.938m

VAT has been excluded from calculations of amounts paid due to the potential for final adjustments on project completion.

4 RECOMMENDATION

The Board is invited to 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 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. 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

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE

ARC(M) 26/01

Minutes of the meeting of the Audit and Risk Committee held on Thursday 29 January 2026.

This meeting was conducted virtually by way of MS Teams and commenced at 9.30am.

Chair:

Vice Board Chair

David McConnell

Present:

Employee Director

Allan Connor

Non-Executive Director

Stuart Currie

Non-Executive Director

Pam Radage

In Attendance:

Corporate Business Manager

Anne Donnelly

Acting Director of Security, Estates and Resilience,

Alan Hardy

Internal Auditor, RSMUK

Asam Hussain

Chief Executive

Gary Jenkins

Director of Finance and eHealth

Robin McNaught

Head of Corporate Planning, Performance & Quality

Monica Merson

External Auditor, KPMG

Matthew Moore

Head of Corporate Governance

Margaret Smith

Director of Workforce

Stephen Wallace [for Item 5]

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell opened the meeting, welcomed everyone and introduced Mr Matthew Moore from KPMG, who was attending his first Committee meeting. He invited members to introduce themselves for Mr Moore's benefit. Mr McConnell also noted his thanks to John Blewitt of KPMG for his contribution to the External Audit of the Hospital in the preceding years of KPMG's appointment.

Apologies were noted from Mr Brian Moore, Board Chair.

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 2 October 2025 were noted to be an accurate record of the meeting.

The Committee:

1. Approved the minute of the meeting held on 2 October 2025.

4 MATTERS ARISING – ROLLING ACTION LIST UPDATE

The Committee reviewed the Rolling Action List and noted the progress of the actions that had either closed or would be picked up as part of the agenda for today's meeting.

Mr McConnell referred to the draft minute in relation to Roster Compliance (Page 4) which included follow up actions. The Committee considered how this should be taken forward and clarified that this would be re-visited under Item 6 of the agenda.

The Committee:

1. Noted the updates from the Rolling Action List.

5 INTERNAL AUDIT REPORTS

a) Absence, Disciplinary and Suspension Management

Mr Hussain of RSMUK presented the findings of the Absence, Disciplinary and Suspension Management Audit, which reviewed the Board's processes over the past 18 months. The audit was assessed as providing "reasonable assurance", noting strong policy compliance, clear communication, and high levels of mandatory training. Testing confirmed generally good practice in key areas including contact during absence, return-to-work meetings, and Occupational Health referrals. Also viewed positively was the HR Team's check-and-challenge approach, with only minor housekeeping issues noted. Some inconsistencies were identified, such as missing documentation for longer absences and occasional gaps in evidence of required referrals. Three of the four agreed actions had been completed, with the remaining action, establishing regular trend reporting on sickness absence, planned for reporting into the next Staff Governance Committee.

Mr McConnell thanked Mr Hussain for the update and welcomed the reasonable assurance conclusion. He invited Mr Wallace to comment, who confirmed that the findings were positive and that core processes, particularly around absence management, were being applied. He was reassured that triggers, patterns and key procedural checks were being followed. He emphasised the need for continued clear communication and support for managers and confirmed he was satisfied with the overall outcome.

Ms Radage was encouraged by the report and the positive assurance it provided, noting that the high volume of activity and strict deadlines made it more likely for small errors to occur. She enquired how managers could be better supported and suggested pairing new managers with experienced managers, or workshops to build confidence and experience. Mr Currie acknowledged the large volume of work required in getting staff back to work. He commented that this had demonstrated the efforts being made to support staff and did not raise any significant concerns.

Mr McConnell thanked members for their contributions and noted he was pleased to see the level of assurance achieved and commented on the volume of work that goes into the audit work, and the helpfulness of the process.

The Committee:

1. Noted the outcome of Internal Audit Report on Absence, Disciplinary and Suspension Management which had an outcome of reasonable assurance.

Mr Wallace left the meeting at this point.

6 INTERNAL AUDIT

a) Audit Progress Report

The Committee received the Audit Progress Report presented by Mr Hussain who reiterated the Absence, Disciplinary and Suspension Management audit had been completed with a reasonable assurance rating with action tracking ongoing. He noted that the Internal Audit team had met with executive colleagues to gather views on next year's audit plan, which was on track to be presented for approval at the March meeting. The final outstanding audit, Resilience Planning and Training was progressing well, with recent onsite work providing useful live insights, and that a positive outcome was anticipated presently.

b) Action Tracking Report

The Committee received the Action Tracking Report from Mr Hussain who highlighted that of the 20 actions on the tracker, eight were closed and one action was superseded. He noted seven actions were not yet due, but updates had been provided within the tracker and two actions had indications that they may not meet the target date due to the work involved.

Four actions required the Committee's agreement to either extend, revise, or supersede their implementation dates. The Roster Compliance actions were dependent on Optima, a national system outside the Board's control. Audit updates were scheduled for the February Staff Governance Committee with the intent of providing assurance on interim measures. Members were therefore asked to approve transferring the Roster Compliance actions to the Staff Governance Committee for ongoing oversight. The Committee agreed to this approach.

Mr Hussain provided an update on the Physical Health Audit report. For this, two KPIs were due to be shared with the Physical Health Steering Group in January 2026; however, at the time the report was written, that meeting had not yet taken place. He also noted the difficulty of setting realistic timescales for actions when these may include national workstreams that were outside of the State Hospital's control – he noted e-rostering systems as an example. Mr Currie agreed with this last point and emphasised the importance of setting realistic targets overall especially in the circumstances outlined by Mr Hussain.

Mr Connor requested clarification on the roster-compliance process, including how Lead Nurses complete consistency checks, what follow-up actions are taken, and how this information is recorded and reported. Ms Smith confirmed these points had been discussed previously and shared with the Associate Nurse Director for inclusion in the February report to the Staff Governance Committee, and Mr Jenkins also confirmed his agreement.

Mr Hussain also highlighted two 'not yet due' actions from the Estates Compliance Audit, noting that, following discussion with Mr Hardy, revised dates of 31 March 2027 were proposed to reflect the resource requirements of the service restructuring and the lead-in time needed if the proposals were approved.

Mr McConnell thanked Mr Hussain for the update and sought clarification on two remaining actions, one relating to the Absence, Disciplinary and Suspension Management audit, and the other to the Physical Health audit.

Mr Hussain confirmed that the Committee was being asked to approve one-month and two-month extensions respectively, and this was agreed around the table.

The Committee:

1. Noted the Audit Progress Report
2. Noted the Action Tracking Report

3. Approved transferring the Roster Compliance actions to the Staff Governance Committee for ongoing oversight.
4. Approved approve one-month and two-month extensions the Absence, Disciplinary and Suspension Management audit actions.
5. Approved the revised implementation dates for the Estates Compliance Audit.

6 CORPORATE RISK REGISTER

Mr Hardy presented the Corporate Risk Register, confirming all risks were up to date with no new additions since the last report. While no risks were assessed as very high, five remained high, and progress on each was outlined in the paper.

Mr Hardy noted that 14 risks had reached their target scores, while 10 remained above target and would be reviewed for potential reduction. He also advised that a new electronic incident-management system would go live before the end of March, after which all corporate and local risk registers would migrate to the new platform, strengthening oversight and control.

Mr Currie welcomed the progress on managing the Board's high-level risks and highlighted the strong progress made in reducing HRD116 (relating to the protecting Vulnerable Groups (PVG) process) from high to low as a significant achievement, especially given the strict national requirement for checks to be fully completed before staff could continue in post, and emphasised that this reflected the focus and diligence of staff.

In relation to FD96, relating to cyber security, Mr McConnell asked for additional assurance on the change in risk level from medium to low was, given that later reporting highlighted high levels of cyber-related activity and sought reassurance that the revised rating remained accurate in the wider context of ongoing cyber risks. Mr McNaught advised that the recent mock exercises had provided assurance that current cyber-security mitigations were effective. While vigilance in respect to cyber activity remained constant, testing indicated that systems were coping well in the present environment, which supported the decision to reduce the risk rating. He emphasised that the position was fluid and the rating could rise should new threats emerge and would continue to be closely monitored.

The Committee:

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

8 FINANCIAL POSITION UPDATE

Mr McNaught presented the Finance Report for month nine (to 31 December 2025) and reported a small variance at this stage, with a year-end break-even position still expected. Directorate meetings continued to monitor progress and were now focused on establishing budgets and savings plans for 2026/27. Ongoing pressures, particularly nursing expenditure, remained under close review. A meeting with the Scottish Government was scheduled for Monday (2 February) to discuss funding for the Women's Service, with the aim of securing clarity for next year. He advised that the Scottish Government was satisfied with the Board's current financial position and year-end projections. Capital funding for 2025/26 had been fully allocated and all projects expected to be completed within the year and priority setting for next year's capital programme was already underway.

Mr Currie welcomed the positive report, particularly given the wider financial pressures facing many NHS Boards. He noted the growing difficulty in achieving recurring savings and the increasing reliance on non-recurring measures, which adds pressure at the start of each financial year. He also observed that many Boards were investing in energy-efficient measures such as LED lighting, which continued to deliver meaningful savings.

Mr McNaught acknowledged the comments and highlighted the volatility of the financial position, noting that even small increases in clinical activity or patient transfers could affect the forecast, reinforcing the need for close monitoring. He confirmed that extensive LED replacement work had already been completed, with further projects underway, and that Estates continued to track costs to identify recurring savings. He added that increased engagement with budget holders over the past 18 months had strengthened financial understanding and accountability, though pressures remained.

Mr McConnell thanked members for their contributions and noted that, although the Board was in a relatively strong position, the operation of the new interim Women's Service continued to present a significant challenge. He noted that further discussions were scheduled with Scottish Government in this respect in the coming days.

The Committee:

1. Noted the Financial Position Update to 31 December 2025

9 AUDIT SCOTLAND NATIONAL REPORTS

Members received the Audit Scotland National Reports presented by Mr McNaught who noted the key themes and highlighted the report's strong focus on financial planning, management and long-term sustainability, with Audit Scotland describing the current delivery model as unsustainable. He advised that the report also referenced brokerage, spending caps and current intervention measures. While there were no recommendations directed specifically at the State Hospital or national boards, the broader recommendations on delivery planning and governance remained relevant. Mr McNaught further noted that the report drew attention to delayed discharges, which, although not applicable to the State Hospital, reflected wider national pressures affecting territorial Boards.

Mr Currie noted the Audit Scotland reports were helpful in the context of the reform required across public services including NHS Scotland, and highlighted the key financial pressures being experienced and the impact this had on service delivery.

Ms Radage noted this was an important point and reflected that it would be important for pressures across NHS Scotland to be understood, in the context of change initiatives.

Mr Jenkins reflected on this in the context of the sub-national planning workstreams would be significant, with financial planning to be in place by the end of this financial year.

Mr McConnell thanked members for their contributions and noted that it was interesting to receive these reports. He noted that, although much of the analysis did not directly impact the Board at present, the broader context of resource challenges was very useful.

The Committee:

1. Noted the Audit Scotland National Report.

10 a) FRAUD UPDATE b) FRAUD ACTION PLAN

The Committee received the Fraud Update and Fraud Action Plan presented by Mr McNaught. He reported two new allegations in the last quarter, both under investigation. One earlier referral had been closed, and neither of the previous two cases (secondary employment during sickness leave and inaccurate recording of hours) required further action by the Board or CFS.

He confirmed that the Fraud Action Plan remained in place and aligned with CFS, and that the team had attended the annual CFS review. While allegation numbers remain low, members took assurance from staff vigilance and willingness to report concerns, demonstrating that the counter-fraud processes were working effectively.

Mr Currie agreed that Mr McNaught had raised an important point, noting that the absence of reported fraud concerns could in of itself be a risk if issues were not being identified or escalated. He highlighted that, at a time of financial pressure and efficiency demands, staff awareness of potential fraud was essential. He welcomed that concerns were being reported and that investigations had found no further action was required, emphasising that timely reporting and investigation help maintain confidence in the organisation's processes.

Mr McConnell thanked Mr McNaught for the update.

The Committee:

1. Noted the Fraud Update and Fraud Action Plan.

11 CYBER CRIME UPDATE

Members received the Cyber Crime Update and Mr McNaught provided details on the ongoing cyber risk position. He noted that there had been no major national or local risks raised in the last quarter but confirmed strong awareness and any notified threats had been successfully quarantined and cyber security training continued through mandatory training requirements.

Mr Hussain commented that the paper was very helpful and commended the team's reassessment and downgrading of the cyber risk which demonstrated that the Board's systems were effectively identifying and containing threats.

Mr McConnell thanked Mr McNaught for the update.

The Committee:

1. Noted the Cyber Crime Update.

12 AUDIT PLANNING/PROGRESS REPORT 2026/27

Mr Moore of KPMG presented the initial Audit Planning and Progress Report for 2026/27. He noted that Board expenditure had increased to £52.5m, resulting in a materiality level for the Audit of £1.3m. Audit testing will be conducted to a threshold of £975k, with any misstatements above £65k, or any instance of fraud or loss of cash, reported to the Board. The key audit risks identified relate to potential manipulation of expenditure under financial pressure, the full valuation of land and buildings due this year, and new transactions associated with the Women's Service. Standard work on management override of controls would continue as in previous years. Interim audit work had commenced, with the full audit plan due by the end of March and final fieldwork scheduled for May and June. Audit fees, mandatory communications, audit team details and confirmation of auditor independence were also provided.

Mr McConnell thanked Mr Moore for the updated asked if the full report with final figures would be provide to the March meeting. Mr Moore explained that, as required under the Audit Scotland approach, only a draft audit plan could be provided at this stage. A full and final plan would be issued once the planning and risk-assessment work had been completed. He confirmed that the next report, containing the complete plan and initial wider-scope findings, would be presented to the Committee in March and the year-end report would come to the Committee in June.

The Committee:

1. Noted the draft Audit Planning / Progress Report for 2026/27.

13 FINANCE, eHEALTH AND AUDIT GROUP UPDATE

The Committee received the Finance, eHealth and Audit Group Update from Mr McNaught who noted that the group continued to conduct business in line with terms of reference and there were no matters highlighted that required escalation to the Committee.

The Committee:

1. Noted the Finance, eHealth and Audit Group Update.

14 SECURITY, RESILIENCE, HEALTH AND SAFETY OVERSIGHT GROUP

The Committee received the Security, Resilience, H&S Oversight Group Update from Mr Hardy who noted that there were no issues from the group that required to be highlighted to the Committee.

Referencing Page 3 of the report Ms Radage sought clarification on two points. She asked whether the active travel initiative to support staff access to the hospital was on hold pending additional resources, and whether a timeline had been identified. Mr Hardy confirmed that this related to a staff vehicle lease scheme and that this was still under development at this stage.

In response to a further query on the governance reporting route for the Health and Safety Committee, Ms Smith confirmed that it reports formally through the Partnership Forum which reports through the Staff Governance Committee. She advised that this arrangement had been strengthened further through the introduction of a Working Environment report.

The Committee:

1. Noted the Security, Resilience, H&S Oversight Group Update.

15 ANY RELEVANT ISSUES ARISING TO BE SHARED WITH OTHER GOVERNANCE COMMITTEES

Mr McConnell noted that the Absence, Disciplinary and Suspension Management Audit report should be shared with Staff Governance Committee. The Committee agreed that the outstanding points from the Roster Compliance Audit would be referred on to the Staff Governance Committee for oversight and monitoring.

Action: Secretariat

16 ANY OTHER BUSINESS

There was no other competent business noted.

17 INTERNAL AUDIT SERVICE PROVISION

The Committee agreed that reporting in relation to the provision of internal audit services would be considered in a private meeting due to the commercial sensitivities involved.

18 DATE OF NEXT MEETING

The next meeting would take place at 9.30am on Thursday 19 March 2026.

The meeting ended at 11.05 am.



THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 16 April 2026
Agenda Reference No: Item No: 20
Author(s): Head of Corporate Governance
Title of Report: Summary Report – Audit and Risk Committee
Purpose of Report: For Noting

This report provides the Board with an update on the key points arising from the Audit and Risk Committee meeting that took place on 19 March 2026.

1	Internal Audit	A finalised audit was reviewed relating to Resilience Planning and Training which received reasonable assurance. The Committee also received the draft annual report for internal audit activity for 2025/26, which had a proposed opinion of positive assurance overall, as well as reviewing the draft internal audit plan for the coming year which outlined the areas covered.
2	External Audit	The External Auditors KMPG attended and provided an update on progress on the audit for the current financial year, with no significant issues identified at this stage, and work progressing on track.
3	Corporate Risk Register	Reporting outlined the position on the Corporate Risk Register, and confirmed that all risks had been reviewed and were up to date and that there were no proposed additions to the register. There was discussion on alignment of risks to standing committees and on the progress being made with migration of risk data to the InPhase system.
4	Finance	The Committee received an update on the financial position to Month 10 reporting a small underspend and continuing indication of breakeven for year end, and noted this positive position. The interim women's service was a key area of focus moving into the next financial year, with notable concern on budgetary funding in this respect along with the potential for increased energy costs.
5	Counter Fraud	The Committee received a quarterly summary of alerts received from Counter Fraud Services (CFS) and noted this with no matters requiring escalation.
6	Cyber Crime Report	The Committee received an update, noting no major or local risks reported in the past quarter. The Committee received assurance on the strong awareness and practices within the organisation. No significant issues affecting the State Hospital had been reported

		during the period covered.
7	Policy Update	Reporting provided a summary of the position, on review and update of organisational policies, and it was noted that further work should continue to streamline policies or convert to procedures. This should have a focus on effectiveness and whether there was a continued need for a policy overall.
8	Anchors Strategy	The Committee received a six month update on the delivery of the Anchors Strategy with work to support community wealth building including continued engagement with local suppliers. In terms of workforce, there had been an expansion of apprentices and uptake of the demonstrator programme. This was received positively in terms of the impact being made by the State Hospital locally.
9	Draft Governance Statement	The Committee reviewed the initial draft of the Governance Statement for the current year, noting the further updates to be added at conclusion of the year, prior to submission to the Board.
10	Review of Accounting Policies	There were no significant changes proposed, and this was approved.
11	Review of Standing Documentation and Committee terms of reference	The Committee received reviews of the Scheme of Delegation and Standing Financial Instructions, with minor amendment. The Committee noted that there were no proposed changes to the Standing Orders or Members Code of Conduct. The Standing Documentation was approved for onward submission to the Board. The Committee reviewed its own terms of reference with no proposed changes.
13	Internal Updates	The Committee received updates from the Finance eHealth and Audit Group, and the Security, Resilience, Health and Safety Group, with no matters requiring escalation.

RECOMMENDATION

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