NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

THURSDAY 26 FEBRUARY 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 18 December 2025	For Approval	TSH(M)25/11
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 26/01
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
9.50am	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Acting Director of Security, Estates & Resilience	For Decision	Paper No. 26/02
8.	**Finance Report – to 31 January 2026** Report by the Director of Finance & eHealth	For Noting	Paper No. 26/03
10.15am	**CLINICAL GOVERNANCE**		
9	**Physical Health Strategy** Report by the Medical Director	For Decision	Paper No. 26/04
10.	**Carers Strategy – Update** Report by Director of Nursing and Operations	For Noting	Paper No. 26/05
11.	**Daytime Confinement (DTC) Report** Report by Director of Nursing and Operations	For Noting	Paper No. 26/06
12.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 26/07
13.	**Clinical Governance Committee:** Approved Minutes of meeting held 13 November 2025	For Noting	CGC(M)25/04
	Report of meeting held 19 February 2026		Paper No. 26/08

10.50am	STAFF GOVERNANCE		
14.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 26/09
15.	**Whistleblowing Report** Report by the Director of Workforce	For Noting	Paper No. 26/10
16.	**Staff Governance Committee:** Approved Minutes of meeting held 20 November 2025	For Noting	SGC(M) 25/04
	Report of meeting held 12 February 2025		Paper No. 26/11

11.10am	BREAK		
11.20am	**CORPORATE GOVERNANCE**		
17.	**Corporate Objectives 2026/27** Report by the Head of Corporate Governance	For Decision	Paper No. 26/12
18.	**Quarterly Update Report Q3 Key Performance Indicator & Annual Delivery Plan Update** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 26/13
19.	**Project Update for the National High Secure Forensic Healthcare Services for Women in Scotland** Report by the Programme Director	For Noting	Paper No. 26/14
20.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Programme Director	For Noting	Paper No. 26/15
21.	**Audit and Risk Committee:** Approved Minutes of meeting held 2 October 2025	For Noting	ARC(M) 25/04
	Report of meeting held 29 January 2026		Paper No. 26/16
22.	**Any Other Business**		Verbal
23.	**Date of next meeting: tbc** 9.30am on 16 April 2026		Verbal
24.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
25.	**Close of Session**		Verbal

Estimated end at 12 noon

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 25/11**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 18 December 2025.

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

Chair:	Brian Moore
Present:	
Employee Director	Allan Connor
Non- Executive Director	Stuart Currie
Non- Executive Director	Cathy Fallon
Chief Executive Officer	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Finance and eHealth Director	Robin McNaught
Non- Executive Director	Pam Radage
Non-Executive Director	Shalinay Raghavan
Medical Director	Lindsay Thomson
In attendance:	
Patients' Advocacy Service Manager	Rebecca Carr [Items 7 & 8]
Acting Director of Security, Estates & Resilience	Allan Hardy
Head of Communications	Caroline McCarron
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minute]
Patients' Advocacy Service	Michael Timmons [Item 8]
Social Work Manager	Lindsey Young [Item 7]
Programme Director	David Walker [Items 21 & 22]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone and noted apologies from Dr Joe Judge, Chair of the Clinical Forum and Mr David Hamilton, Social Work Mental Health Manager.

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 23 October 2025 were noted to be an accurate record of the meeting.

<u>The Board:</u>

1. Approved the minutes of the meeting held on 23 October 2025.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

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

Matters arising that were not on the action log were invited. Mr Jenkins highlighted the imminent return of the resident doctors' ballot on industrial action and confirmed that he had taken forward associated contingency planning, should this prove necessary.

Items 1 and 5 on the action log were noted as being covered later in the agenda in today's meeting.

The Board:

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

5 CHAIR'S REPORT

Mr Moore provided an overview of his activity since the last Board meeting. He reported on the Ministerial Annual Review, which took place on 24 November 2025, and expressed thanks to all staff who had been involved for their contributions. The Minister's letter had been received this week and would be considered under Any Other Business.

He also noted recent celebratory events within the hospital including the Patient Partnership Group Christmas Party which he had attended alongside Mr Jenkins. There had also been a staff Long Service Awards event, which had been very positive. Mr Moore noted that both he and Professor Thomson had attended the national Scotland Health Awards with a team from the State Hospital in conjunction with the Forensic Network had been finalists in the Global Citizenship category.

Mr Moore highlighted the Board Development Session which had taken place on the 30 October and had included discussion on corporate governance and operational effectiveness, communications and the "Made Purple" initiative.

He also reported on discussions at the Board Chairs' meetings, which included sub-national planning, a presentation from the Patient Safety Commissioner for Scotland, and updates on NHS Delivery.

Mr McConnell had attended the Board Chairs' meeting on 3 December, with the Cabinet Secretary for Health and Social Care. He advised that this meeting had also been focused on sub-national planning and the wider NHS reform agenda as well as improvements in the delivery of planned care. The importance of encouraging staff uptake seasonal flu vaccination a well as the progress made in relation to the Reduced Working Week.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided his report, beginning with national updates. He referred to DL(2025)25 on sub-national planning, noting that further detail and discussion would be part of the Private Session. He outlined the work of the Service Reform Oversight Board in relation to governance for major change programmes.

He reported on the transition to a new Multi-Agency Public Protection Arrangements (MAPPA) system, and the key achievement in signing of a Memorandum of Understanding for healthcare in custody between Integration Joint Boards, NHS Boards, and the Scottish Prison Service. He noted that he had proposed the State Hospital as an early pilot site in this regard. He had also attended the cross-ministerial group led by the Cabinet Secretary for Justice. He advised that the NHS Executive Group was progressing business systems change for 2027/28 and that the State Hospital was aligned to these developments.

Turning to local matters, Mr Jenkins also confirmed that the Annual Review had been completed, and the Minister's letter received. A leadership development day had taken place within the hospital on 1 December and had focused on leadership structures and the Annual Delivery Plan. The Strategic Planning and Performance Group had met as well as Directorate Performance Review meetings.

The Scottish Human Rights Commission had visited the hospital, including a tour of the Women's Service. Further, the security project was entering its final stages. He advised that Mr Hardy had hosted a business resilience session in conjunction with Police Scotland, and that a major incident planning document had been developed. He also confirmed the progress made locally on the Reduced Working Week, and that the estimated cost of for the State Hospital was approximately £1.3 million and that planning was being aligned with workforce and finance. He was pleased to note that in relation to performance metrics, a new physical health Key Performance Indicator (KPI) was now in place.

Mr Jenkins advised on the introduction of the Nursing Partnership Forum within the governance framework, and also noted seasonal events at the hospital, including the recent ecumenical service.

The Board:

1. Noted the update from the Chief Executive.

7 PATIENT STORY – PATIENTS RIGHTS DAY

The Board received a presentation on the Patients' Rights Day which had taken place on 20 November. Ms McCaffrey introduced this item, reflecting on the importance of patients being well informed about their rights over a number of areas.

Ms Carr and Ms Young joined the meeting and led the Board through the presentation. This focused on taking forward a rights-based model and fostering a culture to support that. As part of this, it was essential for patients be aware of what rights they have. A Patients' Rights Day had been held in the hospital on 20 November 2025, jointly led by Social Work Services alongside the Patients' Advocacy Service. It offered an opportunity to hear from patients about what rights were important to them, and how to offer support. The theme was focused on Advance Statements, and there were also links to the Complaints Service.

A session was held in the Skye Centre in the morning, with further session within wards in the afternoon in an effort to reach as many patients as possible. Materials were produced to support the event including easy read guides. After the event, positive feedback was received from patients including the helpfulness of support to complete an Advance Statement, and the benefit of being able to come together as peers to discuss rights and what they mean. Patients said that they felt that this made them feel more respected and treated as a person not a patient.

The aim was to make this an annual event, and to take on learning from this first instance. Patients had said that it was easier to speak more freely at the event in the Skye Centre, so the intention was to arrange two group events in the centre next year alongside targeted outreach within wards for patients who would be unable to attend these events. Given the positive reception, it would be helpful to produce more materials such as a rights-based booklet, and there was also a plan to co-produce a poster with the Patient Partnership Group. A further objective was to develop this approach to include an event for carers. The presenters indicated that there would be a need to seek additional funding for the event to take forward these future aims.

Mr Moore thanked Ms Carr and Ms Young for this very interesting presentation and for the work they were leading on, especially the "person not patient" ethos. Professor Thomson agreed with this and offered her support, commenting positively on the theme of channelling awareness of rights with the focus on Advance Statements. She also raised the question of how to build this approach into business-as-usual workstreams. Ms Young noted the role of Key Workers in doing so, as well as Social Work staff with periodic exposure for patients, especially before Care Programme Approach (CPA) meetings.

Ms Fallon thought that the positive collaboration shown here was excellent and supported the idea to

explore the feedback from patients in terms of being able to speak more freely in group sessions, separate from the ward environment. It was also important to embed understanding of patients' rights at ward level. Ms Radage agreed with this and reflected on the way that patients had open discussions within the Patient Partnership Group. Mr Currie explored this further saying that there may be a need to balance expectations, as well as a shift in approach so that this can be seen as a helpful lens rather than a challenge. He referred to the constructive way complaints were managed in the hospital which helped to build confidence in the system. He also asked about how to use every day, accessible language to break down themes, and how to hear from patients who had not felt able to raise their voice.

Mr Jenkins welcomed this work and noted his interest in what the top five rights patients identified through production of the right-based leaflet. He also noted the value in collaborative work and the way that the Patients' Advocacy Service linked positively with other services within the hospital.

Ms McCaffrey spoke further about how to embed this approach further and that her aim was to build on this further in terms of the feedback to date especially around supporting patients across the hospital environment, making this accessible, and also amplifying quieter voices. As well as through the group sessions, patients could be supported individually through clinical teams. Learning could also be routed through the Person-Centred Improvement Group. Ms Merson added that there had been a Quality Improvement project through the TSH3030 workstream, involving patients in the Transition Service called "Voices for Rights", and asked how this linked to this project as there had been similar themes.

Ms Carr provided responses to the points raised including how to link this initiative with the TSH3030. She outlined the contacts that PAS would have with patients within the first 12 weeks of admission, as well as prior to every CPA to ensure that patients were aware of their rights throughout the course of their care.

She thought that it would be important to respond to patient feedback about the setting of these sessions, and their feeling that it was easier to have an open group discussion away from the ward environment and the staff they interacted with on a daily basis. More widely, should patients raise any concerns with PAS, then this would be routed in a way that was comfortable for the individual. It was always important to remember that patients may change their views over time as well and depending whether they had recently been admitted or where close to moving on from the hospital.

Ms Carr was also thoughtful about how patients were able to access a private space away from ward areas to raise any concerns they may have. Patients had also fed back that they had previously found the availability of the dedicated PAS room in the Skye Centre to be really helpful as this facilitated the ability to "drop in" and discuss any issues arising.

Ms Carr said that use of accessible language was really important and used routinely as part of the service, and that advocates would, in discussion with the patient, take steps to ensure that the patient had taken in the information and could talk about the subject in a meaningful way.

Mr Moore summed up the discussion as being a good example of partnership working between services and demonstrated good practice at a local level. He thought that publicising this work may be a good way to showcase and promote the State Hospital, as the initiative continues into next year.

<u>The Board:</u>

1. Noted the update on the Patients' Rights Day which took place on 20 November 2025.

8 PATIENTS' ADVOCACY SERVICE – 12 MONTH REPORT

The Board received a paper (Paper No. 25/107) to set out the activity of the Patients' Advocacy Service over the past 12-month period. Mr Timmons also joined the meeting to co-present the paper with Ms Carr. This included a summary of performance against KPIs, noting that this was a positive picture overall. Mr Timmons commented on the importance of trust in the service from patients, and that there had been an increase in demand for support and the number of patient contacts made which demonstrated increasing trust levels. Whilst there may also be other factors at play, Mr Timmons

highlighted the real and direct efforts of the team to increase their visibility within the hospital.

Ms Carr then outlined the main factors of service development over the period including attendance at 95% of patient meetings, as well as wider patient engagement e.g. involvement in TSH3030, and the development of the “Get On Get Out” book. She also outlined future plans which included expanding the service to include the new Women’s Service, as well as staff wellbeing initiatives.

Ms Raghavan thought that the work that PAS were doing to support patients was of significant benefit for patients, especially providing support in tribunals as this helped to involve the patients. She asked about any perceived risk to the provision of this service, given the size of the team. Ms Radage agreed saying that it was evident that the team provided essential services within limited resources and asked about whether PAS currently linked with carers directly and also noted patient feedback about the way in which CCTV supported transparency.

Mr McConnell also asked about available funding for expansion of the service to the Women’s Service, as well as whether the inclusion of patient representatives had been resolved for the PAS Board. Ms Fallon asked about what changes had been made in relation to the use of talking mats, as this had featured in previous reporting. She also asked whether there was any comparison to how advocacy services operate at other high secure hospital sites in the UK.

Mr Jenkins commented that he thought the report was very welcome and positive, referring to recent comparison of the provision of advocacy services within mental health services across NHS Scotland. He would be pleased to share the report with the NHS Scotland Board Chief Executive cohort as an example of good practice.

Ms Carr acknowledged the risk to the service within a limited funding envelope and confirmed that the costs of extending the service to female patients was being consumed within this. She confirmed that there were now two patient representatives on the PAS Board. Linkage with carers was currently fairly limited, and the thinking in this respect was to take forward a carers information session about how PAS worked with patients. She also said that she would look into how advocacy services operated at other high secure hospitals, to see what information was available and could be shared.

Action – Ms Carr/ Ms McCaffrey

She went on to say that Talking Mats were a specific resource and so were produced on a number of occasions to align with specific areas e.g. CPAs, Advance Statements, court processes. Mr Timmons added that these were based on a specific set of graphics for the State Hospital which could be shared as this may be useful more widely. They were used extensively as it was a good method of communication and helped to gain richer information from patients. Ms McCaffrey also added that she chaired the Forensic Network’s Improving Experience Group, and that a regional approach was being taken. Carers from the State Hospital attended the West of Scotland / North Groups. She thought it would be beneficial to link with PAS so that they could attend a session.

Mr Moore thanked Ms Carr and Mr Timmons for their report and presentation.

<u>The Board:</u>

1. Noted the 12-month report from PAS.

9 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 25/108) from the Acting Director of Security, Resilience and Estates in respect of the Corporate Risk Register. Mr Hardy provided a summary of the key aspects including that the risk ND70 (optimising patient care and experience) had increased to High due to staffing and resource demand. The risk FD96 (cyber security breach) had reduced from Medium to Low as a result of effective management. Workforce risks, including those associated with the Reduced Working Week (RWW) and the Protecting Vulnerable Groups (PVG) process had also reduced.

He advised that the migration to InPhase was scheduled for completion by March 2026, replacing Datix

as an incident reporting system as well as for the management of complaints and legal claims. He confirmed that local registers were being monitored within directorates with an escalation route through the Organisational Management Team (OMT) to the Corporate Management Team (CMT).

Ms Fallon asked for further assurance around the operational model given the increase in the risk grading in ND70, and Ms McCaffrey responded by noting the work progressed to better understand the background and longitudinal data including the impact of clinical acuity. This provided assurance that there had not been an overall shift, but changes within the peaks and troughs of activity. The change experienced had been in the impact of the Women's Service, which was trending to show that a greater staff resource was required than had been anticipated and planned for. This was now being reviewed to better plan resourcing based on the experience since the service had opened.

In response to a request for more information on the change to the KPI linked to MD30 (relating to patient obesity) Professor Thomson explained the background to setting a more meaningful primary KPI i.e. patients to gain less than 15% of body mass during their time at the State Hospital, regardless of length of admission; and that this would be underpinned by secondary KPIs relating to patient care and activity. It was noted that specific reporting in this respect would be routed though the Clinical Governance Committee.

Mr McConnell noted the challenges being experienced across NHS Scotland in relation to managing the RWW, and that it was positive to see that this was not of particular concern within the State Hospital, and Mr Jenkins noted that it was a national challenge that NHS Boards were reviewing collaboratively especially in terms of the additional funding required as a whole.

Mr Hardy also responded to a query in respect of InPhase, in terms of how the benefits of this would be felt as a local level. He said that this was a new national platform which would align data across NHS Boards, especially in terms of performance and risk management reporting.

It was noted that SD51 in respect of the Security Project would be reviewed as the project came towards completion, and that this would be updated and brought back to the Board. The Board also noted the timings of reviews over the Quarter 4, and the work involved during this period.

<u>The Board:</u>

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

10 FINANCE REPORT

The Board received a paper (Paper No. 25/109) from the Director of Finance and eHealth, presenting the financial position to 30 November 2025 (Month 8).

Mr McNaught provided a summary of reporting with a small favourable variance and anticipated a break-even position at year end. Pressures were noted in the nursing budget, particularly due to acuity and the Women's Service. The increased resourcing pressure due to the Women's Service was being escalated to Scottish Government in terms of evaluating the ongoing funding required going into 2026/27. He asked the Board to note that reporting also included more details of the financial cost of sickness absence which was approximately £2m year-to-date, compared to £1.9 million in the prior year.

He advised that the Scottish Government was content with the current forecast and savings trajectory, and finally that the additional capital funding received in-year for maintenance works was being fully utilised.

Ms Raghavan asked about the discussion to date with Scottish Government, and Mr McNaught spoke to the need to progress the valuation of this in terms of clinical acuity and the related staff resourcing requirements. The current estimate may need to be reviewed and subject to change including in terms of patient numbers within the service – so this was a fluid position, and this had been highlighted to government colleagues. Mr Currie agreed with the need to anticipate possible change and asked about

the risk if the additional funding was not within the base budget. He also asked about confidence levels for a break-even position given that this was now near to the end of Quarter 3.

Ms Fallon noted that during a recent walkround in the Estates Department, discussion had been focused on the impact of vacancies within this small team. The availability of additional capital funding was welcomed, but his also caused pressures in order that works could be delivered by year end. She also suggested that it would be helpful to include the background to the M365 project within a Board Development Session to give wider understanding of the position. Further, how assurance could be given on ensuring that Protected Learning Time (PLT) was delivered as part of the Agenda for Change (AfC) agreement given the costs that this would entail.

In terms of the Women's Service, Mr Jenkins noted that the baseline activity in service provision was higher than had been anticipated prior to the service commencing. The available data in this respect would inform what would be required going forward in order to continue to admit patients into the service safely. Work was underway to do so that that this could be included in the draft budget for 2026/27 due to be submitted to Scottish Government by the end of January.

He also agreed with the point raised about the impact of vacancies and confirmed that these had been filled within Estates and that this would help to deliver the required maintenance works which were underway. In terms on M365, he noted that this was the system required in order to deliver the central business systems for NHS Scotland as part of the service renewal agenda. He also advised that understanding at present was that PLT would be supported though funding to NHS Boards. Mr McNaught added that indicative discussions were underway with Scottish Government on this last aspect. He also highlighted that in relation to M365, this was dependent on national timescales being led through NHS National Services for Scotland (NSS). He provided further assurance on the point raised about the break-even forecast saying that this was the indicative position at this stage, with no further concerns to raise at this stage.

Mr Moore thanked Mr McNaught for detailed reporting and noted the ask for the next Board Development Session to include a session on the funding of the Women's Service; as well as a future session on M365.

Action - Ms Smith

The Board:

1. Noted the content of the report.
2. Requested the noted items to be included within Board Development Sessions

11 NURSING RESOURCE STRATEGY 2026/27

The Board received a paper from the Director of Nursing and Operations (Paper No. 25/110) which provided an overview of the direction of strategy, in response to a number of internal and external influences. Ms McCaffrey summarised the detail contained in the paper, describing each of the factors in turn.

She noted the progress made towards e-Rostering following successful roll out in Mull Hub, and the evidence to demonstrate that de-centralising in this way had led to better decision-making. This would now be rolled out across the rest of the hospital. Ms McCaffrey highlighted the impact of the AfC Reduced Working Week for nursing shift work, providing assurance on the review of shift patterns and engagement with staff. There was also work initiated on recruitment to vacancies created by this workstream. In respect of the Band 5/6 review and PLT, any resultant impacts will be managed through the Workforce Governance Group.

A key factor in nurse resourcing challenges was clinical acuity, and Ms McCaffrey acknowledged that whilst longitudinal data did not evidence a shift in trends, peaks in acuity did have clear impact. There was a need to further interrogate this position once staffing levels had returned to the previously agreed (over recruited) position. The opening of the Women's Service mid-year has had considerable impact as it had been operating above its funded establishment since the date of its introduction. The Women's

Service Project Oversight Board were reviewing the estimated staffing requirement for the coming year so that this could be considered in terms of funding.

Ms McCaffrey noted the agreed requirements in this regard, with plans in place to attract male candidates with this having been shown to be successful for Health Care Support Worker (HCSW) roles. The proactive approach to recruitment would continue, with the Corporate Management Team (CMT) having agreed over recruitment to the base establishment at 105% linked to the RWW. Lastly, Ms McCaffrey underlined the persistent high level of sickness absence within the nursing cohort, with key focus being the aim to reduce this to within the 5% target rate; and this was being taken forward in partnership with the HR team.

Ms Fallon thought that the report was helpful as setting out the directorate position, and that this may be a useful tool more widely across directorates. Ms Raghavan echoed this and asked about the challenges being experienced in nursing recruitment on a national level. Ms McCaffrey said that on a comparative basis, the State Hospital was performing well in this regard, whilst it was the case that it was a competitive landscape. She thought that the recruitment initiatives like the open day held in the hospital this year had been very successful, and that there had been success in attracting HCSW in particular. These type of initiatives served to open up forensic mental health care to a wider audience.

Ms Radage also thought reporting was helpful and commented positively on the proactive approach to recruitment being taken, as well as the savings made in the reduction of overtime costs.

Mr Moore summed up for the Board, underling the difficulties being experienced in nurse recruitment across NHS Scotland, and the benefits for the State Hospital to be able to demonstrate that it was a good place to work.

<u>The Board:</u>

1. Noted the content of the report.

12 DAYTIME CONFINEMENT (DTC) REPORT

The Board received a paper from the Director of Nursing and Operations (Paper No. 25/111) which provided an update on the progress to ensure that DTC would cease within the State Hospital. This was presented by Ms McCaffrey, who noted that the hospital continued to be in a period of difficulty due to the impact of the Women's Service as noted earlier.

She advised that a bespoke Incident Command Process had been established, with in-hours approval by herself or the Associate Director of Nursing; and out-of-hours approval by the Duty Director. A standardised template and central record repository had been created. This would ensure that there was a consistent approach as well as robust recording of decisions.

Ms Fallon acknowledged the good progress being made and asked about the pressures on other professional groups within the hospital in this regard. Ms McCaffrey acknowledged the impact on a range of staff cohorts including psychology and Allied Health Professionals (AHPs) saying that delivering services operationally was about balancing risks and patient needs within the parameters given and to be realistic on this. The aim was to minimise impact as much as possible, though some workstreams had necessarily been deferred as safe delivery had not been possible. She added her praise for staff for what they had been able to achieve despite the challenges presented.

Mr Jenkins added that this had also been discussed within the Nursing and Operations Directorate Performance Review meeting, and it had been acknowledged that at times staff from other disciplines were being deployed to support services. However, the key aim was to prevent DTC. If this were not being done then DTC would have to take place, and this would prevent delivery of wider workstreams in any case. He reiterated the point made by Ms McCaffrey in terms of being realistic within this context. Ms Raghavan commented that reporting showed that the approach taken was both thoughtful and innovative, as well as being proportionate. It was important for both staff and patients to be able to see this to aid understanding. In response to a point of clarification on outboarding, she also confirmed that the data presented here was accurate. Mr Moore noted the impact in particular of an additional 19 shifts

per day being required die to clinical acuity which was significant.

Mr Connor asked if there was any additional risk over the seasonal period due to annual leave, given the support being provided by wider clinical professions. Ms McCaffrey said that leave was being managed so that it was not excessive, but that there may be a risk due to seasonal influenza rates. She thanked staff as there had already been many who had volunteered to cover shifts over this period.

The Board also asked for a future update in the implementation of the new Incident Command process.

Action – Ms McCaffrey

The Board:

1. Noted the content of the report.
2. Requested a future update on the implementation of the new Incident Command process.

13 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 25/112) which outlined key aspects of quality assurance and improvement activities since the last meeting. This was presented by Ms Merson, who emphasised the way in which the Clinical Quality Strategy aligned with the Scottish Approach to Change, newly launched through Healthcare Improvement Scotland. Ms Merson reported that four clinical audits had been completed, three with moderate assurance and one with limited assurance, for which an improvement plan had been signed off.

There were ten active quality improvement projects, and a TSH3030 poster had been presented at the Forensic Network Conference which took place in November, with a further poster accepted for the International Forum on Quality and Safety in March 2026. She also advised that Team-Based Quality Reviews (TBQR) had been completed for the Intellectual Disability Service, with this planned for the Admissions and Assessment Service in the New Year. Thirty guidance documents had been reviewed, with the two outstanding evaluation matrices progressing to sign-off in the New Year.

Ms Fallon offered congratulations on the workstreams outlined, particularly the progress on TBQR and poster presentations. She noted the number of QI projects and asked how this compared to previous periods, and how this was assessed. She also underlined that the amber rating aligned to Lewis wards 1 and 2 were noted within clinical audits, and Ms Merson confirmed that this was routed through the clinical team with further oversight through the Clinical Governance Group. Mr Moore commented that it would be helpful to see the master audit data reported regularly through to the Clinical Governance Committee, and this was agreed.

Action – Ms Smith/Ms Merson

Mr McConnell asked about Key Worker attendance at CPAs, as this had decreased. Ms Merson noted that this was often related to staffing pressures around periods of clinical acuity, with staff being required to resource another area. However, the Key Worker would not be the only member of the nursing team with direct knowledge of the patient at the CPA.

Ms Radage commented further on the point raised on the number of QI projects and asked how training was managed and if there was a benchmark figure for the number of staff supported to take part. Ms Merson confirmed that it was voluntary with line manager approval, with three rounds of training each year and a maximum of around eight or nine in each cohort. Therefore, there was good opportunity for staff and for projects to be generated.

The Board:

1. Noted the content of the report.

14 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minutes of the meeting, which had taken place on 14 August 2025, as well as a summary report (Paper No 25/113) of the meeting which had taken place on 13 November 2025.

The Board:

1. Noted the content of the approved minutes dated 14 August 2025.
2. Noted the update from the meeting held on 13 November 2025.

15 CLINICAL FORUM

The Board received the draft minutes of the meeting, which had taken place on 25 August 2025. It was noted that there had been reference to an issue around communication within the minutes and that it would be helpful to receive further clarity in that respect.

The Board:

1. Noted the content of the minutes dated 25 August 2025.

16 STAFF GOVERNANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 25/114) providing an overview of workforce performance data, and this was presented by Mr Wallace. He reported that overall absence in November was 8.5%, with short-term absence increasing due to flu and colds, while long-term absence had decreased for the fourth consecutive month. Nursing short-term absence had increased by 1.8%.

Recruitment campaigns for registered nurses and healthcare support workers were ongoing, with the aim of achieving 105% establishment to reduce overtime and supplementary usage. Mr Wallace noted that staff turnover was 4.78% and the uptake for exit interviews was increasing. Development of ward and specialty dashboards across key performance indicators was underway. Further, that audits were being undertaken around sickness absences for stress and musculoskeletal related absences, as these were the most commonly experienced trends, and this would help to ensure that available resources to assist staff back to work were being utilised effectively.

Mr Moore welcomed this report which provided a high-level overview, whilst the issues involved were examined in greater detail by the Staff Governance Committee. Mr Currie agreed with this and thought that the provision of seasonal trend information was helpful. Further that the pattern of improvement in levels of long-term absence was encouraging, commenting on the importance of recognising when staff were at a tipping point in a shorter-term absence, so as to support them back to work if possible. Mr Wallace responded to this saying that a long-term absence was measured as commencing at 29 days, so this four-week period was extremely important to engage with and support the staff member, using the pathways and support mechanisms in place.

As a point of clarification, Mr Wallace confirmed that the results of the audit work described would be reported to the Staff Governance Committee in February 2026, and that an annual report on feedback from exit interviews would be reported by May 2026.

Ms Radage noted the absence rates for Lewis 3 as reported and reflected on previous clinical audit reporting. She also noted the positive work taken forward on retention of staff. Mr Moore noted the reporting previously received at this meeting linking staff absences to financial cost.

In this respect, Mr Wallace commented on the way in which the HR team were keen to work with line managers and departments to improve performance, and the aim was to develop a score card approach bringing together data across different areas of performance. Mr Jenkins agreed with this point, and the need to do this at different levels within directorates to be able to scrutinise performance and opportunity for improvement. He also said that there was further work to be done around improving

sickness absence in particular, given the impact of this financially on the organisation. Mr Moore agreed with this, saying that the more detailed data that was available at departmental and local levels was helpful in drilling down to the root causes, and focusing on improvement.

The Board:

1. Noted the content of the report.

17 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 21 August 2025; as well as a summary report (Paper No 25/115) of the key areas of reporting and discussion at the meeting which had taken place on 20 November 2025. Ms Radage noted the continued fruitful discussion at meetings, and welcomed the improved reporting received.

The Board:

1. Noted the content of the approved minutes of the meeting on 21 August 2025.
2. Noted the update in relation to the meeting held on 20 November 2025.

18 CLIMATE CHANGE AND SUSTAINABILITY

The Board received a paper (Paper No. 25/116) from the Acting Director of Security, Estates and Resilience in the form of an annual report setting out the actions and progress made in relation to climate change and sustainability during 2024/25. Mr Hardy presented this paper, noting that its purpose was to focus on the environmental performance of the organisation, as well as to highlight any outstanding actions or forward planning in place. The report was being made to the Board for its approval prior to onward submission to the Scottish Government.

Mr Hardy emphasised the good progress made, most notably that the State Hospital was already ahead of its Net Zero target by 17% based on 2024/25 data. During the current year, a key priority was creating and implementing a high-level waste route map as well as advancing active travel initiatives. Additionally, there was planning in place to raise further awareness on biodiversity and greenspace opportunities as well as fully implementing an Environmental Management System (EMS) within the hospital. Mr Hardy said that the key would be continuous improvement, reflecting that the LED lighting roll out was a good example of this.

In her role as Climate and Sustainability Champion for the Board, Ms Fallon offered thanks to Mr Hardy and his wider team for all of the good work to date, saying that reporting demonstrated this. It was a good position to be in, especially in the context of limited resources. Mr Currie also thought that reporting was positive, and that there may be potential for further savings to be made in time through initial investment initiatives e.g. air source pumps. Further, that the savings available through switching to LED lighting could be significant.

Ms Raghavan asked whether there was indication from Scottish Government at this stage for further funding or other means of support, as well noting that the State Hospital’s location could be challenging for active travel initiatives. Ms Radage then asked about the rate of take-up for salary sacrifice schemes such as cycle to work, and Mr Hardy noted that he would clarify this.

Action – Mr Hardy

Mr Jenkins added that a range of smaller initiatives could build impact over time in this area, referring to the Anchors Strategy, which was linked, with projects like “No Mow May” underway supporting nature and cross pollination in the spring months. In answer to a query from Mr Moore about the existing funding for the switch to LED lighting, Mr Hardy confirmed that this was currently at 50% of the estate, and further capital funding would be sought to roll this out further.

The Board approved the Annual Report for submission to the Scottish Government.

The Board:

1. Approved reporting and endorsed submission to Scottish Government
2. Requested further data on the level of take-up for salary sacrifice schemes linked to active travel initiatives.

19 BOARD WORKPLAN 2026

The Board received a paper (Paper No. 25/117) from the Head of Corporate Governance setting out the programme of work for the coming year. Ms Smith highlighted the kay aspects including review of the Board's Corporate Objectives, strategy, and related planning. Reporting summarised the changes made from the previous year's plan, as well as incorporating new aims and objectives. Ms Smith noted that whilst the plan provided an overarching structure, it would also be essential to be cognisance of changes throughout the year and the need to stand up additional reporting to reflect this. She also noted the importance of the Board Development Sessions and that a total of six had now been arranged for during 2026.

Mr Jenkins noted that the potential for change in the coming year, especially in the context of the new sub-national planning structure, and that this was also likely to be impactful.

The Board agreed that the work plan was endorsed on this basis.

The Board:

1. Approved the Board Workplan for 2026.

20 PERFORMANCE REPORT

The Board received a paper (Paper No. 25/118) from the Head of Planning, Performance and Quality, which set out the position in terms of performance against KPIs during Quarter 2 as well as performance against the commitments of the Annual Delivery Plan 205/26.

Ms Merson provided a summary of the paper, noting that of twelve key performance indicators, nine of which were green and three red (care and treatment plan reviews at 89.4%, healthy BMI at 10%, and sickness absence at 7.5%). She noted improvement in the KPI relating to patient activity levels which had moved into green.

Ms Merson confirmed that ADP key themes and deliverables were progressing, including those relating to the Women's Service where an enormous amount of work and commitment had meant that the service had become operable by its target date.

Mr Moore thanked Ms Merson for reporting and said that this demonstrated a positive statement especially around the delivery of the ADP. This was a helpful overview of the way in which actions were progressing for the Board.

The Board:

1. Noted the content of the report.

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

The Board received a paper (Paper No. 25/119) 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.

Mr Walker advise that the Women's Project Oversight Board had last met on 27 November and had approved a pilot proposal as a test of change as set out within reporting. Further stakeholder engagements would continue in the new year to identify shared learning which would help inform practice for the Outreach Service. In particular, a stakeholder event was planned for early in the New Year to finalise arrangements with the Scottish Prison Service and medium secure providers.

He confirmed that the adaptations outlined in reporting relating to Phase 1 were almost completed, with works planned for CCTV installation in the two low-stimulus rooms for early 2026, as well as works in relation to the garden area.

In relation to Phase 2, Mr Walker advised that in respect of the Strategic Assessment, work was continuing on development of the proposal as agreed, with the aim for submission of this to the Board scheduled for April in April 2026, in preparation for submission to the Scottish Government Capital Investment Group.

Lastly, Mr Walker noted that the Scottish Human Rights Commission had visited the hospital including the interim service, on 3 December and that there had been positive feedback from the visit. The Commission planned to return for a further visit to meet with the Patient Partnership Group, as well as the Patients' Advocacy Service.

The Board noted the complexity and range of works progressed, especially within a limited resource and to meet a complex range of care needs.

The Board:

1. Noted the update within reporting.

22 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report (Paper No. 25/120) which provided assurance that the project was nearing completion. Mr Walker noted the three areas that were outstanding: water ingress to cable ducts, Operations and Maintenance Manuals and CCTV cameras affected by power fluctuations during generator test. Mr Walker confirmed that a further update would be provided within the private session of the Board today, given the commercial and security sensitivities involved.

Mr Currie highlighted the need to continually assess the effectiveness of the equipment installed as part of this project, going forward, especially given the fast-paced change of technological change. Mr Walker agreed with this sentiment and provided assurance that continual review would be essential.

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.

23 ANY OTHER BUSINESS

Mr Moore noted that a letter had been received from Mr Tom Arthur MSP, Minister for Social Care and Mental Wellbeing, following his visit to the hospital to conduct the Annual Review on 24 November 2025. The letter was included in the papers circulated for this meeting.

Mr Moore noted that the letter expressed appreciation for staff and patients, acknowledged the positive financial position, referenced workforce messages, digital inclusion, and recognised the Interim Women's Service. The Minister also confirmed in the letter that a response to Recommendation 1 of the Barron Report, and the subsequent Forensic Governance Advisory Group Report would follow in due course.

The Board agreed that actions and updates requested in the Minister's letter would be routed

through the Directorate Performance Review structure and reflected in Board reporting.

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

24 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 26 February 2026.

25 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.

26 CLOSE OF MEETING

Mr Moore brought the session to a close, thanking everyone for their contributions. He thanked everyone around the table and their teams for their input throughput 2025, recognising it as having been a positive year. The Board was in a good position in terms of governance, and this reflected well on the efforts of all including Executive Officers, Non-Executive Directors and support staff.

The meeting ended at 12.35pm

ADOPTED BY THE BOARD ______________________________

CHAIR ______________________________

DATE ______________________________

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	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:** Report on agenda (Item 20) re project progress and action to be considered thereafter.
2	October 25	Finance report	Request for review of further detail in respect of estimated costs of sickness absence	R McNaught	December 25	**December Update:** Information provided within reporting on agenda (Item 10). Will be incorporated into reporting in future. **CLOSED**

3	October 25	QI and QA report	Feedback on food and fluid guidelines – are there concerns as there had been discussion within PPG	M Merson	December 25	**December Update:** No specific concerns are ongoing in terms of the guidelines. More widely, The Catering Manager attends Patient Partnership Group monthly. Any Issues raised are addressed straight away or before the next meeting. Actions are tracked and monitored. **CLOSED**
4	December 2025	Patient Advisory (PAS) 12 Month Report	Provide feedback if possible on how advocacy services operate at other UK Sites	K McCaffrey	April 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.
5	December 2025	Finance Report	Add Women's Service to next Board development session with focus on funding. Also add M365 to future session as part of digital services	M Smith	Immediate	**February Update:** Items added for January and March development sessions, to close on action list. **CLOSED**
6	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)
7	December 2025	QI and QA Report	To provide update to CGC on master audit sheet	M Merson	February 26	**February Update:** A report on the master audit adherence presented at Clinical Governance Group in February 2026 and then at six 6 monthly intervals thereafter, to provide oversight **CLOSED**

8	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.
9	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.

Last updated – 19.2.26 MS

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 7
Sponsoring Director:	Interim Director of Security, Estates and Resilience
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

Each corporate risk has a nominated executive director who is accountable for that risk, as well as a nominated manager who is responsible for ensuring adequate control measures are implemented.

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix 1.

3.2 Out of Date Risks

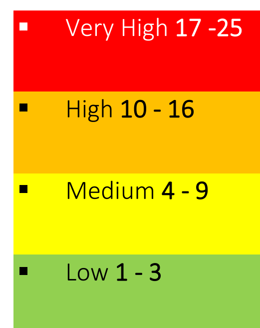
All risks are in date.

3.3 Risk 12 Month Movement and recent updates

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

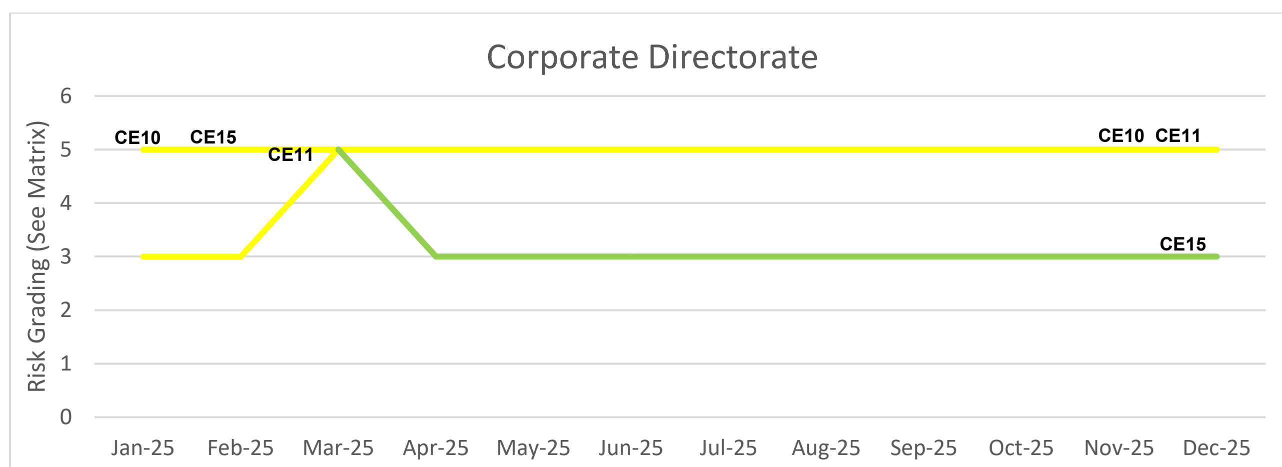
Risk Matrix

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



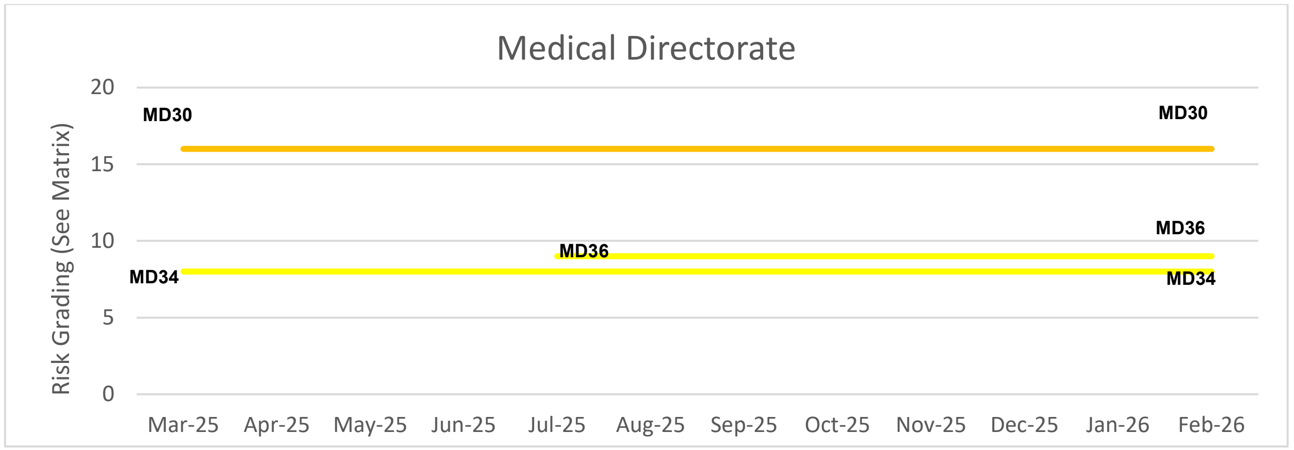
Corporate

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



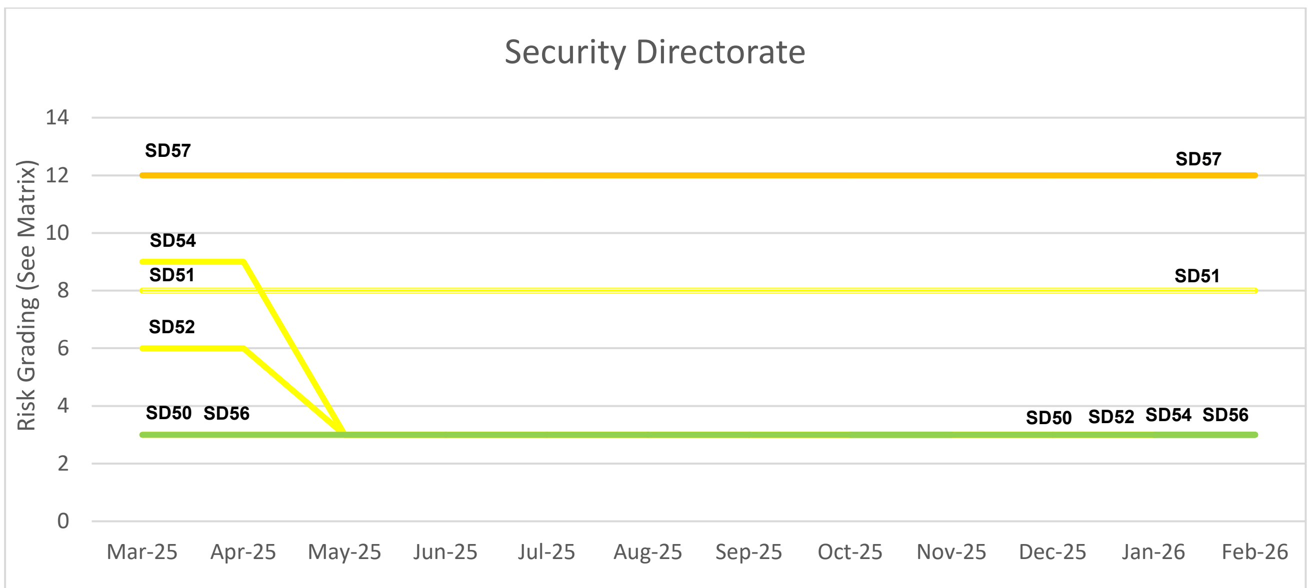
Medical

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



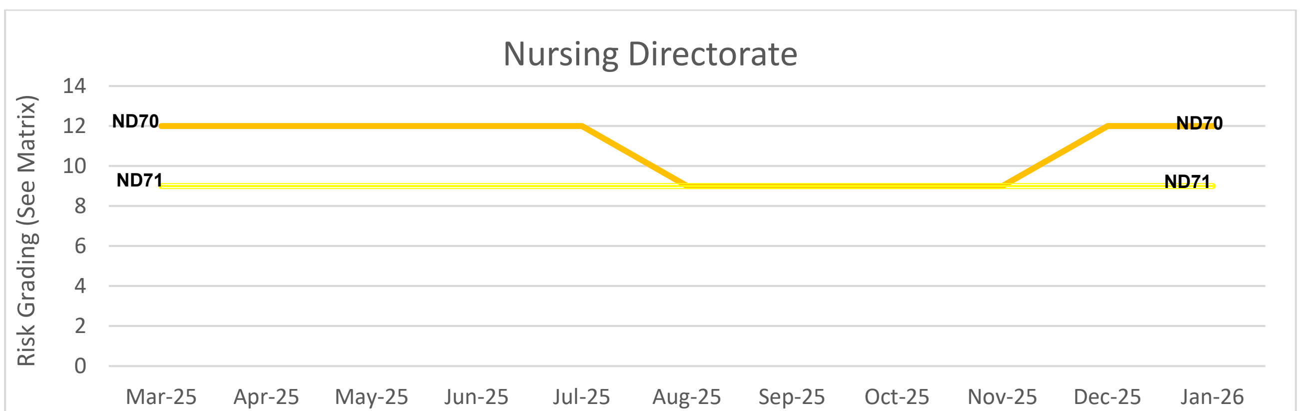
Security

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



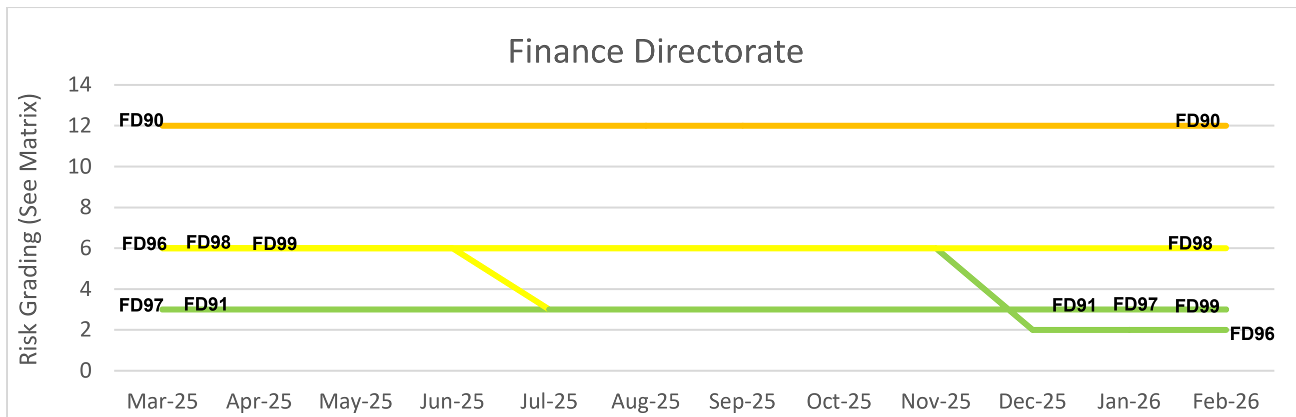
Nursing

There are no changes to the risk gradings within the Directorate



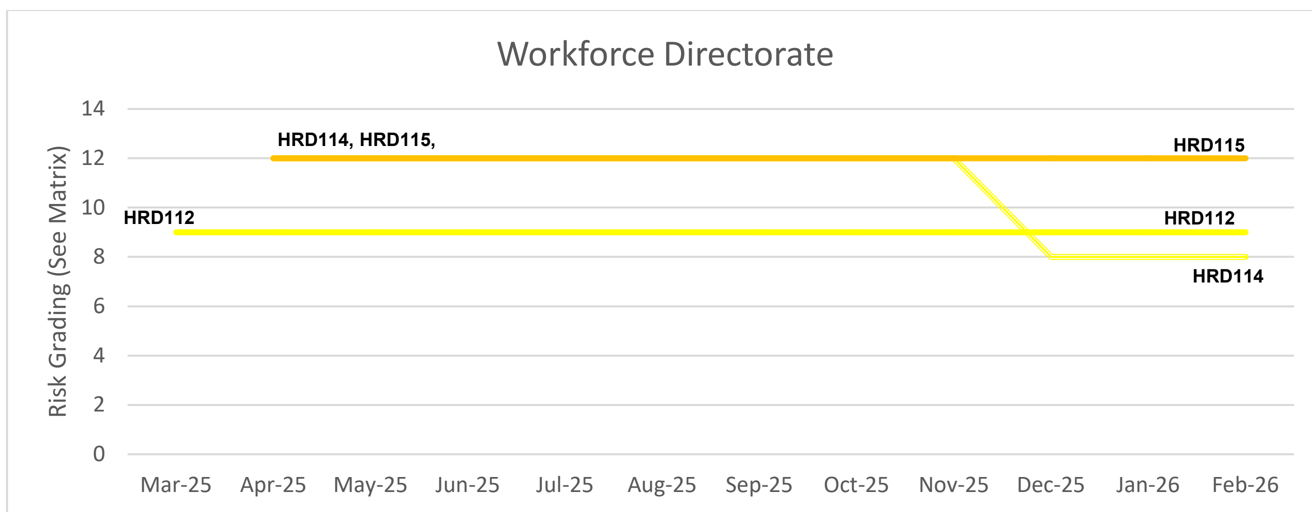
Finance

There are no changes to the gradings within the Directorate.



Workforce

HRD116 PVG checks are now managed through the local risk register. Retrospective checks by Disclosure Scotland caused concerns about delays, but these issues have been resolved, with no current delays. It remains listed on the local risk register.



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

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

3.5 High and Very High Updates

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

Medical Director:

MD30- Failure to prevent/mitigate obesity.

The revised KPI was agreed through CMT with four major change components. This will be monitored through the Clinical Governance Committee. A revised MD30 will be presented in the Board Report April.

Security Director:

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

SD57 was elevated to 'High' in October 2024 for not meeting national event review deadlines. Using the new process, members reported greater efficiency and transparency. 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 evaluated.

Finance Director:

FD90: Failure to implement a sustainable long-term model

FD90 highlights ongoing financial challenges and anticipated budget constraints for 2024/2025. Regular meetings occur with the government and monthly internal reviews are held. The organisation is at break-even, but 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:

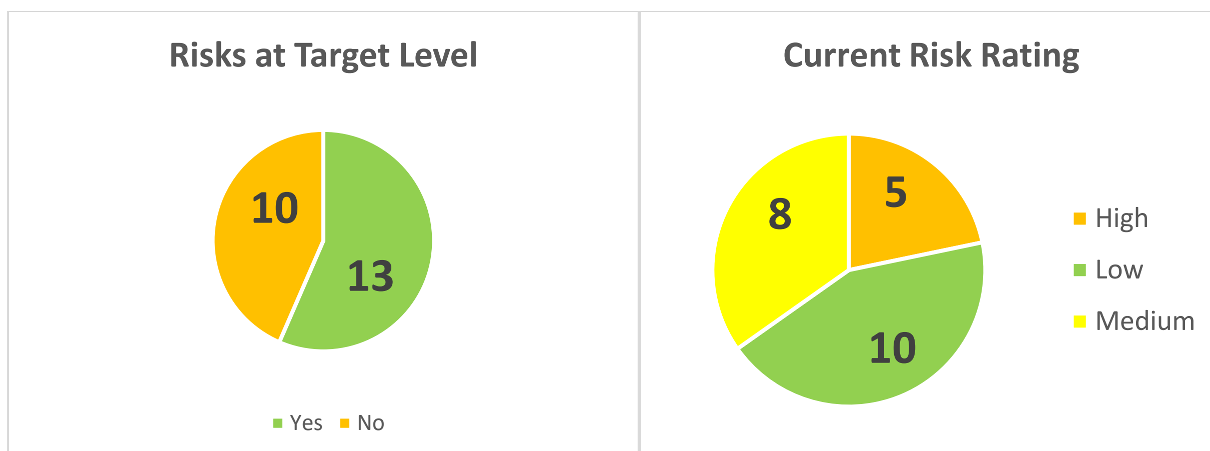
HRD115 Sickness absence levels increase above acceptable levels remains at **'High'.** Progress on absence is positive and showing significant improvement since December 24. Absence figures remain above the 5% target as of December 25.

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. A meeting has taken place with Scottish Government Finance colleagues to seek additional recurring revenue for the Women's Service.

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

Implementation of the new Incident Management software (InPhase) is on track, with full rollout expected by March 2026; it will be used for incident and risk register recording at both Local and Corporate levels starting then. The module to record Risks has been developed and is currently undergoing testing. The system will be live in March 2026 with training on the system to roll out soon after.

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. OMT provide the oversight and should only escalate to CMT should there be any issues such as local risks requiring to become corporate risks or any compliance issues.
.

Risks may be added from:

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

4 RECOMMENDATION

The Board are asked to endorse the current Corporate Risk Register as an accurate representation of the organisation's risk profile.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Monitoring of all Corporate Risks aligned to the organisation
Corporate Objectives Please note which objective is linked to this paper	**Better Care** • Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk. • Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. • Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system. **Better workforce** • Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation. •
Workforce Implications	N/A
Financial Implications	N/A
Route to Board 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.	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).	

High Risks – Reviewed Monthly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	Movement Since Last Report
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	Mar 26	Clinical Governance Committee	Not at Target	-
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Major x Almost Certain	Major x Possible	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	Mar 26	Finance and Performance Group	Not at Target	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Likely	Moderate x Likely	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	Mar 26	Security, Risk and Resilience Oversight Group	Not at Target	-
Workforce HRD115	Workforce	Sickness absence levels increase above acceptable levels	Major X Possible	Major x Possible	Moderate x Possible	Director of Workforce	Head of HR	Mar 26	Workforce Governance Group	Not at Target	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Major x Likely	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Mar 26	Clinical Governance Committee	Not at Target	-

Medium Risks – Review Quarterly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Major x Rare	Major Rare	Chief Executive	Board Secretary	May 26	Corporate Governance Group	At Target	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Moderate x unlikely	Moderate x Unlikely	Chief Executive	Head of Risk and Resilience	May 26	Clinical Governance Committee	At Target	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Likely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	May 26	Clinical Governance Committee	At Target	-

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	Movement Since Last Report
Corporate 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	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	Mar 26	Security, Risk and Resilience Oversight Group	Not at Target	-
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Mar 26	Clinical Governance Committee	Not at Target	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth/ Info Gov Officer	Mar 26	Information Governance Committee	At Target	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Possible	Moderate x Rare	HR Director	Training & Professional Development Manager	Mar 26	Clinical Governance Group	Not at Target	-
Workforce HRD114	Workforce	Impact of reduced working week	Major X Possible	Major x Unlikely	Moderate x Unlikely	Director of Workforce	Head of HR	Mar 26	Workforce Governance Group	Not at Target	-

Low Risks – Reviewed 6 Monthly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	Movement Since Last Report
Corporate CE15	Reputation	Impact of Covid-19 Inquiry	Extreme x Likely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	Apr 26	Covid Inquiry SLWG	At Target	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident or Breach	Extreme x Likely	Moderate x Rare	Moderate x Rare	Security Director	Security Director	Aug 26	Security, Risk and Resilience Oversight Group	At Target	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Security Director	Mar 26	Security, Risk and Resilience Oversight Group	At Target	-

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Target Level Achieved	Movement Since Last Report
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Mar 26	Security, Risk and Resilience Oversight Group	At Target	-
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	Security, Risk and Resilience Oversight Group	At Target	-
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Negligible x Possible	Negligible x Possible	Finance & Performance Director	Head of eHealth	Apr -26	Finance and Performance Group	At Target	-
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Negligible x Unlikely	Negligible x Unlikely	Finance and Performance Director	Head of eHealth	Jun 26	Information Governance Committee	At Target	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	Aug 26	Information Governance Committee	At Target	-
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	Apr 26	Information Governance Committee	At Target	-

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 26 February 2026

Agenda Reference No: Item No: 8

Sponsoring Director: Director of Finance and E-Health

Author(s): Deputy Director of Finance

Title of Report: Finance Report to 31 January 2026

Purpose of Report: For Noting

1 SITUATION

This report provides an update on financial performance for Month 10 (M10), 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 at which satisfaction was noted with the Hospitals position re revenue spend, capital expenditure and savings for 2025/26.

3 ASSESSMENT

3.1 Budget

The current budget comprises SG Revenue Resource Limit (core and non-core) allocations of £55,750k. 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 £57,401k There has also been an additional Digital Capital allocation (£100k); Discretionary Award Funding (£36k); and it is anticipated there will be remaining budget from the AFC Reform allocation.

As a result of the delayed start to the female service the full budget allocation of £3.1m has not yet 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 and submitted for 2026/27. While savings plans have been identified overall, a small number of departments are still working with the finance team to finalise their plans.

3.2 Year-to-date position 2025/26 – allocated by Board Function / Directorate

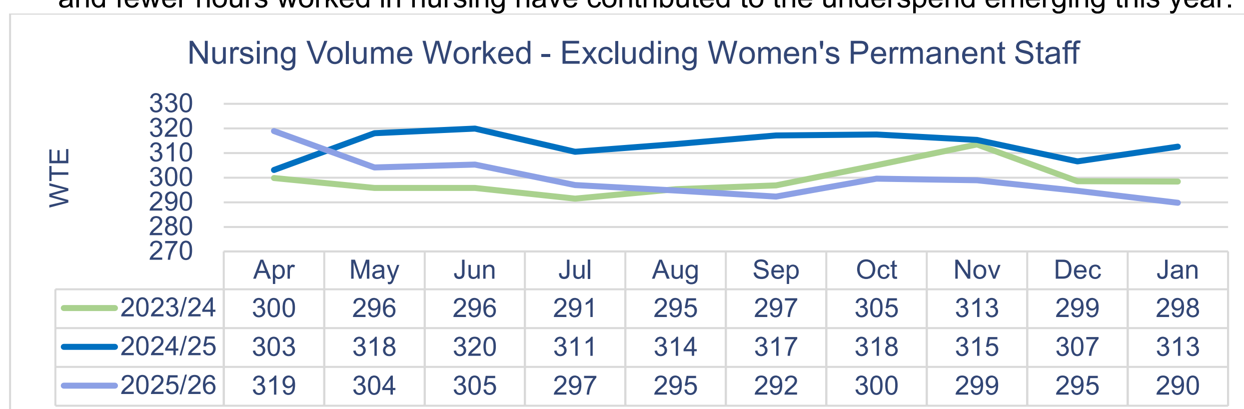
- Month 10 position: £49k underspend
- Year-to-Date Position: £469k underspend

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	3,760	3,765	(5)	0.00	0.00	Capital charges have increased £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	2,700	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	2,778	2,311	2,274	37	25.87	24.87	Vacancies within departments are resulting in a small underspend overall.
Finance	2,937	2,479	2,459	20	32.58	28.99	Pressure is resulting from service contracts within Ehealth, this is offset against vacancies in finance and procurement. Annual cost pressure of £185k to cover M365 has been funded non recurringly from reserves.
Human Resources Directorate	1,244	1,037	991	46	16.03	15.14	Underspend in training and vacancies across the directorate. £16k pressure within HR as a result of additional PVG certificates.
Medical	3,867	3,237	3,201	36	20.68	23.63	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.
Misc Income	(120)	(104)	(89)	(14)	0.00	0.00	Income has been received from exceptional circumstances patients, no further recharges are anticipated this financial year. The underachieved income pressure will grow.
Nursing And Ahp's	30,176	25,049	24,819	230	444.16	445.45	see below for detailed narrative from nursing directorate
Security And Facilities	9,301	7,764	7,643	120	124.83	122.16	Vacancies across the directorate are contributing to underspend, utilities pressures have been funded from reserves.
	57,401	**45,532**	**45,063**	**469**	**664.15**	**660.24**	

Key Drivers:

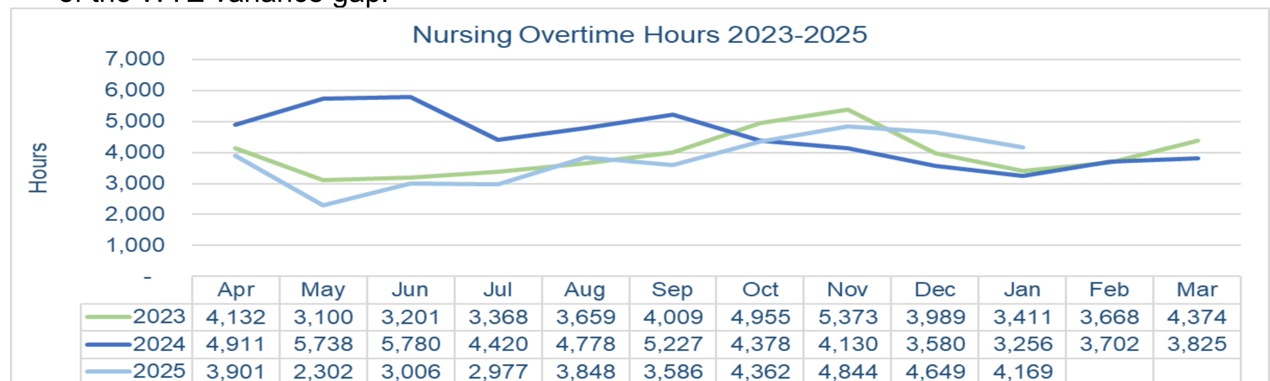
- The year-to-date underspend continues, driven primarily by vacancies across all directorates. Although vacancies have existed for several years, reduced overtime usage and fewer hours worked in nursing have contributed to the underspend emerging this year.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2023/24	300	296	296	291	295	297	305	313	299	298
2024/25	303	318	320	311	314	317	318	315	307	313
2025/26	319	304	305	297	295	292	300	299	295	290

- The total volume worked, including overtime, is slightly above budget, the current volume worked is considerably lower than previous years.

- Vacancies in registered nursing posts continue, with unregistered nursing staff offsetting part of the WTE variance gap.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023	4,132	3,100	3,201	3,368	3,659	4,009	4,955	5,373	3,989	3,411	3,668	4,374
2024	4,911	5,738	5,780	4,420	4,778	5,227	4,378	4,130	3,580	3,256	3,702	3,825
2025	3,901	2,302	3,006	2,977	3,848	3,586	4,362	4,844	4,649	4,169		

There have been reduced costs year-to-date in nursing overtime as a result of lower overtime hours being utilised in earlier months.

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 CMT 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 Head of Finance to ensure the Nursing Directorate remains on track to meet all financial savings and requirements.

Financial Pressures:

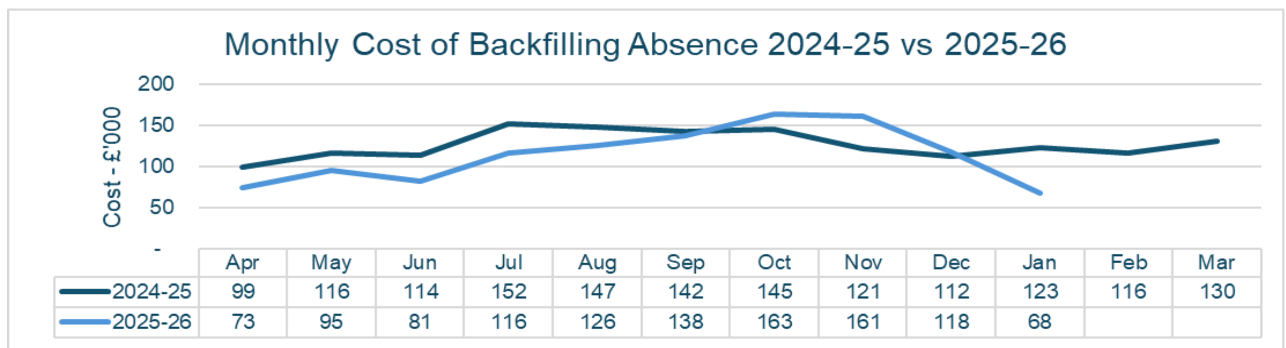
Sickness Absence

- Month 1–10 2025/26 cost: £2,586k (vs £2,397k last year)
- Nursing sickness absences have reduced, but costs have increased in medical staffing and senior roles.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25	186	210	205	263	229	231	284	261	248	280	243	264
2025-26	239	219	206	220	273	302	292	285	295	257		

Backfill Costs

- Month 1–10 2025/26: £1,139k (vs £1,271k last year)
- The majority of costs relate to ward nursing.
- SSTS reason codes do not allow separation of sickness backfill from other absences.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2024-25	99	116	114	152	147	142	145	121	112	123	116	130
2025-26	73	95	81	116	126	138	163	161	118	68		

M365

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

Energy and Inflation Increases

- Utilities spend expected £200k above budget; funded from non-recurring reserves

AFC Reform

- Recurring budget of £1.4m was allocated from The Scottish Government to manage AFC reform, this budget was required to reduce from 37 hours down to 36 hours. Additional budget requirements have been highlighted in our 3-year plan to cover the initial decrease from 37.5 hours to 37 hours for staff that are currently utilizing TOIL to cover the gap.

Women's Services

- 2026 funding remains unconfirmed – for which we are awaiting decision from SG further to meetings and discussion in recent weeks.
- At present, the estimated recurrent cost from 2026/27 is £5.2m to provide the current service with 3 patients rising to £6.3m at full capacity – which has been notified to SG.

Enhanced Security Project

- Fully capitalised; staffing and project management costs are now reported as revenue pressure.
- £17k costs incurred in Month 10. Year-to-date cost pressure is £100k.

Benefits:

Travel & Training

- There is 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) – with current assessment being made of the required level of charging.

4 ASSESSMENT – SAVINGS

- Annual Target: £1,920k (≈3.8%) to ensure breakeven.
- Achieved to Date: £1,600k (82%)
- This continues to be on track for full achievement by year-end.

Directorate	Annual Target £k	YTD Target £k	Savings Achieved £k	Suplus/ (Shortfall) £k
Chief Exec	70	58	57	(1)
Finance	128	106	105	(1)
Human Resources Directorate	37	31	31	0
Medical	113	94	94	0
Nursing And Ahp's	872	727	729	2
Security And Facilities	700	584	584	0
	1,920	**1,600**	**1,600**	**0**

5 CAPITAL RESOURCE LIMIT

Capital budget is fully committed for the year as below:

Capital CRL 2025/26	Annual Plan £k	YTD Spend £k
Capital		
Anti Barricade and Observation Panels	53	35
E-health equipment	54	30
Kitchen Equipment/Doors	36	11
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**	**191**
BCP Funding		
Islay Repair	100	0
Patient Wander Path	185	0
Animal Shed Replacement	94	29
Fire Alarm Replacement	80	0
BCP Allocation	**459**	**29**
Additional Capital		
LED Lighting Replacement	220	120
Additional Capital Allocation	**220**	**120**
Total CRL	**961**	**340**

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 Board Which groups were involved in contributing to the paper and recommendations.	Deputy Director of Finance CMT Partnership Forum Board
Risk Assessment (Outline any significant risks and associated mitigation)	None Identified
Assessment of Impact on Stakeholder Experience	None Identified
Equality Impact Assessment	No implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None Identified
Data Protection Impact Assessment (DPIA) See IG 16. 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

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 9
Sponsoring Director:	Medical Director
Author(s):	Chair of Physical Health Steering Group Head of Clinical Quality
Title of Report:	Physical Health Strategy
Purpose of Report:	For Decision

1 SITUATION

The State Hospital has developed a new Physical Health Strategy (2026–2029) to address the significantly poorer physical health outcomes experienced by individuals with severe mental illness (SMI). Patients with SMI die 15–20 years earlier than the general population, predominantly due to preventable chronic conditions linked to modifiable lifestyle factors such as smoking, alcohol use, inactivity, and poor diet. The strategy sets out a commitment to improving physical health outcomes through evidence-based practice, prevention, and integrated whole-system approaches.

2 BACKGROUND

Staff across The State Hospital already take a holistic approach to care, delivering Annual Health Reviews, screening programmes, vaccinations, clozapine monitoring, and chronic disease management through the Primary Care and Clinical Teams.

Tools such as RiO dashboards support monitoring of BMI and physical activity, while psychology and dietetics deliver health-focused group interventions.

The opening of the Interim High Secure Women's Service (July 2025) requires additional focus on female-specific healthcare including reproductive health, cervical screening, and maternity care.

Staff training programmes support ongoing upskilling in physical healthcare delivery.

3 ASSESSMENT

Despite strong existing foundations, further improvement is required to reduce health inequalities and strengthen physical health outcomes. Key areas identified include:

- Screening uptake: Need to improve participation, particularly ensuring provision for women's services.
- Vaccinations: Engagement varies and requires increased health promotion.

- Physical activity: Opportunities exist to enhance engagement, tailoring activities to patient interests.
- Weight management: Continued high prevalence of obesity and weight gain linked to psychotropic medications.
- Data visibility: Need for reliable systems tracking BMI trends, physical activity, shop spend, and intervention uptake.
- Training and culture: All staff require ongoing reinforcement to deliver preventative, proactive care.
- Unscheduled care: Out-of-hours medical pathways need improvement.
  Overall, success depends on adopting the Scottish Approach to Change—aligning planning, assurance, and improvement within one learning system.

4 RECOMMENDATION

The Board is invited to: note the following recommendations and endorse the Physical Health Strategy:

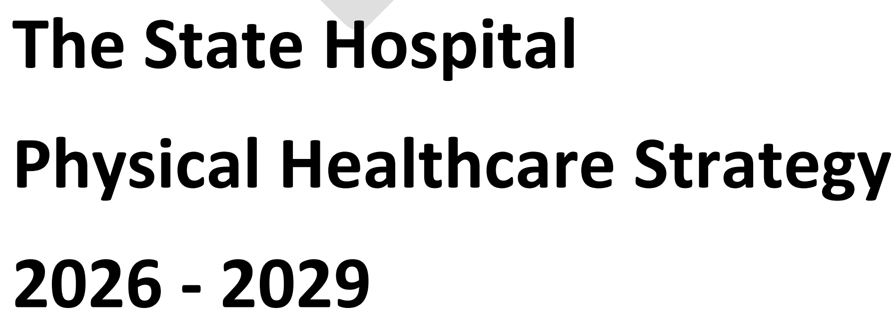
To achieve the desired outcomes by 2029, it is recommended that The State Hospital:

1. Strengthen multi-pronged prevention efforts, particularly limiting weight gain via medication review, early metformin co-prescribing, and enhanced lifestyle interventions.
2. Increase screening and vaccination engagement using targeted health education and patient-centred conversations.
3. Enhance physical activity uptake through personalised programmes and improved encouragement from Clinical Teams, Service Leadership Teams, and the Skye Centre.
4. Improve digital monitoring systems (RiO, Tableau) to support real-time tracking of physical health metrics.
5. Embed women’s health pathways including cervical screening, breast screening, maternity support, and nutrition guidance.
6. Expand staff, patient, and carer education to ensure consistent physical health messaging across all interactions.
7. Improve unscheduled care pathways, including the new out-of-hours protocol incorporating the FNC.
8. Monitor progress using qualitative and quantitative measures, including corporate KPIs, patient feedback, and What Matters to Me events.
9. Ensure governance oversight through the Physical Health Steering Group, Clinical Governance structures, and clear accountability for all staff.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	
Corporate Objectives Please note which objective is linked to this paper	The Physical Health Strategy directly supports the Board's corporate objectives relating to: • Safe, effective, person-centred care • Reducing health inequalities • Improving patient outcomes through prevention and evidence-based practice • Strengthening data-driven quality improvement and governance processes It aligns with national priorities on physical health for people with severe mental illness and supports the Scottish Approach to Change.
Workforce Implications	Delivery of the Strategy requires continued upskilling of staff in physical healthcare, including training in health promotion, metabolic monitoring, behavioural change, women's health competencies, and enhanced multidisciplinary working. Additional resource implications may arise from proposed expansion of physical-health-focused posts (dietetics, health psychology, health improvement staff). Operational leadership input is needed to embed preventative physical health conversations in CTMs, SLTs and Skye Centre practice.
Financial Implications	No immediate high-cost investments anticipated. Potential financial considerations include: • Expansion of physical-health workforce roles • Enhancements to digital systems (RiO, Tableau) for monitoring physical health metrics • Support for training delivery • Costs associated with enhanced screening and women's health pathways Any costs will be considered through existing governance and budget-setting processes.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Physical Health Steering Group Corporate Management Team Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	**Risks:** • Failure to improve physical health outcomes, widening inequality • Poor uptake of screening/vaccination programmes • Inconsistent implementation of weight-management interventions • Insufficient data visibility due to gaps in digital monitoring • Workforce gaps in physical health expertise • Challenges in delivering women's health pathways as services expand **Mitigation:**

	• Robust governance via PHSG • Clear KPIs and 6-monthly evaluation cycle • Strengthened training and multidisciplinary support • Use of RiO and Tableau dashboards for monitoring • Enhanced Primary Care
Assessment of Impact on Stakeholder Experience	The Strategy is expected to significantly improve patient experience through more personalised, preventative physical healthcare; enhanced access to screening, vaccination and activity opportunities; improved environments supporting healthy choices; and greater shared decision-making via What Matters To Me events and physical health reviews. Carers and staff will benefit from clearer pathways, training, and data-informed decision-making.
Equality Impact Assessment	An Equality Impact Assessment is not required because the Physical Health Strategy does not introduce any new policies, pathways, or service changes that would alter access, eligibility, or provision for any protected characteristic groups; instead, it consolidates and strengthens existing physical-health practices. All actions fall within current clinical governance frameworks and maintain equitable access to care across all patient groups, including the Women's Service.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	The Strategy supports reduction of health inequalities for people with severe mental illness, a population experiencing significant socioeconomic and health disadvantage. Actions within the Strategy directly address inequality through prevention, enhanced access, system redesign, and improved workforce capability.
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).	The Strategy includes enhanced use of RiO dashboards, Tableau reporting, and analysis of activity, screening and BMI data. These use existing approved systems and do not introduce new personal-data processes requiring a full DPIA.



The State Hospital

Physical Healthcare Strategy

2026 - 2029

Section 1 – Why do we need a Strategy?

The Physical Healthcare Strategy for The State Hospital aims to improve physical health outcomes for patients with severe mental illness in a forensic setting. This aligns with the hospital's organisational core purpose: to deliver safe, effective, person-centred care that supports recovery and reduces health inequalities.

The physical health of people with severe mental illness (SMI) is known to be significantly worse than that of the general population; these individuals on average die 15-20 years prematurely. The vast majority of these premature deaths are not due to suicide, but instead are caused by a complex interplay between biological, psychological and social factors, including a range of chronic health conditions such as obesity, diabetes and cardiovascular disease. Whilst not entirely preventable, there are a number of modifiable factors that can reduce risk e.g. adopting a range of health behaviours such as a balanced and varied diet, physical activity and exercise, good quality and quantity of sleep are important factors that can reduce risk of diseases such as type 2 diabetes, obesity and cardiovascular disease and all-cause mortality risk by up to 66% (Loef & Walach, 2012), as can tobacco and alcohol consumption, medication and the secure hospital environment.

By effectively addressing known modifiable risk factors, the physical health outcomes of our patients can be significantly improved. The inequality in life expectancy and physical health outcomes between people with mental health disorders and the general population also has the potential to be considerably reduced. This was apparent in a paper published in 2020 looking at long-term outcomes of the recovery approach in a high security mental health setting: a 20 year follow-up study.

This Physical Health Strategy sets out the Board's unwavering commitment to improving the quality of the care and treatment for patients through our everyday work and behaviours. This focus on delivering evidence-based practice through a process of continuous improvement in turn, builds a shared understanding and an organisation where improvement in quality is embedded in how we work.

Section 2 – Where are we now?

The staff within the State Hospital have worked hard over the years to ensure we take a holistic approach to patient care within the high secure care setting.

Primary Prevention

- All patients are offered Annual Health Reviews, including blood monitoring, blood pressure checks, nurse overview, and General Practitioner consultation.
- Nutritional Screening and Care Planning are embedded in practice via an evolving progress over almost 2 decades to support patients. The most recent change is a Nutrition and Physical Healthcare Checklist is completed on admission and monthly thereafter, that should inform conversations at the CTMs
- Health promotion events are run throughout the year
- All patients are seen by a dietitian within 2 weeks of admission.

Primary Care Team

Our Primary Care team work closely with our Clinical Teams to provide the following:

DRAFT

- Clozapine Monitoring: monitored with blood and electrocardiogram.
- Vaccination Programmes: Flu and COVID vaccines are administered.
- Screening Programmes: Bowel screening, Abdominal Aortic Aneurysm
- Cardiovascular risk monitoring through QRISK3.
- Diabetes Management: Regular monitoring and foot/retinopathy screening.
- Respiratory Monitoring: Asthma, Chronic Obstructive Pulmonary Disease; regular nurse follow-up.
- Dentistry interventions, both preventative and proactive
- Podiatry interventions including diabetic foot screening
- Physiotherapy focusing on musculoskeletal and rehabilitation.
- Optometry monthly clinics for preventative and proactive interventions

Clinical Teams and Service Leadership Teams

- RiO dashboards are available to show the patient's Body Mass Index (BMI) over time and the physical activity that they have engaged with – this information should be taken into the weekly Clinical Team Meeting (CTM)
- Clinical Teams work hard to come up with innovative ways to encourage patients to engage with physical activity and refer to interventions (1:1 and groups) that improve physical health that are facilitated by Psychology and Dietetics.

Staff Training

There are a number of modules and training events to support staff to upskill themselves to enable them to provide the best physical health care/awareness to our patients, and the skills needed to apply this understanding in an evidence based way. These include:

- Guide to Healthy Eating Online
- Healthy Eating in Forensic Care Settings
- Physical Health Issues in Forensic Care
- MAP of Health Behaviour Change training
- Psychology of Health (introduces a biopsychosocial approach to health with a focus on weight and chronic stress)
- REHIS training on Food and Health is aimed to be delivered annually to a wide range of clinical (nursing and AHP's) and non clinical (catering staff) to help support the nutritional needs of our patient group.

In additional we have close links with our partnering health boards where specialist services have been used to ensure our patients get the best evidence-based care.

Established interventions and programmes of work

The Physical Health Steering Group oversees all the various elements of physical health of our patients and has a comprehensive work plan that they will deliver over the life of this strategy.

TSH has a long history of proactively supporting patients' physical health through 1:1 and group based interventions, delivered both as part of routine care and from specialised services/staff within the hospital. These include:

DRAFT

Food, Fluid & Nutrition (FFN): Nutritional Screening and Nutrition and Physical Health Care Plans are completed for patients. Anthropometric Monitoring: Monthly Body Mass Index and six-monthly waist circumference and waist to height ratio tracking are recorded.

A comprehensive psychology service is place within TSH, and this includes psychological interventions that focus on physical health. This is provided by the hospital's Health Psychologist through a health psychology tiered model of care: Tier 1: Psychologically informed care, Tier 2: Indirect psychological interventions for physical health. Tier 3: direct psychological interventions for physical health. This model captures a wide range of interventions and services, supporting the strategic direction of the hospital, staff members through training and supervision, and patients directly through 1:1 and group interventions and therapies.

The Supporting Healthy Choices (SHC) programme focuses on the prevention and management of obesity and aims to create an environment that enhances the opportunity, capability, and motivation of patients and staff to engage in behaviours that support healthy weight and physical health. It is grounded in behavioural science, nutrition, and quality improvement and adopts a "Whole Systems Approach" to prevent and mitigate obesity and provide evidence-based interventions. This approach includes specific objectives to support the workforce and services (admissions, treatment & recovery, intellectual disability and transitions) focusing on interpersonal, intrapersonal, environmental and societal & cultural factors that enable or pose barriers to healthy weight. Since the launch of the SHC practice guidance and implementation plan, a focus has been placed on mitigating weight gain within the admission service, re-designing the hospital shop to better support health and rehabilitation, and ensuring robust monitoring and governance structures are in place. Moving ahead, further actions from the implementation plan will be implemented, utilising the evidence based to guide intervention development and evaluation.

Section 3 – Where do we want to be?

Improve physical health indicators by:

- Limiting weight gain across all services and its comorbid side effects
- Restructure the physical environment, policies and practices to better support physical health and weight maintenance
- Increasing screening uptake and ensuring we have screening set up for the Women's Service
- Encouraging patients to engage with vaccination programmes
- Enhancing patient engagement in physical activity through conversations in Clinical Team meetings, Service Leadership Team meetings and the Skye Centre
- Enhancing physical health outcomes and reducing side effects from psychotropic medications
- Having the confidence our patients, carers and staff are well educated on physical health and wellbeing
- Ensuring we have data management systems that can track BMI, physical activity, shop spend, and patient engagement using electronic RiO and Tableau dashboards.
- Expand the workforce who have a focus on physical health (dietetics, healthy improvement teams, health psychology, health promotion) to ensure parity of esteem with mental health.

Health Services for Women

DRAFT

The Interim High Secure Women's Service opened in July 2025 and the Clinical Guidance for the service has been developed to support staff in delivering high quality physical health care to women. Within the first year staff will upskill in women's specific health issues such as reproductive health and nutrition.

General Practice provision to The State Hospital has been increased to accommodate the service and a female GP has been recruited so that patients are able to request to be seen by a female for non-urgent issues if desired. National screening programmes will be adhered to with provision for intimate examinations and cervical screening to be delivered on site, and patients will be escorted to NHS Lanarkshire for Breast Screening.

Any pregnant patients will be supported to access Maternity Services in NHS Lanarkshire. Significant care planning will be required to maintain the safety and health of the patient and unborn child. Where necessary, specialist peri-natal psychiatric advice will be sought.

Women's nutritional needs will be supported within their general care and any additional needs considered on a one-to-one basis. Specialist support for those with for example nutritional needs during pregnancy or the menopause or for those with eating disorders will be aided via in house and external resources as required.

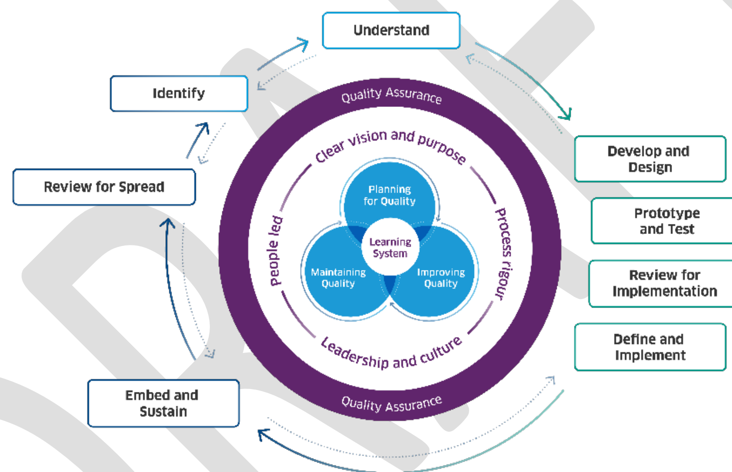
Section 4 – How do we get there?

The State Hospital will have to take a multi-pronged approach to allow them to deliver on their vision. This will include:

- Limiting weight gain and its comorbid side effects: this will include through ensuring teams are looking at all aspects of mental health and physical health when prescribing medication on admission and also referring to activities. New guidance on considering pharmacological weight management is available to support clinical teams and a designated staff team to initiate and monitor this.
- Increasing screening uptake and ensuring we have screening set up for the Women's Service: through more education/promotion events and one to one conversations with patients who are struggling to see the benefits.
- Encouraging patients to engage with vaccination programmes: through more education/health promotion activities and including it in some of the group work that is undertaken within the hospital.
- Enhancing patient engagement in physical activity through conversations in Clinical Team meetings, Service Leadership Team meetings and the opportunities available for them at the Skye Centre. We need to find out what patients find interesting and ensure, wherever possible, we provide them with activities that they are going enjoy and feel confident in, as this will support ongoing motivation and behaviour change, thus their physical health risks.
- Enhancing physical health outcomes and reducing psychotropic side effects by combining proactive monitoring, careful medication selection, patient engagement in behaviour change interventions, and co-produced care plans that ensure continuity of care. Improving the experience of our patient.

- Reviewing our Group and one-to-one work to see where we can include more information on the risks posed to our patients to ensure we are working with them in partnership over the physical healthcare aspect of their recovery as well as their mental recovery.
- Exploring patient, carer and staff training to ensure that every patient, every time, is being given preventative and proactive physical healthcare information.
- Improving the experience of unscheduled outings; a new out of hours medical protocol that incorporates the Flow Navigation Centre (FNC) is being designed.
- Reviewing what matters to the patients and how best we can work in partnership with them to support their physical wellbeing and their mental wellbeing.
- Expand the workforce who have focus on physical health through a collaborative multidisciplinary approach.

We will also, as a Health Board, use the Scottish Approach to Change framework to ensure we are bringing together planning, assurance and improvement together under a single learning system to support staff.



Section 5 – How do we know we're getting it right?

There will be a mix of qualitative and quantitative measures that will give us an indication whether we are getting it right. Qualitative means may include:

- Specific What Matters to Me events looking at the patient physical wellbeing
- Feedback from Patient and Carer surveys
- The internal feedback mechanisms that are in place
- Feedback from patient groups and interventions that focus on physical health
- Feedback from the Patient Partnership Group – we also need to work closely with this group to really understand what is important to our patients when it comes to their physical health.
- Feedback from patients about their annual physical health review and the service they received from our Primary Care Team.

Quantitative measures being considered:

Corporate KPIs

1. 60% of patients will gain less than 15% of their admission body weight during their TSH stay no matter the length
2. 70% of patients will undertake 150 minutes of physical activity per week
3. 100% of patients will undertake annual physical health overview by the practice nurse
4. 100% of patients requiring primary care services will have access within 48 hours

Local KPIs

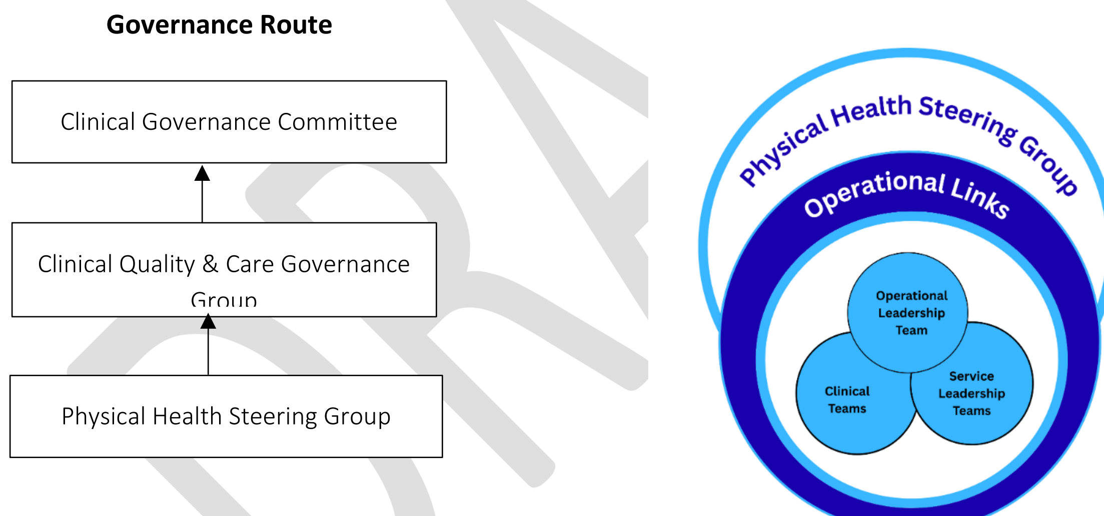
Local KPIs for weight, pharmacological treatments and psychological treatments, including the delivery of the Healthy Living Group (part of the obesity KPI as above) will be agreed as part of the delivery plan for the Strategy to allow 6 monthly evaluations of the strategy.

Section 6 – Accountabilities and Responsibilities

Responsibility for the physical wellbeing of our patients within the State Hospital sits with every member of staff who has interactions with them.

Accountability sits with every member of staff within Clinical Teams, Service Leadership Teams, Operational Management Team and Clinical Governance Group:

Governance Route



Physical Health Steering Group oversees the development work with regards to physical wellbeing with sub-groups commissioned as and when required.

This Strategy should be read in conjunction with the following national and local publications:
Improving the physical health of adults with severe mental illness: essential actions (October 2016)
Physical Activity for Health: Scotland's National Framework (October 2016)
Food, Fluid and Nutritional Care Standards (Healthcare Improvement Scotland) (31 October 2014)
Standards for the delivery of tier 2 and tier 3 weight management service for adults in Scotland (2 July 2019)

DRAFT

BAP guidelines on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment (April 2016)
Managing a healthy weight in adult secure services – practice guidance (12 February 2021)
WHO Guidelines on physical activity and sedentary behaviour (26 November 2020)
A healthier future – Scotland's diet and healthy weight delivery plan (29 June 2018)
Food, Fluid and Nutritional Care policy
Food and Fluid Refusal policy
Moving Towards and Healthier State Hospital (Supporting Healthy Choices workplan)
Exploration of morbidity, suicide and all-cause mortality in a Scottish forensic cohort over 20 years (Pub 2020)
Moving Towards a Healthier State Hospital: A Whole Systems Approach (Supporting Healthy Choices Practice Guidance, January 2024)
Loef, M., & Walach, H. (2012). The combined effects of healthy lifestyle behaviors on all cause mortality: a systematic review and meta-analysis. Preventive medicine, 55(3), 163-170.
Scottish Government consensus statement on GLP prescribing
Food in Hospitals (will be 2026 link due January)

29/01/2026

DRAFT

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 10
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Skye Centre Manager
Title of Report:	Carer Strategy Update
Purpose of Report:	For Noting

1 SITUATION

Over the past year progress has been made across multiple workstreams aligned to the State Hospital's Carer Strategy 2024–2027. Activity has focused on strengthening engagement, improving communication, enhancing the visitor experience, and embedding carers' voices into service improvement. Work has been delivered both locally and in partnership with the Forensic Network.

2 BACKGROUND

Following carer engagement, three strategic priority areas were incorporated into the State Hospital Carer Strategy 2024–2027. The Person Centred Improvement Group developed a delivery plan with at least three improvement activities under each priority, ensuring actions reflect what carers told us they want to see improved. These priority areas are as follows:

- **Priority 1 – Triangle of Care:** Using the self-assessment tool to help carers understand standards of care beyond the secure environment, supporting their ability to navigate our policies and procedures.
- **Priority 2 – Communication and Information:** Strengthening the quality, accessibility and timeliness of information provided to carers to support wellbeing and reduce the likelihood of crisis situations.
- **Priority 3** –Improve the carers visiting experience through providing a comprehensive introduction to the hospital and a range of carer support mechanisms related to the visiting experience.
- **Priority 4 – Carer Pathway:** Developing a clear pathway that links carers into the wider Forensic Network and third-sector partners, ensuring personalised, outcomes-focused support throughout the patient journey.

3 ASSESSMENT

<u>Triangle of Care (ToC) – Review and Future Actions</u>

Progress continues across the Triangle of Care action plan, with workstreams focused on strengthening carer engagement, improving consistency of information sharing, and enhancing governance across clinical teams. Key developments include refreshed carer feedback

processes, improved staff awareness of Person-Centred Improvement Advisor (PCIA) role, and ongoing development of Carer Awareness training. Information-sharing arrangements are being reinforced through updated guidance and clinical documentation. A programme of routine audits is underway—including carer contact timelines, introductory letters, first-visit support, post-visit communication, information packs and discharge questionnaires—with processes being amended where improvements are needed. Overall, the plan is moving toward more consistent, reliable practice and improved support for carers throughout their journey.

Key Areas for Improvement & Audit

Carer Engagement

- Refresh and strengthen carer feedback processes and follow-up arrangements.
- Improve evidence of carer involvement in service improvement and peer support activity.

Staff Awareness & Training

- Enhance staff knowledge of PCIA role through updated induction materials and communication.
- Finalise and implement the Carer Awareness training module.

Information Sharing & Governance

- Develop and disseminate updated information-sharing guidelines.

Audit Priorities

- Carer contact within 10 days and timeliness of introductory letters.
- First-visit support processes and post-visit communication recording.
- Accuracy, distribution and accessibility of the carer information pack.
- Completion and quality of discharge questionnaires and feedback mechanisms.
- Completion of Advance Statements and consistency of documentation.

Engagement with Carers and Visitor Experience

National Forensic Network Carers Toolkit

As part of national work to develop a Forensic Network Carers Toolkit, all approved visitors were contacted to provide feedback on their experience of visiting the State Hospital. Five carers responded and this feedback has been collated and shared with the Forensic Network for anonymisation prior to discussion at the next Improving Carer Experience Group meeting.

Key themes emerging from feedback included:

- **Positive reflections** on staff interactions, the Family Centre environment and security processes.
- **Areas for improvement**, specifically relating to:
  - communication with families and carers
  - clarity of first-visit expectations and supervision processes during visits
  - booking processes (telephone/email)
  - updates during early-admission stages
  - processes for internal ward transfers and belongings
  - practicalities around travel, hospitality, and on-site procedures

These insights will inform future updates to the Patient Visitor Welcome Pack and broader work to improve visitor experience.

Care Programme Approach (CPA) – Review and Carer Involvement

The Care Programme Approach process has been reviewed and ensures that there is opportunity for the carer voice at each stage. This ensures that carer perspectives are formally and consistently incorporated into care planning, review, and decision-making pathways.

Key developments include:

- Carer feedback mechanisms embedded into CPA governance through questionnaires.
- Quality reviews in the form of Peer Review panels to include evaluation of carer involvement and experience.
- Carer-focused questions related to the CPA process have been added to the Carer Experience Questionnaire.

This represents a strengthening of the carer voice within clinical decision-making and service monitoring.

Digital and Practical Support for Carers

- Carers have been supported to maintain meaningful contact through video visiting, with iPads issued to those requiring assistance.
- This has been particularly important where travel barriers exist and have supported carer inclusion in care processes.

Development of a Carer Pathway

Progress includes:

- Recognition of the carer's journey as distinct and requiring structured, consistent support.
- Work aligned to transitional points within the clinical model to ensure carers are supported as patients progress through care.
- Preparatory support for carers ahead of discharge.
- Strengthening links with third-sector and Forensic Network partners to support personalised local support aligned to carers identified outcomes.

Policy Review and Alignment

Supporting Carer Involvement Policy

The existing policy has been reviewed and archived, with its key components redistributed to ensure improved clarity and operational relevance:

- Elements supporting practical carer engagement have been transferred to the Carer Strategy Action Plan.
- Provisions related to communication have been incorporated into the new Communication Guidance Document.
- Requirements relating to interpretation and accessibility have been formalised within the Interpreting Services Procedure document.

This ensures policy alignment and reduces duplication.

National Engagement

Healthcare Improvement Scotland (HIS) Engagement Practice Learning and Improvement System.

The Skye Centre Manager attended HIS's introductory session on the new Engagement Practice Learning and Improvement System. This system aims to:

- Embed high-quality, consistent public engagement.
- Build organisational capability and confidence in engagement practice.
- Ensure voices of people with lived and living experience are central to change and improvement.

Key points and developments:

- A national Engagement Practice Learning Programme is in development, with modules to be hosted via NHS Education for Scotland (NES) LearnPro.
- Establishment of:
    - Engagement Practice Network – Communities of Practice
    - Carer Experience Improvement Model (CEIM) Leaders Peer Network
- Planned launch of an Engagement Practice Responsive Support Service (Jan/Feb 2026).
- Updated resources and toolkits now available on the HIS website.

Learning from this session will support our ongoing work to strengthen carer involvement and experience across care pathways.

Summary and Next Steps

Progress has been made in delivering the Carer Strategy priorities, particularly in relation to carer engagement, communication improvements and strengthening carer involvement at key points in the care pathway.
The focus areas for 2026 include:

- Implementing actions arising from Triangle of Care self-assessment.
- Further developing the Carer Pathway collaborating with the Transitions Service Leadership Team to support carers during patient transitions and discharge.
- Enhanced support during the admission process, including engagement by the Person Centred Improvement Advisor.
- Planning for a Visitor Satisfaction Survey in May 2026, with results to inform activities for Carers Week in June 2026.
- Continued work with the Forensic Network on the Carers Toolkit.
- Ensuring updated materials and communications reflects carers' feedback and needs.
- Updating all carer communication materials and ensuring accessibility via the hospital website.
- Embedding learning from HIS's Engagement System into practice.

This programme of work continues to strengthen the recognition, inclusion, and support of carers across all aspects of the patient journey.

4 RECOMMENDATION

The Board is invited to note the update and progress.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Supports the Equality Agenda and ongoing work related to the Person Centred Improvement Group
Corporate Objectives Please note which objective is linked to this paper	
Workforce Implications	Awareness Training and development of staff in the area of the priorities set within the Strategy and outcomes of the Triangle of Care self-assessment
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	Person Centred Improvement group – reporting via the Clinical Governance Group
Risk Assessment (Outline any significant risks and associated mitigation)	na
Assessment of Impact on Stakeholder Experience	na
Equality Impact Assessment	na
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

Paper No. 26/06

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 26 February 2026

Agenda Reference No: Item 11

Sponsoring Director: Director of Nursing and Operations

Author(s): Director of Nursing and Operartions

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.

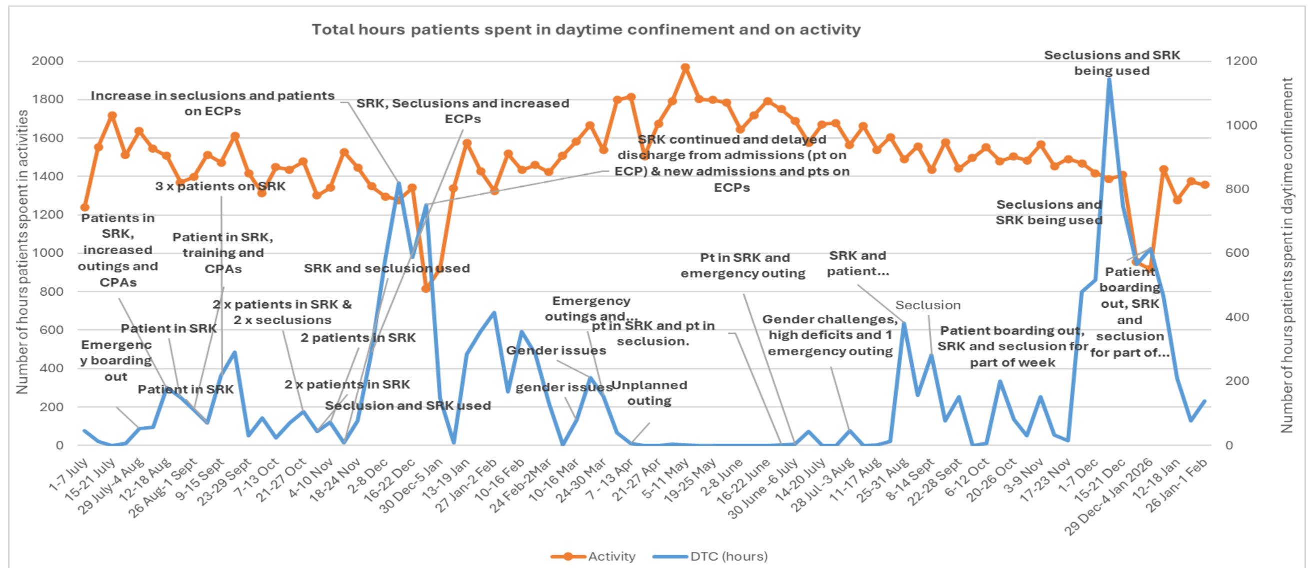
The data presented in the report covers the period up to and including the 31 January 2026.

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)

December - saw an increase in DTC from 676.6 hours to 2975.3 hours (see also clinical acuity update below). The number of activities being provided to our patients decreased with these ranging from 953.7 hours week beginning 22 December and 1416.7 hours week beginning 1 December. It should be noted that week beginning 22 December has 2 public holidays within it and will have therefore impacted activities within the wards and over in the Skye Centre.

January - saw a decrease in DTC from 2975.3 hours to 1505.5 hours. The number of activities being provided to our patients decreased with these ranging from 917.6 hours week beginning 29 December and 1439.4 hours week beginning 5 January. It should be noted that week beginning 29 December had 2 public holidays within it and will have therefore impacted activities within the wards and over in the Skye Centre.

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. There are plans to undertake a process mapping exercise on the 18th March to look at these meetings in more detail and ensure process is efficient and effective. There is also a need to further develop the recording of these meetings and communicating the decisions that they make.

There is now a central Teams Channel which will hold all relevant information pertaining to DTC. All approvals are recorded and held in a folder in the DTC Teams Channel.

Recruitment - December and January

Over recent months the Nursing Department has worked to fill the vacancy gaps created by the opening of the Interim women's Service. There was recognition that during this transition period the hospital would experience DTC and teams have been working together to reduce the impact.

In December the Nursing Directorate were given approval 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. Onboarding is scheduled for March 2026.

Over the month of December recruitment campaigns were also undertaken for vacancies in Band 6 and Band 7 posts and over the coming weeks further Band 6 recruitment will be undertaken. It is worth noting that any internal appointments to these posts (as with previous internal appointments) will have an impact on existing vacancies. This continues to be monitored by Lead nurses and the Associate Director of Nursing.

The Directorate continues to monitor the impact on resourcing as a consequence of the opening of a Women's Service at TSH. However, as noted above, the senior nursing team are responding to these resource implications with pro-active over-recruitment of Healthcare Support Workers.

Future Plans

Recruitment efforts to close the band 5 vacancy gap will remain ongoing with monthly adverts scheduled through to August 2026. The State Hospital will also be attending three in-person university; two recruitment fairs and a presentation to learning disability nursing students nearing completion of their studies. In addition, a Recruitment Fair will be held within the hospital on 23rd March, providing potential candidates with the opportunity to visit the site, speak with current staff, and, where possible, visit a ward. Nursing and HR colleagues will also trial "on the day"

interviews for interested candidates – the detail of this being working through by members of the Nursing Practice Development and HR team.

Clinical Acuity
Throughout the month of December, the hospital experienced a sustained period of clinical acuity (including multiple SRK use; seclusions and periods of outboarding) operating at approximately 30-35 staff above funded establishment each day, at its peak. Bed occupancy increased from 107 patients (as at 1st December 2025) to 112 patients (as at 31st December 2025) with seven admissions between 02/12/25 and 29/12/25; three of these admission during the festive holiday period.

As noted above, nursing continue to monitor the impact of the Women's Service with three patients at present; all of whom require to be cared separately from each other, requiring three separate care teams. Clinical teams continue to review all patients on enhanced levels of care to ensure they are necessary and proportionate to level of need. A review of the data regarding the impact of the fluctuations in acuity is currently being undertaken, with a view to considering how these fluctuations in demand can more easily absorbed.

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. This has been in place since early December and has been working well.

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: 26 February 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

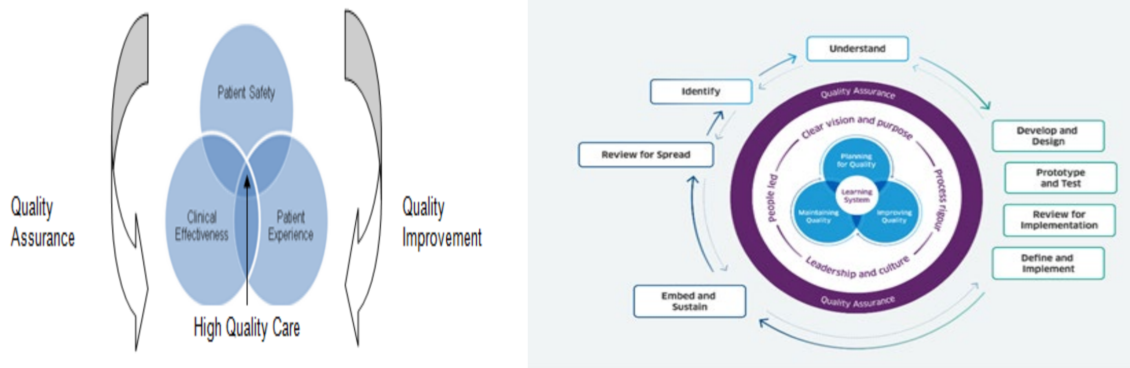
2 BACKGROUND

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 Board Which groups were involved in contributing to the paper and recommendations.	This paper reports directly to the Board. It is shared with the QI Forum.
Risk Assessment (Outline any significant risks and associated mitigation)	The main risk to the organisation is where audits show clinicians are not following evidence-based practice.
Assessment of Impact on Stakeholder Experience	It is hoped that the positive outcomes with the service level reports will have a positive impact on stakeholder experience as they bring attention to provision of timetable sessions.
Equality Impact Assessment	All the policies that are audited and included within the quality assurance section have been equality impact assessed. All larger QI projects are also equality impact assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This will be part of the project teamwork for any of the QI projects within the report.

Data Protection Impact Assessment (DPIA) See IG 16. 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 – OCT/NOV 2025

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 three local audits completed by the Clinical Quality Department and actioned through the Commissioning Groups. All three audits gave excellent assurance to the organisation, with only a few minor improvements required.

- RMO engagement with patients
- Unvalidated entries
- Diabetes 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 recent local audit outcomes for each ward. Compliance is indicated by a colour code: green for excellent adherence or minimal improvement, amber for areas requiring action, and red for significant improvements required.

Table 1: Master Audits

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

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

1.2 CPA oversight monitoring report

The paper-based variance analysis tools that staff completed for the last 22 years were decommissioned at the end of December, with all the data now being gathered directly from source (through RiO). 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. 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:** Nine active QI projects are underway, led by multidisciplinary teams across clinical, operational, and patient groups. These initiatives are designed to deliver measurable improvements in care quality and patient experience.

- **Recent Achievements:** One project have been successfully completed since the last report as part of the national Scottish Improvement Leaders Programme (ScIL) contributing to enhanced processes and outcomes within the hospital.

- **The International Forum on Quality and Safety in Healthcare scheduled for March 2026:** Two posters have been accepted and will be 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 have also been invited to deliver a workshop at the Conference based on the TSH3030 QI sprint.

- **TSH3030:** Planning for the 2026 cycle of TSH3030 has commenced with support from CMT. This QI sprint will take place throughout May 2026.

2.3 QI Capacity Building

2.3.1 – Scottish Improvement Leaders Programme (ScIL)

Cohort 50 – one member of staff submitted their portfolio which received a pass mark in February 2026.

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 commenced in December 2025, with four staff members participating in the course.

2.4 Realistic Medicine

Work continues to support the Realistic Medicine 2025/26 action plan. 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.

3. EVIDENCE FOR QUALITY

3.1 National and local evidence-based guidelines and standards

The State Hospital has a robust process for reviewing all incoming guidance to determine its relevance to the State Hospital. Pertinent documents are evaluated by multidisciplinary teams using an evaluation matrix to ensure compliance. During the period 1 December 2025 to 2 February 2026, 21 guidance documents have been reviewed: 16 documents were considered either not relevant or were overridden by Scottish guidance and three were shared for information. The two remaining guidance documents in relation to Chronic Pain and Overweight and Obesity Management required an evaluation matrix to be completed and this process has commenced.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required
SIGN	1	0	1
MWC	3	3	0
National Institute for Health & Care Excellence (NICE)	17	0	1

There are currently two additional evaluation matrices which have been outstanding for a prolonged period. The review process for the HIS Gender Identity Healthcare Standards Gender ID Healthcare gap analysis has now been completed and will be tabled at the Person Centred Improvement Steering Group (PCISG) and then at Physical Health Steering Group (PHSG) for final sign off at the end of February 2026.

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 has now been completed and is out for content review prior to tabling at the PHSG in February 2026.

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 Content agreement from PCISG in December 2025 was delayed and will be tabled at same in February 2026. Final sign off by PHSG anticipated for end of February 2026.	September 2024	January 2025

Body	Title	Steering Group	Current Situation	Publication Date	Projected Completion Date
NICE	Overweight and obesity management	PHSG	To be progressed in absence of current Scottish guidance (publication anticipated March 2027). Evaluation matrix completed by SHC group and is currently out for content review prior to tabling at PHSG in February 2026 for final sign off.	January 2025	February 2026

STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

CGC(M)25/04

Minutes of the meeting of the Clinical Governance Committee held on Thursday 13 November 2025.

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

Chair:

Non-Executive Director	Cathy Fallon

Present:

Non-Executive Director	Stuart Currie
Non-Executive Director	David McConnell
Board Chair	Brian Moore

In Attendance:

Associate Director of Nursing	Josephine Clark [Items 11a and 11b]
Consultant Psychiatrisât	Dr Jana de Villiers [Item 5]
Corporate Business Manager	Anne Donnelly
Health Psychologist	Alison Eadie [Item 18]
Head of Psychology	Dr Liz Flynn
Skye Centre Manager	Jacqueline Garrity [Item 16]
Personal Assistant	Vicky Gregg [Minutes]
Social Work Mental Health Manager	David Hamilton [Items 14 and 15]
Acting Director of Estates and Resilience	Allan Hardy
Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist	Dr Khuram Khan [Items 17 and 18]
Director of Nursing and Operations	Karen McCaffrey
Director of Finance & eHealth	Robin McNaught
Head of Corporate Planning, Performance and Quality	Monica Merson
Consultant Forensic Psychiatrist	Gordon Skilling
Medical Director	Professor Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon opened the meeting and noted apologies from Ms Margaret Smith, Head of Corporate Governance and Ms Sheila Smith, Head of Clinical Quality.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF PREVIOUS MEETING

The Committee approved the minutes of the meeting held on 14 August 2025, with one minor correction of a misnomer.

Action: Secretariat

The Committee:

1. Approved the minute of the meeting held on 14 August 2025.

4 MATTERS ARISING / ROLLING ACTIONS LIST

Ms Fallon requested an update on the Women's Outreach Service stakeholder meeting referenced at the previous meeting. Mr Jenkins reported that he had chaired the meeting and outlined expectations to stakeholders. He noted that further updates would be provided following review by the Women's Project Oversight Board.

In relation to the Rolling Actions list, the Committee noted that actions had progressed or were on the agenda for today's meeting.

Professor Thomson asked the Committee to note that further progress had been made on Action No. 1 in that two research invoices had been cleared and one was nearing resolution.

Mr Moore requested an update on Action No. 5 in relation to revision of the Mechanical Restraint Policy and Ms McCaffrey advised that the review was ongoing, with new recommendations from the Patient Safety group under consideration.

<u>The Committee:</u>

1. Noted the updates from the Rolling Action List.

5 DISCUSSION ITEM: INTELLECTUAL DISABILITES SERVICE

Dr de Villiers joined the meeting and presented a comprehensive overview of the Intellectual Disabilities (ID) Service. She explained that the forensic ID population represented a small proportion of patients in forensic inpatient care. She noted that the forensic ID population was distinct from the general forensic mental health population in that patients presented with complex needs, including conditions such as Autism Spectrum Disorder, Fetal Alcohol Syndrome, ADHD, and genetic disorders, often with physical health co-morbidities.

Dr de Villiers outlined the current configuration of the ID service at TSH, which was resourced for 12 male beds but had been operating over capacity with 15 patients for the past three years. She outlined the three-year plan for the ID Service following implementation of the new Clinical Model, noting that in the first-year focus had been on improving the Positive Behavioural Support (PBS) Programme with the aim of reducing incidents of violence. She presented data trends showing a marked reduction in the use of physical restraint and in self-harm incidents since the introduction of PBS.

Dr de Villiers highlighted the ongoing challenges for the ID service, including bed capacity, patient mix, and delayed discharges. She noted that future development priorities included improving grounds access for ID patients, extension of the fenced garden areas outside of the wards, and creation of sensory rooms in each ward. She added that a proposal for creation of the sensory rooms had been submitted to the Corporate Management Team (CMT) for consideration.

Mr Currie thanked Dr de Villiers for her presentation and asked if all referrals to the ID service came through the Criminal Justice System. He also asked if the delayed discharges were linked to budget constraints such as the cost of high-level care packages.

Dr de Villiers advised that not all referrals came through the Criminal Justice System, and patients in lower security levels may be moved to higher security if their behaviour escalates. In relation to delayed discharges, she explained that this was due to a national shortage of male medium secure ID beds, with only eight available across Scotland.

Mr McConnell asked if the shortage of male medium secure ID beds was a temporary issue and Dr de Villiers advised that this was a longstanding issue that had been highlighted to Scottish Government, and was also compounded by the withdrawal of a Service Level Agreement by the National Services Division for the provision of four male medium secure ID beds in Newcastle that could be utilised if required.

Mr Moore thanked Dr de Villiers for her informative presentation and asked if there was any feedback on the proposal for the sensory rooms. Mr Jenkins responded and said that the proposal had been agreed at CMT last week and that Professor Thomson was discussing funding arrangements with Mr McNaught.

Mr Jenkins thanked Dr de Villiers for her presentation and commended her leadership of the ID service. He said that he would welcome a capital proposal for extension of the fenced areas for consideration in 2026.

Ms Fallon echoed Mr Jenkins comments and noted that improving grounds access for ID patients was an important issue to be addressed. She requested that an update regarding this return to the Committee in six months.

Action: Professor Thomson / Secretariat

The Committee:

1. Discussed and noted the content of the presentation.
2. Requested an update on grounds access for ID patients to return in six months.

6 DAYTIME CONFINEMENT

Committee members received the Daytime Confinement (DTC) report presented by Ms McCaffrey covering the period from 30 June to 28 September 2025. She highlighted the challenges experienced during this period, largely due to staffing pressures following the opening of the Women's Service.

She emphasised that staff continued to be supported in decision-making around DTC by senior managers, and robust recording of DTC was in place. The DTC Oversight Group continued to meet monthly to review all instances of DTC and identify any learning points or actions required. Incident command training had been delivered and there would be a review of feedback from staff who attended training sessions to support the ongoing operational management of DTC.

Ms McCaffrey provided an update on nursing recruitment and noted that 12 Band 5 nurses had been shortlisted for interview next week and that further recruitment campaigns were planned to address anticipated staff turnover and to prepare for the impact of implementing the Reduced Working Week. She added that there was approval to over-recruit up to the turnover rate, but this may need to be extended further to offset the reduction in available hours per staff member once the new working pattern was implemented.

Mr Jenkins acknowledged the operational challenges experienced in recent months and reaffirmed the organisations commitment to the eradication of DTC.

Mr Moore asked if consideration had been given to over-recruitment beyond the current approval, noting that a proactive approach to workforce planning could mitigate similar challenges in the future. He highlighted the interval between staff departures and the commencement of recruitment activity and asked if the process could be refined through improved forecasting and planning to reduce this gap.

In response to Mr Moore's question Mr Jenkins confirmed that over-recruitment approval had been in place for a year, including permission to recruit up to the nursing turnover rate. He noted that recruitment typically took around 90 days from advertising to onboarding and adverts often predate vacancies. He added that there was continuous cycle of recruitment to maintain staffing levels, with a target of 7-11% above the baseline.

Ms Fallon thanked Ms McCaffrey for her report and noted that it was important to acknowledge the national context of recruitment challenges.

The Committee:

1. Noted the content of reporting.

7 LEARNING POINTS FROM SAERS

Committee members received the Learning from Serious and Adverse Event Reviews (SAERs) Report presented by Mr Hardy who outlined recent changes in the governance of SAERs to align with national reporting. He advised that Healthcare Improvement Scotland had sent all NHS Boards a self-assessment to evaluate their SAER processes, with returns due at the end of November. Mr Hardy advised the Committee that work on this was underway.

Mr Hardy informed the Committee that one Category 1 review related to clinical matters remained outstanding. Six actions from previous investigations involving clinical matters remained outstanding and the Clinical Governance Committee continued to monitor these actions.

Mr Currie asked how the Committee could take assurance that learning from adverse events was being embedded and that repeat incidents were being prevented, without being overwhelmed by detail or duplicating the work of operational groups.

Mr Jenkins echoed Mr Currie's comments, noting the complexity of SAER oversight across multiple committees without a single point of responsibility. He proposed expanding the remit of the Audit and Risk Committee to include performance, and this Committee would have oversight of SAERs. Committee members agreed to this proposal, and Mr Jenkins would consult the Head of Corporate Governance to ensure alignment with the governance framework. Mr McConnell suggested adding this topic to the agenda for discussion at the next Board Development Session.

Action: Mr Jenkins

Regarding the outstanding actions, Mr Currie asked how it could be evidenced that delays were due to issues outwith the organisation's control, such as legal issues causing the delay. In response, Mr Jenkins offered assurance that the Corporate Management Team monitored all outstanding actions. Professor Thomson added further assurance that the Clinical Governance Group continued to monitor SAERs.

The Committee:

1. Noted the content of reporting,

8 LEARNING FROM FEEDBACK AND COMPLAINTS

Committee members received the Learning from Feedback and Complaints presented by Ms Donnelly who provided an overview of complaints activity in the last quarter. She noted that 49 complaints had been received which was a noticeable increase on previous years, but this was largely driven by a small number of patients submitting multiple complaints. Most complaints had been resolved at stage one, with themes including clinical treatment, staffing shortages, and equipment issues.

Ms Donnelly advised that one complaint had highlighted the difficulty in ensuring that patients are informed about making a claim for Department for Work and Pensions (DWP) benefits upon admission, particularly if they are unwell, as the DWP only allows claims to be backdated by one month from the application date. This matter had been referred to the Person-Centred Improvement Team for review. Professor Thomson noted that any concerns regarding a patient's capacity to complete benefit forms should be referred to the patient's Responsible Medical Officer.

Mr Moore noted the lack of awareness by clinical teams that the "What Matters to Me Plan" should be completed in collaboration with the patient and asked how this would be addressed going forward. In

response, Ms McCaffrey advised that this would be raised at the next Person-Centred Improvement Group and she would provide feedback at the next Committee.

Action: Ms McCaffrey

Ms Donnelly asked Committee members if the content of the report was too detailed and if a high-level summary would be more helpful. There was discussion around the table on this matter and the Committee agreed that the level of detail in the report was useful. Mr Jenkins also commented on the possibility of adding more detail about low-level complaints, such as verbal assaults, to provide further assurance.

Ms Fallon thanked Ms Donnelly for her report and raised the question of how patients received information about claiming benefits when they were admitted, and it was noted that this would be reviewed.

Action: Ms McCaffrey

The Committee:

1. Noted the content of reporting.
2. Provide update on “What Matters To Me Plan”
3. Provide update on advice to patients around claiming benefits.

9 BED CAPACITY REPORT AND APPENDIX 1

Members received the Bed Capacity Report presented by Professor Thomson who provided an overview and noted that bed capacity was manageable at present. She highlighted that the report had been updated to include the bed position for the Women’s Service, which had one patient at the time of reporting, with a second patient admitted recently.

Mr Currie thanked Professor Thomson for her report. He asked if there was pressure from the wider system to admit patients to TSH if bed capacity at medium secure was limited, and if the available beds at TSH could be used to accommodate patients requiring medium secure care on a temporary basis. Professor Thomson advised that discussions were ongoing with colleagues across the forensic estate regarding bed capacity and explained that the Exceptional Circumstances clause could be used for admitting patients to TSH who were significantly unwell and there were no beds available at medium secure. At present due to numbers, clinical acuity and DTC, TSH is closed to exceptional circumstances.

Mr Moore noted that Appendix 1 was useful and asked if the 27 patients currently on the waiting list for admission to Leverndale Hospital was having an impact on the wider system. Professor Thomson noted that a significant amount of work had been carried out by colleagues in Rowanbank Clinic and Leverndale Hospital to reduce the waiting list for medium secure beds, however there was now a bottleneck for transition from medium to low secure beds.

Ms Fallon thanked Professor Thomson for the report and overview provided.

The Committee:

1. Noted the content of reporting, and Appendix 1.

10 UNSCHEDULED CARE 6M UPDATE

The Committee received the Unscheduled Care six-month update presented by Professor Thomson who provided an update on the work of the Unscheduled Care Short Life Working Group (SLWG) as detailed in reporting.

She noted that the protocol for the Flow Navigation Centre (FNC) pilot had been approved by the medical group and was now under review by nursing colleagues. Once the protocol was finalised it was anticipated that the FNC would commence in January 2026. The virtual beds pilot was still in development by NHS Lanarkshire and was expected to be operational next year.

Mr McConnell thanked Professor Thomson for the update and recommended removing the reference in the report that attributed delays in the FNC pilot to a lack of secretarial support. Committee members agreed with this suggestion and Professor Thomson would highlight this to the report author.

Action: Professor Thomson

The Committee:

1. Noted the full update within reporting.

11 a) CLINICAL CARE POLICY INTERNAL AUDIT REPORT b) CLINICAL CARE POLICY INTERNAL AUDIT REVIEW

Members received the Clinical Care Policy Internal Audit Report and Internal Audit Review Update presented by Ms Clark who noted that the Clinical Care Policy had been implemented in May 2024 and a one-year review examining the policy transition into practice and compliance against the policy was undertaken. The findings of the review had been discussed at the Patient Safety Group and presented to the Clinical Governance Group.

Five recommendations had been made in relation to improvement in practice and governance, particularly around monitoring patients on enhanced care. A small working group was created to address these recommendations and actions were being tracked through the Patient Safety Group, with regular reporting to the Clinical Governance Group.

Mr McConnell thanked Ms Clark for her update and noted that the Internal Audit Report had been presented to the Audit and Risk Committee and had received substantial assurance. He commended Ms Clark for the work undertaken to achieve this level of assurance.

Professor Thomson proposed that the Clinical Care Policy was scheduled as a discussion item at the May Committee meeting and Ms Fallon was content with this proposal.

Action: Secretariat

The Committee:

1. Noted the content of reporting.
2. Requested that the Clinical Care Policy was scheduled as a discussion item at the May Committee meeting.

12 CORPORATE RISK REGISTER – CLINICAL RISKS

The Committee received the report on Corporate Risk Register – Clinical Risks from Mr Hardy who noted that that no new risks had been identified. Risk ND70 in relation to optimising excellent patient care and experience had been reduced to medium following review and this was attributed to improved data collection and tracking. He highlighted that risk MD30 – failure to prevent/mitigate obesity remained at high and was subject to ongoing review.

Professor Thomson highlighted the limitations of using BMI as a Key Performance Indicator (KPI), noting it had not been effective for tracking progress. Alternative measures, such as percentage weight gain since admission, were being trialled. This new approach incorporated three strands: biological, psychological, and social and would focus on prevention and treatment of obesity.

The Committee:

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

13 INCIDENTS AND PATIENT RESTRICTIONS

The Committee received the Incidents and Patient Restrictions Report presented by Mr Hardy who outlined the revised format of the report which had been streamlined to give the Committee a high-level overview of incidents and restrictions applied in the last quarter. He noted that restrictions in relation to grounds access had been included in reporting however it was extremely positive that 70% of patient had some form of grounds access.

Mr Currie commended the high percentage of patients who had grounds access and acknowledged the ongoing effort required to maintain this standard, given the complexities of the patient population. He praised the balance between detail and clarity in the report, noting that the cover paper contained sufficient information for the Committee to take assurance, while allowing readers to explore further detail if desired. He particularly appreciated the inclusion of a statement about the Clinical Governance Group's oversight of operational issues that arise from any clinically related incidents and said this gave him confidence that incidents were being managed appropriately.

Mr Moore highlighted the three incidents involving patients making racist remarks and emphasised the need to monitor such occurrences, given the vulnerabilities of the patient group. Mr Hardy assured Mr Moore that these incidents were closely monitored.

Ms Fallon thanked Mr Hardy for the report and noted that the revised reporting format was effective. She asked about the incident involving the search process of a patient being newly admitted to the hospital. In response, Mr Hardy advised that a full review had been conducted, staff training refreshed, and searching procedures updated to prevent recurrence.

The Committee:

1. Noted the content of reporting.

14 PRE-TRANSFER CPA / MAPPA 12 MONTH REPORT

Mr Hamilton joined the meeting to present the Pre-Transfer Care Programme Approach (CPA) and Multi-Agency Public Protection Arrangements (MAPPA) 12 Month Report. He noted that 100% of all transfers and discharges had been managed through the CPA process. During the reporting period, 28 patients were transferred or discharged, and 34 CPA meetings were held.

He noted that 74% of patients attended their CPA meetings and that regular attendance by Advocacy at CPAs meant that the patient voice was represented even if they chose not to attend. There was a notable increase in carer attendance at CPAs, and he explained that the Social Work service proactively engaged with carers prior to meetings to ensure their views were appropriately represented, further strengthening the patient-centred approach.

Mr Hamilton highlighted a persistent challenge with completion of patient experience feedback forms after CPA meetings and advised that the team was in the early stages of exploring a digital interface to make feedback easier and more accessible for patients.

In relation to MAPPA, during the reporting period, 33 patients were admitted, 12 of whom were subject to MAPPA restrictions upon admission. 18 MAPPA restricted patients were discharged and a further six patients had a change in their status. Notifications to MAPPA were provided in all cases. Mr Hamilton advised that work continued nationally on the Multi-Agency Public Protection System (MAPPS) which would replace the current VISOR system with a planned implementation date of 2027.

Mr Jenkins thanked Mr Hamilton for the report and noted that a Charter of Agreement for MAPPS had been discussed at the Chief Executives' meeting the previous day, with a target for sign-off in 2028.

Ms Fallon thanked Mr Hamilton for the high standard of his report.

The Committee:

1. Noted the content of reporting.

15 CHILD AND ADULT PROTECTION FORUM (INCL. CORPORATE PARENTING) 12 MONTH REPORT

The Committee received the Child and Adult Protection Forum 12 Month Report presented by Mr Hamilton who provided a summary overview of child and adult protection activity in the last 12 months as detailed in reporting. He highlighted the publication of a new Corporate Parenting Plan and the ongoing work to meet statutory responsibilities, including those under the United Nations Convention on the Rights of the Child (UNCRC).

Mr McConnell thanked Mr Hamilton for his report and enquired about the extension of corporate parenting responsibilities beyond age 26 and how national guidance applied to the high secure environment. Mr Hamilton clarified that, although not mandated by law, the hospital's approach was to maintain support and communication with Local Authorities and other agencies to ensure that young people did not lose access to services or advocacy simply because they had passed a particular age threshold.

Ms Fallon thanked Mr Hamilton for his comprehensive report and congratulated the Social Work team on winning the TSH30310 Oscar. She requested an update on the review of the child searching process to return to the next Committee.

Action: Ms McCaffrey / Secretariat

The Committee:

1. Noted the content of reporting.
2. Requested an update on the review of the child searching process to return in February 2026.

16 PERSON-CENTRED IMPROVEMENT SERVICE 12 MONTH REPORT

The Committee received the Person-Centred Improvement Service 12 Month Report presented by Ms Garrity who provided an overview of the activity of the Person-Centred Improvement Team (PCIT) in the last 12 months. She highlighted the work of the Patient Partnership Group (PPG) who had been actively involved in a variety of processes including reviewing and updating the volunteer policies.

She noted that the "Safely Recovering: Your Experiences in The State Hospital" patient questionnaire had been developed and sent out to patients for completion. To share the outcomes of the questionnaire with the wider patient group a feedback poster had been created which shared the main themes, summary of the outcome results and areas of improvement. She outlined the planned workstreams for the next 12 months and noted that progress would be reported to the Patient Safety Group on a quarterly basis.

Mr Moore thanked Ms Garrity for the report and asked if she could provide further details on the Triangle of Care audit, including an update on when the self-assessment was expected to be completed. She replied that the initial audit, conducted before COVID, had prompted a follow-up to ensure that best practices were still being maintained. Key individuals from each ward were tasked with reviewing the self-assessment, and the results were expected by the end of December. Any areas for improvement would be incorporated into an action plan for the coming year.

Mr Jenkins thanked Ms Garrity for her report and commended her on raising the profile of the person-centred agenda across the hospital.

Ms Fallon echoed Mr Jenkins' remarks and asked if the 12-month update was shared with the PPG. In response Ms Garrity confirmed that the PPG would have access to the update, and Ms Fallon suggested that it would be useful to incorporate patient feedback in future reporting to the Committee to demonstrate the impact of the activities undertaken by the PCIT.

Action: Ms McCaffrey / Secretariat

<u>The Committee:</u>

1. Noted the content of reporting.
2. Requested future reporting to incorporate patient feedback on the activities undertaken by the PCIT.

17 PHYSICAL HEALTH STEERING GROUP 12 MONTH REPORT

The Committee received the Physical Health Steering Group 12 Month Report presented by Dr Khan who highlighted the key achievements over the last 12 months, including the introduction of a weekly female GP-led women's health service, colorectal and aortic screening for eligible patients, and implementation of the QRISK3 cardiovascular risk assessment.

Dr Khan noted that there had been an increase in vaccination uptake by at-risk patients however the overall uptake of the flu and COVID vaccines had declined, which he attributed to vaccine fatigue and misinformation, and there would be targeted education and health promotion events to try and address this.

The new care planning process had been fully rolled out, with an audit underway to assess its effectiveness. Physical activity compliance reached 79%, reflecting the hospital's commitment to promoting exercise and healthy living. The epilepsy audit showed good compliance as did the observation of care audit.

Dr Khan outlined the workplan for the coming year including strengthening obesity prevention in admission wards, embedding audit recommendations and improving consistency across wards, and conducting an audit of out of hours patient care via NHS 24 to ensure the newly developed flow navigation chart was being followed by staff.

Mr McConnell thanked Dr Khan for his report and asked how TSH vaccine uptake compared to the broader population, and Dr Khan confirmed that uptake mirrored national trends.
Mr Currie asked if vaccine misinformation was mainly restricted to patient-to-patient interactions and if healthcare staff who do not take up the vaccine had views that were influencing others. Dr Khan confirmed that misinformation generally occurred between patients. Ms McCaffrey added that staff had been given clear guidance by the Infection Control Committee that they should promote patient uptake of vaccinations regardless of their personal views.

Ms Fallon thanked Dr Khan for his report and requested that the Committee received future reporting in relation to the BMI KPI and on the flow navigation process.

Action: Professor Thomson / Secretariat

<u>The Committee:</u>

1. Noted the content of reporting.
2. Requested future reporting on the BMI KPI and flow navigation process.

18 SUPPORTING HEALTHY CHOICES 12 MONTH REPORTs

Committee members received the Supporting Healthy Choices 12 Month Report presented by Dr Khan and Ms Eadie who highlighted key achievements, particularly in relation to the patient shop and the planned introduction of an electronic point of sale (EPOS) system which would enable better tracking of purchases and support future stock management.

Ms Eadie reported that operational changes to the shop had progressed, although certain restrictions remained subject to ongoing legal consultation and patient engagement. Professor Thomson outlined the implications of the Lady Dorian ruling, which differentiated between operational changes that were permissible without consultation, and health-related changes that required patient involvement. She stated that the team had been confident in the operational rationale for the new till system and stock review, while noting that further legal guidance would be sought if necessary.

Ms Fallon thanked Ms Eadie and Dr Khan for their report and requested that updates on the patient shop, patient volunteer shop assistant, and scenario planning for grounds access to take place at an earlier stage after admission, return to the Committee in six months.

Action: Professor Thomson / Secretariat

The Committee:

1. Noted the content of reporting.
2. Requested updates on the patient shop, patient volunteer shop assistant, and scenario planning for grounds access to take place at an earlier stage after admission, to return in six months.

19 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

Professor Thomson commended the brevity of the meeting papers and highlighted this as an example of good practice.

The Committee agreed the following as areas of good practice:
- Physical health annual screening
- High rates of ground access
- The transfer CPA completion rate of 100%

The Committee noted no areas of concern.

20 DRAFT COMMITTEE WORKPLAN FOR 2026

The Committee reviewed and endorsed the draft work plan for 2026. Mr Moore said that he found the presentation on the ID service useful and informative and asked if similar presentations from other hub areas would be beneficial for the Committee. Ms Fallon thanked Mr Moore for his suggestion and said she would discuss this further with Professor Thomson prior to the next meeting.

Action: Ms Fallon / Professor Thomson

21 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Ms Fallon stated that she would share concerns about the impact of violent incidents on staff and the recruitment turnover rate with Ms Radage, as these issues were relevant to the Staff Governance Committee. Mr McConnell noted that extending the remit of the Audit and Risk Committee to include performance should be shared with Audit and Risk and Staff Governance Committees.

22 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

Ms Fallon noted that Structured Clinical Care had already been agreed as a discussion item at the next meeting.

24 ANY OTHER BUSINESS

There was no other business raised at this meeting.

23 DATE OF NEXT MEETING

The next meeting would be held on Thursday, 19 February 2026 at 9:30am.

The meeting concluded at 12:28pm

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 13
Author(s):	Head of Corporate Governance
Title of Report:	Summary Report – Clinical Governance Committee
Purpose of Report:	For Noting

This report provides an update on the key points arising from the Clinical Governance Committee meeting that took place on 19 February 2026.

1	Triangle of Care	The Committee received a presentation providing an overview of the key aspects within this workstream, focusing on strengthening partnership between patients, carers, and professionals. The presentation covered how this is being delivered within the context of forensic mental health in the State Hospital, especially for a patient cohort with complex needs. The Committee discussed the progress to date, and future improvements planned.
2	Daytime Confinement	Reporting provided an overview for the period 28 September to 27 December, including the challenges and pressures experienced. The Committee recognised the impact of the interim women's service, and the current work taken forward to reassess the service resourcing needs. Discussion included the impacts across the organisation, and it was agreed that further reporting would come to the Board in April.
2	12 Month Reports: Psychological Therapies (PTS) Activity Oversight Group (AOG) Clinical Governance Group	The Committee received assurance reporting in the form of 12 month across a range of areas, including Psychology Services and Activity Oversight Group, focusing on the improvement mechanisms outlined within reporting. The strong sense of progress in PTS was commended. It was noted that the AOG was being stood down as part of organisational structural change and care would be taken to ensure continued monitoring of all areas. Reporting was also received on the very wide range of oversight undertaken by the Clinical Governance Group over the course of the last 12 months, and the Committee took positive assurance in this respect.
3	Mental Health Practice Steering Group – Update Report	Reporting including updates across the remit of this group and noted in particular the importance of the focus on quality assurance mechanisms, commending the approach being taken. There were also updates on Trauma Informed Care and Care Programme Approach (CPA) practice.

4	Learning point from SAERS	The Committee noted the good work progressed in progressing the actions, and asked for further consideration as to the qualitative review of the learning taken asking for six monthly reporting on this in future.
5	Incident Reporting and Patient restrictions	Reporting provided the Committee with the Quarter 3 position on the types and numbers of incidents, including RIDDOR reporting, SAERs and patient restrictions during this period. The Committee considered the range of metrics reported which was covered in detail, and considered how to ensure data reported was meaningful in terms of providing assurance.
6	Learning from Complaints & Feedback	The Committee received Quarter 3 reporting in relation to complaints and feedback. Reporting highlighted the main issues raised, as well as the actions progressed in several areas as a result. The Committee noted the way patients engage with the complaints service as well as through wider opportunities for stakeholder engagement, and are able to give meaningful feedback.
7	Bed Capacity Report	The Committee received a report to provide data across patient admissions and transfers, and across services within the hospital. This was in context of position in wider estate nationally.
8	Clinical Model Research findings	The Committee received a research report commissioned through the University of Edinburgh, providing findings into the implementation of the clinical model, and agreed to discuss this further within a board development session.
9	Corporate Risk Register / Risk Reporting	The Committee reviewed the clinical risks within the Corporate Risk Register and agreed that reporting represented an accurate statement of risk. The Committee discussed the wider context of risks and consequential impacts, seeking for this to be reflected in reporting.
10	Areas of good practice/concerns	The work on streamlining patient activity taken through the AOG, and the excellent work on eliminating clinical waste incidents were noted as areas of good practice.

RECOMMENDATION

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 14
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

The State Hospital use a dashboard system called Tableau. The Workforce Dashboards are available for access by Tableau users and the system has the ability for managers to set up subscriptions to reports on particular days so that they receive an auto-notification.

Information and analysis is provided to the Workforce Governance Group, the Operational Management Team and Corporate Management Team. Information is also provided on a 6-weekly basis to the Partnership Forum.

3 ASSESSMENT

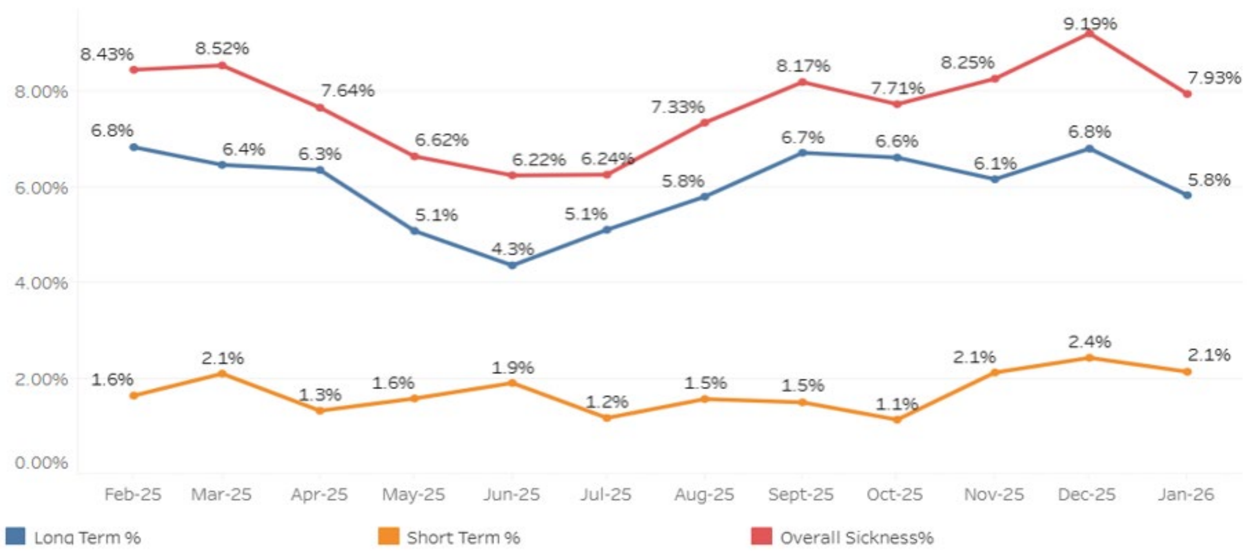
(a) ATTENDANCE MANAGEMENT

TSH Sickness Absence (February 25 to January 26)

Following a winter peak from October to December, Sickness Absence reduced in January 2026 to 7.93% from 9.19% in December 2025.

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

GRAPH 1 – all staff



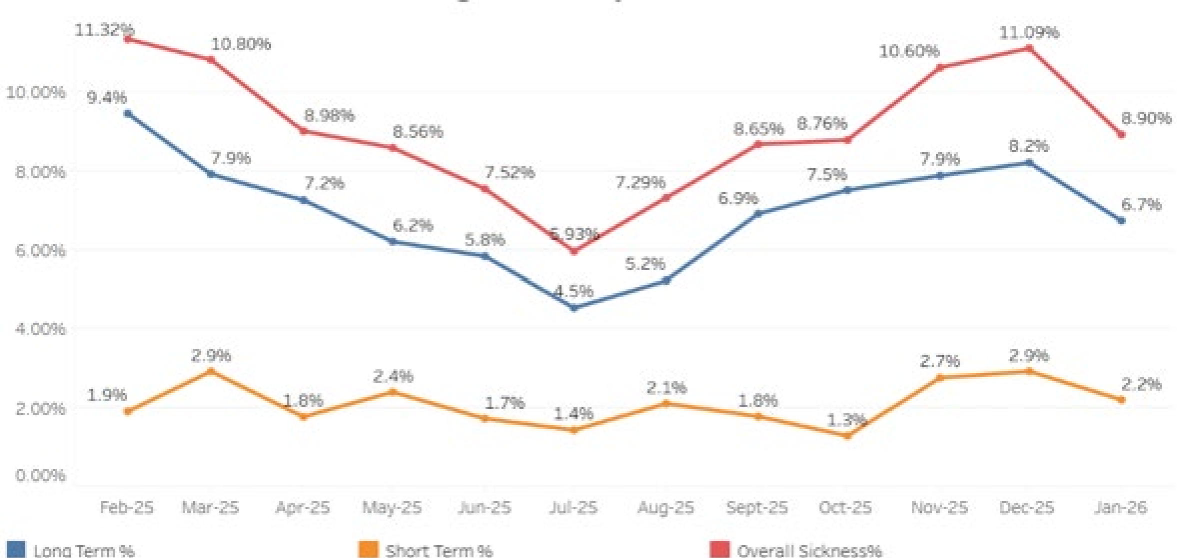
The main contributing factors to the reduced absence figure is:

- Fall in Nursing by over 2% (further illustrated in graph below)
- Reduction of 1% in long term absence
- Smaller reduction in short term absence

Nursing Sickness Absence (Feb 25 to Jan 26)

The reduction in absence is reflected in Nursing (from 11.09% in December to 8.9% in January 26). For comparison, our Nursing absence for January is 8.90% is lower than long term absence of Nursing for February 25 (which was 9.4%)

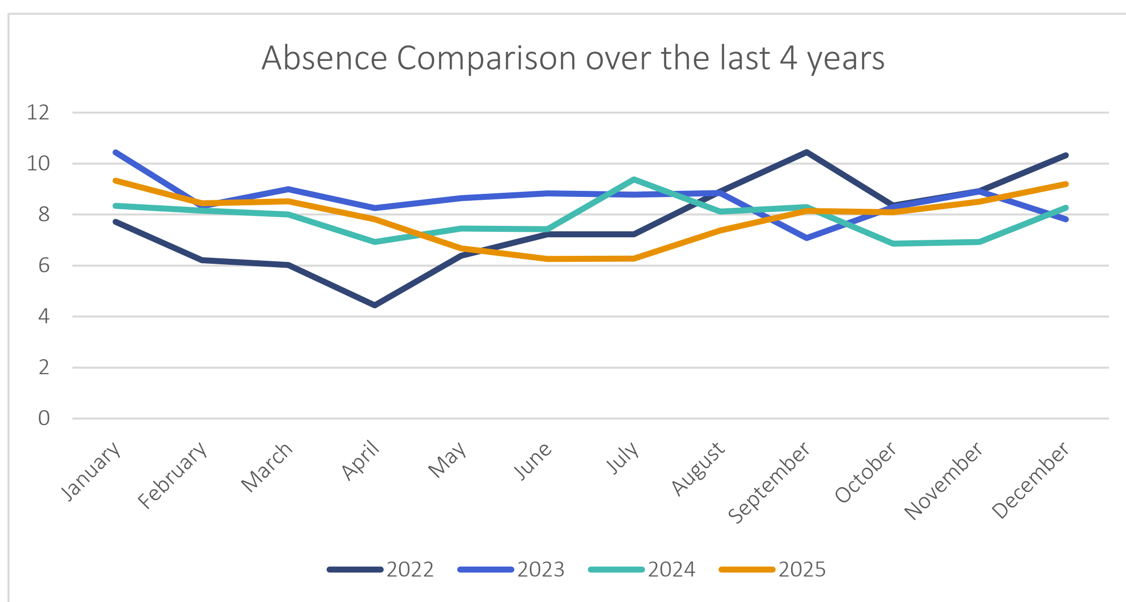
GRAPH 2 – nursing hubs



GRAPH 3 – Seasonal Trends

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

- However, 2025 shows the most sustained period between 6% and 8% (April to August), excluding 2022, which would have significant absence discounted as special leave.
- There was an early winter peak in November and December, fuelled by short term absence and significant flu.
- In general, 2025 seems to have a slightly lower baseline, although the 12-month average is approximately 7.86%
- The January 26 position of 7.94% will provide the lowest starting point for a calendar year since 2022.



ATTENDANCE MANAGEMENT OBSERVATIONS

Patterns/Trends for TSH:	Short-term absence: 2.19% (December was 2.90%) a decrease by 0.71% Long-term absence: 6.71% (December was 8.20%) a decrease by 1.49%	
Identified Departments of Concern:	Lewis 3 Mull 1 Lewis 2	27.46% 20.84% 15.06%
	The full range of maximising attendance support (as outlined in the final paragraph of this section) continues to be focused across the above areas. The HR Advisors for the relevant wards will be meetings with SCN's to discuss support required, and this will also be reinforced through the Workforce Governance Group.	
Identified Departments of Improvement:	Arran 1 Iona 3 Psychology	19.89% to 14.39% 8.47% to 6.46% 6.41% to 3.01%

	Areas of improvement are recognised through WGG and reinforced by local meetings with SCNs. We will continue to review progress within these areas to identify sustainable trends and ongoing improvement.
Reasons:	**Key reasons for long-term absence:** Anxiety/Stress/depression/other psychiatric illnesses, injury fracture, other known causes not otherwise classified **Key reasons for short-term absence:** Cold, Cough Flu-Influenza, injury fracture Other known causes
Activity:	At the time of reporting, for the month of January, 19 members of staff were invited to a Stage meeting, 18 for stage 1 and 1 for Stage 2 and 1 stage 3. 52% of people on active monitoring are being monitored for between 6-12 months. 48% of people on active monitoring are being monitored for between 3-5 months. Occupational Health issued 42 appointments in January 2026. Of all appointments issued, 32 were attended, 6 were cancelled/rearranged and 4 DNAs.

National Position

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

Sickness Absence Statistics by NHS Board
1st November 2025 - 30th November 2025

	Absence Rate			Instances			Absence Reason	
	Total	Long Term[1]	Short Term[2]	Total	Long Term[1]	Short Term[2]	Yes	No[3]
Scotland	**6.71**	**3.99**	**2.72**	**40,578**	**10,573**	**30,005**	**37,308**	**3,270**
NHS Ayrshire & Arran	6.57	4.11	2.46	2,268	627	1,641	2,118	150
NHS Borders	5.84	3.36	2.48	678	168	510	589	89
NHS National Services Scotland	4.82	3.04	1.78	524	149	375	495	29
NHS 24	11.09	6.84	4.25	781	204	577	761	20
NHS Education For Scotland	2.13	1.40	0.74	199	52	147	169	30
Healthcare Improvement Scotland	5.19	3.37	1.83	93	31	62	89	4
Public Health Scotland	4.08	2.20	1.88	188	34	154	179	9
Scottish Ambulance Service	9.25	6.07	3.18	1,356	451	905	1,148	208
The State Hospital	7.92	5.64	2.28	132	58	74	126	6
National Waiting Times Centre	6.49	3.69	2.80	604	159	445	544	60
NHS Fife	7.19	4.81	2.39	1,996	662	1,334	1,900	96
NHS Greater Glasgow & Clyde	6.97	4.26	2.71	9,555	2,785	6,770	9,039	516
NHS Highland	6.53	3.86	2.67	2,437	596	1,841	1,978	459
NHS Lanarkshire	7.83	5.14	2.69	3,184	1,041	2,143	2,906	278
NHS Grampian	5.42	2.61	2.81	3,760	656	3,104	3,332	428
NHS Orkney	6.90	4.28	2.63	147	40	107	136	11
NHS Lothian	6.36	3.39	2.98	6,364	1,341	5,023	5,880	484
NHS Tayside	6.61	3.87	2.74	3,144	764	2,380	2,836	308
NHS Forth Valley	7.87	5.03	2.84	1,583	469	1,114	1,541	42
NHS Western Isles	6.64	3.75	2.89	254	50	204	244	10
NHS Dumfries & Galloway	6.67	3.21	3.46	1,170	209	961	1,143	27
NHS Shetland	4.54	2.09	2.45	161	27	134	155	6

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 (3 of 11 Nursing wards below 5%)
- Audit and monitoring of consistent Pathways usage
- Manager development
- Accountability and performance management for areas which require additional support

In order to support Bespoke Wellbeing Plans for each service area, our new Staff Care Specialist will start in April 26.

(b) RECRUITMENT /ESTABLISHMENT/ SUPERNUMARY STAFFING

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

<table>
<tr><td>TIME TO HIRE</td><td>75 days</td><td>In line with our Time to Hire KPI</td></tr>
<tr><td>VACANCIES ADVERTISED</td><td colspan="2">7 posts were advertised in January, totalling 9 vacancies.</td></tr>
<tr><td>NURSING RECRUITMENT</td><td colspan="2">Ward-Based Nursing
14 WTE Nursing Assistants – Due to start 9 March 2026
2 WTE Registered Nurses to start Feb/March
13 WTE Registered Nurses Advertised – 8 Invited to Interview

Charge Nurse Recruitment
Three Charge Nurse posts are currently at advert. Any internal appointments may have an impact on existing vacancy figures.</td></tr>
<tr><td>EMPLOYABLITY:</td><td colspan="2">As part of our Workforce Plan and Anchor Strategy, we aim to increase the number of Modern Apprenticeships in the next 3 years. We encourage managers to consider whether their teams could accommodate a Modern Apprentice before roles are formally advertised.

A Modern Apprentice has recently been appointed to the Procurement Assistant role and is due to start at the end of March. This position includes completing the Healthcare Support Worker apprenticeship, alongside gaining a forklift licence and other relevant procurement-related industry certifications.</td></tr>
</table>

- **ESTABLISHMENT (Organisation Wide)**
  - **Planned establishment:** 665.93 WTE
  - **Actual establishment:** 619.90 WTE
  - **Variance:** 46.03 WTE

- **Ward Based Nursing (Excluding SCN)**
  - **Planned establishment:** 298.86 WTE
  - **Actual establishment:** 280.00 WTE
  - **Variance:** 18.86 WTE

The challenges of bridging the resourcing gap, which we have almost achieved, was exacerbated by significant patient acuity over December, which is evidenced by the increase across Nursing OT and Excess and SSR usage.

OT & EXCESS	56.31 WTE (increasing from 49.19 WTE in Dec)
NURSING	40.27 WTE (increasing from 33.26 WTE in Dec)
SSR	9.21 WTE (rising from 8.77 WTE in December)

(c) EMPLOYEE RELATIONS - LIVE CASES

- There are 2 formal conduct cases ongoing.
- The formal Grievance is ongoing and has progressed to Stage 2.
- 2 bullying and harassment cases from the past six months have now concluded.

(d) LEAVERS

- There were 3 leavers in January 2026. 2 within the Nursing and AHP Directorate, 1 within the Security Directorate.
- This totals 40 leavers with a turnover of 6.09% financial year to date.
- Exit interview compliance within the current financial year is 47% with 19 out of 40 leavers completing this.

(e) JOB EVALUATION – JANUARY 2026

Progress & Status

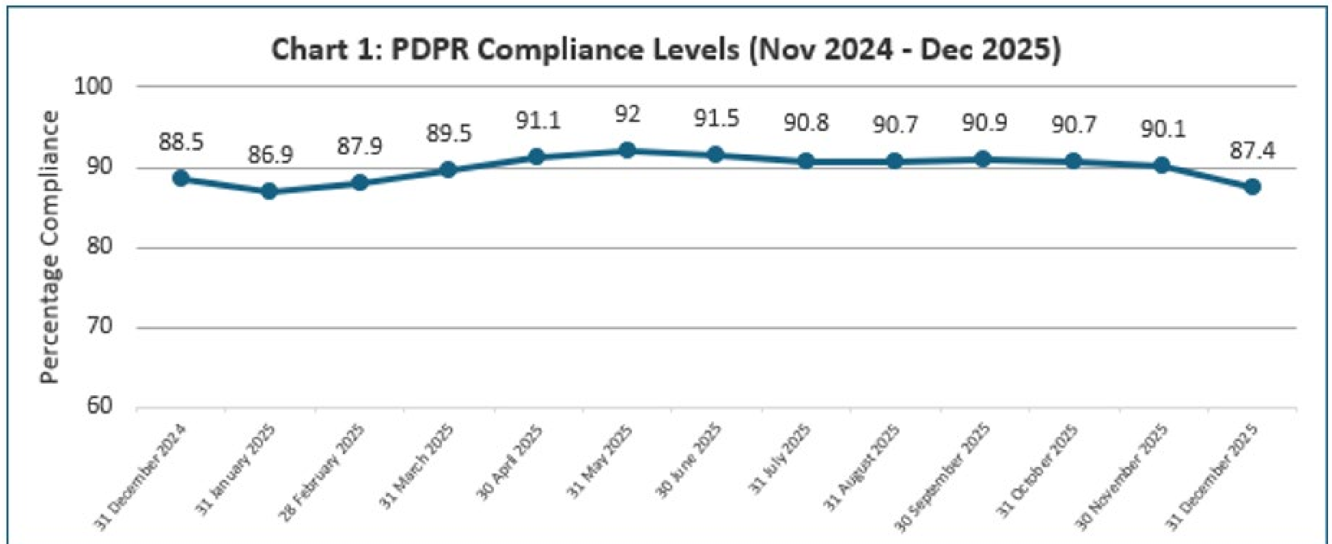
- One new job description received during January
- There was one panel held during January
- This post progressed to Quality Checking panel – outcome requires this post to return to a reconvened panel – date arranged early February

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

Departments	48 to 50 hours	51 to 55 hours	56 hours and above
Nursing Wards	21	13	10
Skye Centre	0	2	0

Board wide, there were 46 staff who breached the average 48 hour working week as defined by WTD as highlighted above. This number has slightly increased from the 40 staff last month. Monthly reports are issued to Heads of Service to highlight those who are breaching, along with whether a waiver has been completed.

(g) PDPR COMPLIANCE (Nov 24 to Dec 25)



PDPR Compliance saw a drop in December 2024 to 87.4% which is likely to be directly related to the resourcing challenges and subsequent delays in PDPR Completion. Early figures for Jan 26 have indicated that PDPR compliance has risen again above 90%.

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.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 15
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Report – Q3
Purpose of Report:	For Noting

1 SITUATION

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

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

2 BACKGROUND

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

3 ASSESSMENT

The Quarter 3 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 to date.

4 RECOMMENDATION

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

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

STAFF GOVERNANCE COMMITTEE **SGC(M)25/04**

Minutes of the meeting of the Staff Governance Committee held on Thursday 20 November 2025.

This meeting was conducted virtually, by way of MS Teams, and commenced at 9.30am.

Chair:

Non-Executive Director	Pam Radage

Present:

Employee Director	Allan Connor
Non-Executive Director	Cathy Fallon
Board Chair	Brian Moore
Non-Executive Director	Shalinay Raghavan [from Item 7]

In attendance:

Joint Head of Organisational Development and Learning	Graeme Anderson
POA Representative	Alan Blackwood
Associate Director of Nursing	Josie Clark
Personal Assistant	Vicky Gregg [Minutes]
RCN Representative	Richard Nelson
Head of Human Resources	Laura Nisbet
Head of Corporate Governance	Margaret Smith
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage opened the meeting and noted apologies from Mr Stuart Currie, Non-Executive Director, Mr Gary Jenkins, Chief Executive, Ms Monica Merson, Head of Corporate Planning, Performance and Quality and Mr Anthony Mcfarlane representing Unison.

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The Committee approved the minute of the previous meeting held on 21 August 2025.

Ms Fallon asked if there was an update on the workforce assessment tool in development by NHS Education for Scotland (NES). Mr Wallace advised that there was no update available at present, however a number of meetings were scheduled in the coming weeks, and he would hope to have an update available at the next Committee. Ms Radage requested that this matter remained on the agenda for continued monitoring.

Action: Mr Wallace

Ms Radage asked about the progress of implementation of SafeCare and Optima in Iona and Arran hubs. Ms Clark responded that SafeCare had been rolled out across all hubs and that work was in progress with e-Health to incorporate a site-wide staffing overview into SafeCare. She added that further information on this was detailed in the Health and Care (Staffing) (Scotland) Act Quarter 2 Update Report scheduled for discussion later in this meeting.

The Committee:

1. Approved the minute of the meeting held on 21 August 2025.
2. Agreed that development of the workforce assessment validation tool by NES would remain on the agenda for continued monitoring.

4 MATTERS ARISING AND ROLLING ACTIONS LIST

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

In relation to Action No. 4, Mr Wallace asked the Committee to note that he would be meeting with Mr Jenkins, Mr Connor and Ms Nisbet to review complex employee relations cases and identify any areas for improvement, and that an update would come to the Committee in February.

Action: Mr Wallace

The Committee:

1. Noted the updates from the Rolling Actions List.

5 STAFF GOVERNANCE MONITORING RETURN

The Committee received the Staff Governance Monitoring Return presented by Mr Wallace who explained that the Staff Governance Monitoring exercise was conducted annually to provide Scottish Government with assurance of the Board's compliance with Staff Governance Standards.

He highlighted the achievements and challenges over the last year as detailed within the report. Ms Radage thanked Mr Wallace for his presentation and noted that the Partnership Forum had met earlier this week to approve the return prior to its submission to the Committee for endorsement.

Mr Nelson expressed concerns that the report focused on progress and did not include recent concerns that had been raised through partnership discussions. In response, Mr Wallace explained that the report related to the period ending 31 March 2025 and that the current period would be noted in next year's return to Scottish Government. Ms Radage acknowledged Mr Nelson's concerns and emphasised the need to reflect these issues moving forward.

Ms Fallon suggested that the report should specifically reference the organisation's work on occupational health, given its active role in supporting staff and managing sickness absence challenges. She suggested extending the report to list three key successes. There was agreement around the table to the suggestions made by Ms Fallon, and this would be taken forward.

Action: Mr Wallace

Mr Moore requested sight of the documents referenced in the return such as the annual work plan and action plan, before he would be content to sign-off the return, and Mr Wallace agreed to share these documents with him.

Action: Mr Wallace

Ms Radage also noted the importance of organisational learning from all employment relation

cases, including those where the employee had left the State Hospital, ensuring that learning was captured and shared with the Committee.

The Committee:

1. Endorsed the Staff Governance Monitoring Return.

6 CORPORATE RISK REGISTER – STAFF GOVERNANCE RISKS

Committee members received the Corporate Risk Register – Staff Governance Risks presented by Mr Wallace who provided an overview of the five active risks within the register led by the Workforce Directorate as detailed within reporting.

On behalf of the RCN, Mr Nelson was concerned that the risks presented did not include the recent concerns raised which were pertinent as risks especially in terms of staff experience relating to resourcing challenges. Mr Connor noted that these concerns had been discussed very fully at the Partnership Forum, and it had been agreed that a Nursing Partnership Forum would be stood up which would serve as a platform for nursing staff to raise issues. Mr Connor highlighted ongoing efforts to improve communication and engagement with staff, including the dissemination of updates and the provision of feedback mechanisms.

Mr Wallace added that this new forum would follow up on the concerns, which had been raised recently and that he would meet with Mr Nelson directly in this regard as well. Ms Radage noted that the concerns raised particularly around resourcing were well understood and that in terms of the Corporate Risk Register, it was important to be clear about the identified risk to consider how this could be mitigated. Mr Moore echoed Ms Radage's comments and noted that Mr Jenkins had drafted a response to RCN representatives offering to meet with them. Mr Nelson stated that he could not fully endorse the register unless these specific risks were included, and this was noted.

Ms Fallon suggested that the register cross-reference the risk register for the Women's Service to determine if it contained any relevant information that could help address the concerns raised. She asked for clarification on risk HRD112 – Compliance with Mandatory Level 2 PMVA training as it was noted within reporting that the risk had remained at medium since the last Committee yet also indicated that it had been increased to medium. Further, she asked if risk HRD113 in relation to job evaluations would remain at medium or the recommendation was to reduce the risk to low.

Mr Wallace advised that recommendation was to reduce risk HRD113 to low. In relation to HRD112 Mr Wallace explained the risk had been increased to medium last year however the context for this had not been included in reporting, and he would update his report to reflect this.

Mr Moore asked Mr Wallace if plans for implementing the Reduced Working Week (RWW) were progressing as planned. Mr Wallace responded that a timeline had been established for staff engagement on the RWW, and a ballot was scheduled to present options for new shift patterns. He explained that feedback from the ballot would be reviewed, and he was confident that the RWW would be implemented by April 2026.

Ms Radage noted that the Committee was content to endorse the register subject to a caveat regarding staff-side concerns, and she would welcome an update to the February Committee on the concerns raised.

The Committee:

1. Endorsed the Corporate Risk Register – Staff Governance Risks subject to a caveat regarding staff-side concerns as detailed within discussions.

7 iMATTER ANNUAL REPORT

The Committee received the iMatter Annual Report presented by Mr Anderson who outlined the key areas for the benefit of members. He noted that limited national comparators were available as the national iMatter report had only been published last week, and a full iMatter report would come to the Committee in February.

Action: Mr Anderson

Mr Anderson highlighted that the survey response rate was 9% higher than the national average but had fallen by 6% compared with 2024. He attributed this to survey fatigue as a number of surveys had been circulated to staff as part of the organisational development (OD) workstream. He noted that a key success was the progress made with action plans. In 2024, 56% of teams had completed action plans. This year, that figure had increased to 75% which had been achieved through a targeted approach that focused on specific teams and supported them in developing their plans.

Ms Fallon thanked Mr Anderson for his helpful overview. She noted the disparity between staff perceptions of support from line managers versus the organisation as a whole, suggesting that further work was needed to bridge this gap. Further, she expressed concerns that current Board engagement activities such as the Non-Executive Director walkrounds were not sufficiently impactful to staff, and that staff perceived a lack of involvement in decision-making processes.

In response to Ms Fallon, Mr Anderson noted that the gap between perceptions of line manager and organisational support aligned with national trends, reflecting the strong impact of team environments on staff wellbeing. He acknowledged that the Non-Executive Director walkrounds were a relatively new initiative and agreed that broader engagement was needed to improve organisational visibility and involvement in decision-making.

Mr Moore suggested that a staff bulletin as an opportunity to include a narrative alongside the statistical data from the iMatter survey, encouraging reflection and engagement across all levels of the organisation. Mr Wallace concurred with Mr Moore and proposed linking the iMatter results to the ongoing OD work to make the communication more meaningful for staff.

Action: Mr Wallace/ Mr Anderson

Ms Radage thanked Mr Anderson for his report and for the useful discussions this had generated. She highlighted the low score received on the question relating to performance management within the organisation and noted that this was an area that required further exploration.

The Committee:

1. Noted the iMatter Annual Report.
2. Agreed that a full report on the iMatter survey would return to the Committee in February.
3. Consider new ways of communication/ engagement with staff e.g. staff bulletin

8.1 OD LEARNING & WELLBEING REPORT

Committee members received the OD Learning and Wellbeing report presented by Mr Anderson who outlined compliance levels for Personal Development Plan Reviews (PDPRs), statutory and mandatory training, and Healthcare Support Worker inductions. He noted that a significant number of nominations had been received for the Staff Excellence Awards, in particular there was a marked rise in the number of nominations made by patients this year.

Ms Fallon commended Mr Anderson on the progress made on the provision of OD, learning and wellbeing resources for staff. In relation to role-specific training she asked if lower compliance levels affected safe staffing at ward level. Ms Clark provided assurance on this point, in terms of

good compliance rates in role specific training needs. Mr Wallace highlighted the need to benchmark compliance figures against national standards to provide context and assurance within reporting, and to take into account statutory leave and/or absence. It was agreed that Mr Anderson would review to see how comparative data could be included in future reporting to the Committee.

Action: Mr Anderson

Ms Radage thanked Mr Anderson for his report and noted that there was high compliance with PDPRs, but this did not translate into staff experience of performance management within the organisation. Mr Anderson replied that 90% PDPR compliance was positive but may not reflect the quality of PDPR discussions or demonstrate their meaningfulness, and this was something that line managers should be supported with in their role.

The Committee:

1. Noted the OD Learning and Wellbeing Report.
2. Agreed for future reporting to return as noted within the discussion.

8.2 OD STRATEGY UPDATE

The Committee received the OD Strategy update presented by Mr Anderson who noted that the OD Strategy had been approved by the Board was now being operationalised. He provided a brief update on the Year 1 strategy commitments, which included the Culture Change Programme and the Leadership and Management Development Framework

The Culture Change Programme was in its first phase, using Affina OD diagnostics to assess Directorates. Mr Anderson advised that early engagement sessions had been completed. Mr Anderson outlined the Leadership and Management Development Framework, aimed at strengthening leadership skills and providing enhanced support for existing, new, and aspiring managers. He highlighted that a pilot programme of structured management courses was underway and positive feedback had been received from the pilot cohort.

Ms Fallon asked about consideration of staff who may be content in their current roles and did not wish to progress into a management role, as the Board wanted assurance that these individuals would not be overlooked. Mr Wallace responded to Ms Fallon, explaining that this would be addressed through the PDPR process by appraising staff performance and making them aware that they had the option to develop within their role.

Mr Moore welcomed the Leadership and Management Framework and asked how the delivery and impact of the framework would be measured in the longer term. Further, he asked about capacity of staff to be released from the wards to undertake training and management development opportunities. In response, Mr Anderson noted that managers and staff were receptive to training opportunities. Further, he observed that the organisational development initiatives undertaken over the past year have had a noticeable impact, with staff showing strong receptiveness to training opportunities.

Mr Radage thanked Mr Anderson for his update and said that it was positive to see that there was an appetite for training. She noted that the Committee was asked to endorse the Leadership and Management Development Framework and there was agreement by the Committee to do so.

The Committee:

1. Noted the OD Strategy Update
2. Endorsed the Leadership and Management Development Framework.

9.1 WORKFORCE REPORT

The Committee received the Workforce Report presented by Ms Nisbet who outlined the key metrics for the benefit of members. She reported that staffing deficits remained within the nursing service. Seven Registered Nurses had been appointed yesterday which would reduce the number of nursing vacancies to 4WTE. Ms Nisbet noted that Working Time Directive (WTD) breaches had increased marginally, and she attributed this due to ongoing vacancies. Staff turnover remained low and exit interviews continued to show positive feedback.

Mr Connor thanked Ms Nisbet for her report and commended the increase in the response rate to exit interviews. He noted that two bullying and harassment employee relations cases had been ongoing since May 2025, and Ms Nisbet advised that the timescale for both cases was being closely monitored. Ms Raghavan asked if the informal resolution process was effective in addressing bullying and harassment cases and if this approach reduced the need for formal investigations. Ms Nisbet replied stating that early engagement with staff had helped to resolve issues before they escalated to formal grievance procedures, and that all informal resolution cases were fully documented to monitor outcomes and ensure compliance with policy.

Mr Nelson raised concerns regarding staff leavers and the associated organisational risk. He highlighted issues with the timing of exit interviews, noting short notice to complete this for staff just prior to leaving. He suggested improving transparency and timeliness to increase participation. Ms Nisbet thanked Mr Nelson for his feedback and said she would explore this further, as the central leavers process should inform HR as soon as a leaver notification is received which would prompt an exit interview. Mr Blackwood commented that the exit interview section of the report should include the reasons for staff departures to provide insight into why individuals choose to leave. Ms Radage agreed with Mr Blackwood's point and suggested that qualitative data around exit interviews was included in future reporting to the Committee.

Action: Ms Nisbet

<u>The Committee:</u>

1. Noted the Workforce Report.
2. Requested future reporting to include qualitative data in relation to exit interviews as noted within the discussion.

9.2 MAXIMISING ATTENDANCE UPDATE

The Committee received the Maximising Attendance Update presented by Ms Nisbet who highlighted that long term sickness absence remained a challenge. Year-on-year figures had shown improvement, and efforts had focused on providing qualitative support to staff and managers, including reasonable adjustments and temporary duties. She advised that an audit of stress and also muscular skeletal absences had been planned to identify underlying causes and inform future interventions, and this was welcomed by the Committee. It was agreed that these should be reported to the Committee, once available.

Action: Ms Nisbet

Ms Fallon said that she appreciated the employee story included within the paper and commended the support provided by the RCN representative to the staff member involved.

Ms Raghavan thanked Ms Nisbet for the update and enquired if any support was available for staff on long term sickness absence once their sick pay entitlement ends, such as an extension of sick pay or access to a Welfare Rights Officer. In response, Ms Nisbet advised that employees could apply for an extension of their sick pay and there was also signposting to support available to staff.

Ms Radage thanked Ms Nisbet for her report highlighting the employee story as a good example of supporting a staff member to return to work. Further, the positive impact of the work progressed in terms of pathways for staff to support them back to work.

The Committee:

1. Noted the Maximising Attendance Update
2. Agreed that the outcomes and learning from audits underway should be reported to the Committee.

9.3 HEALTH AND CARE STAFFING AND eROSTERING UPDATE

The Committee received the Health and Care Staffing and eRostering Update and Ms Clark provided members with a summary of the progress towards compliance the Health and Care (Staffing) (Scotland) (2019) Act and implementation of the eRostering system. She noted that SafeCare had been rolled out to all wards and the focus was on improving the Optima e-rostering system and its interface with SafeCare. It was anticipated that SafeCare and Optima would be fully embedded by April 2026.

Ms Raghavan asked about the effectiveness of the e-rostering system, and the experience of staff using it. Ms Clark replied that this was an area of progress and that improvement was expected once staff became more familiar with the system and the multiple recording layers had been removed. Mr Moore noted that the Optima system had the facility to provide reports and key metrics, and he asked Ms Clark if this facility was useful, and Ms Clark agreed on this. Mr Wallace added that further benefits were expected once the move over to the new system had been completed.

Ms Radage thanked Ms Clark for the update and remarked that it was positive to see the progress made with implementation of the systems.

The Committee:

1. Endorsed the Health and Care Staffing and e-Rostering Update, which should be submitted as a quarterly return.

10.1 WORKING ENVIRONMENT REPORT

Members received the Working Environment Report presented by Mr Wallace who explained that this was the first iteration of the report that was requested at the last Committee. He noted that the purpose of the report was to monitor, review, and improve performance in line with the Staff Governance Standards, ensuring that staff had a safe and continuously improving working environment, both physically and psychologically.

Mr Wallace highlighted that the report consolidated data from multiple sources, including DATIX, RIDDOR notifications, sickness absence records, employee relations cases, and staff access to wellbeing resources. He outlined the initiatives introduced to enhance the psychological environment for staff, such as quarterly drop-in sessions with the Whistleblowing Champion and a seminar series focused on the importance of psychological safety in the workplace

Mr Connor thanked Mr Wallace for the report and commented that it was a helpful first iteration. Ms Fallon echoed Mr Connor's comments and suggested that the report should include not only incidents of physical harm, but also patient self-harm, which could have a profound psychological impact on staff. She also noted the level of incidents related to staff resourcing. This led to a broader discussion on the need to recognise and address wider impacts of staff of working in a high secure environment, and the importance of providing appropriate support.

Ms Radage welcomed the report and requested that it be presented to the Committee on a quarterly basis, and Mr Wallace would refine the report as outlined in discussions.

Action: Secretariat/ Mr Wallace

The Committee:

1. Noted the Working Environment Report
2. Requested quarterly reporting on the Working Environment – add to workplan

10.2 ONCE FOR SCOTLAND POLICIES UPDATE

The Committee received an update on implementation of the Once for Scotland suite of policies from Ms Nisbet who advised that Phase 3 of the implementation plan had commenced, with a soft launch on 3 November 2025, and full implementation anticipated in early 2026. She outlined the approach that was being taken for the soft launch, noting that the HR team had developed manager-friendly briefing materials and was delivering targeted presentations within existing management forums.

Ms Raghavan queried if the Central Legal Office (CLO) within Scottish Government played any role in reviewing policies, highlighting the extensive range of policies and the considerable time required for managers, who are not HR specialists, to undertake such reviews. In response, Ms Nisbet said that all policies were reviewed by the CLO before being rolled out, and ongoing support from HR was available to managers during and after the rollout process.

Mr Moore asked if there was a Once for Scotland Policy regarding home working. Mr Wallace replied that this would be covered in the Flexible Work Location Policy.

The Committee:

1. Noted the Once for Scotland Policies Update.

10.3 a) WORKFORCE EQUALITIES GROUP UPDATE
b) APPENDIX A

The Committee received the Workforce Equalities Group Update and Appendix A presented by Mr Wallace who provided an update on the work of Workforce Equalities Group and their progress towards completion of an Equalities Action Plan. He outlined the actions planned to address the key themes and priorities identified by the group. He noted that the group would meet next week to agree an action plan that would include anti racism priorities, and that the action plan would come to Committee in February.

Action: Mr Wallace/ Secretariat

Ms Radage thanked Mr Wallace for his helpful update.

The Committee:

1. Noted the Workforce Equalities Group Update and Appendix A.
2. Agreed the Action Plan would be reported at the next meeting

11.1 PARTNERSHIP FORUM APPROVED MINUTES

The Committee received the approved Partnership Forum minutes from 26 August 2025, 24 September 2025 and draft meeting minutes from 7 October 2025. These were welcomed as they

provided context on the issues under discussion and linked to papers on the agenda.

The Committee:

1. Noted the Partnership Forum Minutes.

11.2 WORKFORCE GOVERNANCE GORUP DRAFT MINUTES

The Committee received and noted the draft Workforce Governance Group Meeting minutes from 16 September 2025.

The Committee:

1. Noted the Workforce Governance Group Minutes

12.1 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

Mr Moore commended Mr Anderson's work on organisational development, highlighting the leadership and management development approach and cultural initiatives as examples of good practice. Ms Fallon welcomed the audits on stress-related and musculoskeletal illnesses. She added that the HR department working in partnership with managers to support implementation of the Once for Scotland polices was an area of good practice. Ms Radage noted that the staff member's story about being supported to return to work demonstrated a strong commitment to helping staff reintegrate into the workplace.

Ms Fallon highlighted the rise in incidents reported relating to staff resourcing as an area that should continue to be monitored closely.

12.2 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Ms Fallon noted that assaultive incidents against staff and the potential impact on staff exposed to traumatic events would continue to be monitored by the Clinical Governance Committee.

Ms Radage noted that updates on the e-rostering system would be shared with the Audit and Risk Committee.

Action: Secretariat

13 ANY OTHER BUSINESS

The Committee received the Nursing Staff Update presented by Mr Wallace who highlighted concerns raised by the RCN and Prison Officers Association (POA) in relation to nursing staff. He provided a summary of the key themes emerging from these concerns and outlined the approach taken to working in partnership with staff-side organisations to address these concerns and support the staffing cohort.

Mr Wallace informed members that he had met with the POA representatives and agreed on several actions to address their concerns, and a meeting was scheduled to meet with the RCN Regional Officer and local representatives to ensure their concerns were fully understood. Mr Connor offered his assurance that these matters were being addressed.

Ms Radage asked Mr Wallace how the Committee could take assurance that the concerns were being addressed going forward. Mr Wallace suggested incorporating updates into the Working Environment Report, and that this would follow on from discussion at the Nursing Partnership

Forum, and the organisational Partnership Forum in the intervening period. The Committee was content to agree to this approach.

Action: Mr Wallace

14 DATE OF NEXT MEETING

The next meeting would be held on Thursday, 12 February 2026 at 9.30am.

The meeting concluded at 12.20pm

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 26 February 2026

Agenda Reference No: Item No: 16

Author(s): Head of Corporate Governance

Title of Report: Summary Report – Staff Governance Committee

Purpose of Report: For Noting

This report provides an update on the key points arising from the Staff Governance Committee meeting that took place on 12 February 2026.

1	Corporate Risk Register Quarterly Update	Reporting detailed corporate risks assigned to the Workforce Directorate, with five active risks, and agreed that this was an accurate statement of risk. Risk ND70 was also referenced in respect of operational care delivery for wider context reflecting staffing pressures with mitigation through planned over recruitment within nursing. The Committee also noted the good progress made on the Protecting Vulnerable Groups workstream enabling the risk rating to be lowered.
2	iMatter Annual Report – National context	The Committee received reporting which summarised the iMatter results for the State Hospital and placed these within the context of the national report in this regard. Reporting outlined the six priority areas for the coming year. The Committee discussed in particular what the findings demonstrated at team, departmental and organisational levels; as well as strengthening staff engagement routes and how to lead cultural change.
3	OD Learning & Wellbeing Report	Reporting provided data demonstrating compliance in PDPR completion. Members discussed how to embed support for staff through rounded and ongoing discussions, and not just at one point. The Committee also reviewed compliance levels for statutory and mandatory training, taking assurance from reporting.
4	Healthcare and Staffing and eRostering /Audit Update	The Committee received a draft annual report for HCSA, and discussed the progress of this. Reporting also covered progress in e-rostering delivery, as well as work progressed to audit current practice in the management of rosters. Further work will progress on this and return to the Committee.
5	Workforce Report /Maximising Attendance	Reporting covered a wide range of workforce metrics, as well as providing detailed background on the maximising attendance approach aimed at improving sickness absence levels. The had been a drop in the rate of this for January following a seasonal peak. The Committee noted good practice in the delivery of support for staff, and requested further reporting for the next meeting taking a deeper dive into areas experiencing challenge.

6	Internal Audit Report – Absence Disciplinary and Suspension Management	The Committee received an internal audit report shared by the Audit and Risk Committee. Members found this helpful and noted that it provided reasonable assurance around practice, and there were no key areas of concern.
7	Employee Relations Cases - Learning	Reporting was focused on how to take learning from recent investigations, especially around the benefit of effective management of the timescale for cases to be progressed and concluded. The need for further improvement was highlighted.
8	Occupational Health Update	The Committee received a six month update, noting positive assurance in this respect in terms of the delivery of the service.
9	Working Environment Report	Reporting focused on the provision of an improving and safe working environment, promoting the health and wellbeing of staff, patients, and wider community. The Committee considered how to balance this with reporting around clinical incidents routed through the Clinical Governance Committee- and this would be reviewed.
10	Workforce Equalities Group Update	An update was provided on this workstream, and assurance provided that an action plan was under development and would be provided for review to the next Committee meeting.
11	Nurse Practice Development (NPD) Update	The Committee received an update on progress against the priorities for NPD including evaluation of training needs and supporting staff education, and building engagement in and uptake of clinical supervision. Reporting was received positively with commendation of the approach taken and work to date.
12	Workforce Plan: Action Plan	Reporting provided an update on the progress against action for the current year, as well as outlining the proposed actions for 2026/27 which align with the Annual Delivery Plan.
13	Minutes/	The Committee received the minutes of meetings held in the past quarter from the Partnership Forum and the Workforce Governance Group, and commented positively on the openness and transparency evidenced.
14	Areas of good practice / concern	Members reflected on the way in which papers supported good discussions, and oversight and also demonstrated active partnership working.

RECOMMENDATION

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 25 February 2026

Agenda Reference No: Item No: 17

Sponsoring Director: Chief Executive Officer

Author(s): Head of Corporate Governance

Title of Report: Draft Corporate Objectives 2026/27

Purpose of Report: For Decision

1 SITUATION

The State Hospitals Board for Scotland undertakes a review of its Corporate Objectives on an annual basis, aiming to provide a high-level statement of strategic goals for the following year. This brings together the priorities for the Board across each strand of governance around the key themes of Better Care, Better Health, Better Values and Better Workplace. This report sets out the draft Corporate Objectives for the period 1 April 2026 until 31 March 2027

2 BACKGROUND

Corporate Objectives should align with the operational business model for the State Hospital through the Annual Delivery Plan for 2026/27, identifying key deliverables within the wider context of the Medium-Term Plan for 2025/28.

Therefore, the Corporate Objectives focus on the delivery of safe and secure patient care, within a sustainable financial plan; as well as reflecting the organisational aim to build a sustainable workforce who feel supported within the workplace environment.

This provides a high-level overview of the key strategic parameters through which the Board will conduct its business, seeking assurance on performance and delivery and identifying any risks arising. The Board's Performance Management Framework and Corporate Risk Register are thus closely aligned to this.

3 ASSESSMENT

The draft Corporate Objectives are attached (**Appendix A)** and group the key aims around the following themes:

- Improve the quality of care for patients by targeting investment and focus on improving services within a high security environment and for providing the most effective support for all. **(Better Care)**

- Improve health and wellbeing by promoting and supporting healthier lives and choices, addressing inequality, and adopting an approach based on recovery, care, and treatment. **(Better Health)**

- Increase the value from, and financial sustainability of, care by making the most effective use of available resources through efficient and effective service delivery **(Best Value)**

- Improve the engagement of staff and opportunity for development through effective values based leadership resulting in a culture of quality and accountability **(Better Workplace)**

The changes made from the 2025/26 objectives have been highlighted in a document circulated to Board members for ease of reference.

The Board is asked in particular to note the refreshment of the objectives relating to the balance of care across all services, and the continued development of the women's service.

Further, the fluid position on subnational and national planning priorities, and the potential for impact on the State Hospital during this period.

The key changes are as follows:

- Alignment with key strategies and the ADP for 2026/27
- Restructure of management and leadership teams
- Elimination and daytime confinement and related Incident Control process
- Balance of safe care for male services and interim women's service
- Women's service outreach service and medium term to longer term plan.
- Recognition of need for collaboration through subnational and national frameworks through context of NHS and wider public sector reform.
- Patient physical health strategy and change metrics and approach to patient obesity
- Engagement with full review expected for NIS once new process and framework is set out.
- The aim to complete the Security Project and move to business-as-usual processes on core security.
- Organisational governance and management reporting refresh
- Embedding Directorate Performance Meeting further in management reporting
- Updated position on key strategic plans (the OD Strategy and the Workforce Plan) which have moved from the development stage to implementation.
- Refresh of recruitment and retention strategy
- Developing an Equalities Action Plan
- Continuous improvement in working environment, including health, safety, and welfare.
- Maximising Attendance approach to managing sickness absence.
- Implementing a refreshed approach to implementing the whistleblowing standards

Performance Framework

The Corporate Objectives form the basis for setting the individual objectives for each of the Directors, with detailed oversight of performance then taken by the Remuneration Committee within the structure of the NHSScotland National Performance Monitoring Committee. The Remuneration Committee takes active consideration of the way in which it seeks assurance and related evidence for its consideration of individual performance.

The Corporate Objectives are aligned to planning and performance frameworks. This process is underpinned by structured Directorate Performance Meetings, led by the Chief Executive, which are strongly embedded within management reporting systems. This will be strengthened further in the coming year and linked formally through governance structures. The objectives are mapped across to the Annual Delivery Plan (ADP) and Medium Term Plan (MTP) and related key deliverables. These structures underpin assurance reporting to the Board and standing committees. In the past year, papers submitted must demonstrate any appropriate link to these objectives.

The Minister for Social Care and Mental Wellbeing undertook the Annual Review for 2024/25 on 24 November 2025 and wrote formally with the outcome. This was generally very supportive, with no substantial concerns raised. Further engagement will continue through the Sponsor Team in the coming year, through quarterly sponsor meetings held between Executive Leadership and the Scottish Government colleagues.

Corporate Risk Register

Work should continue to link clearly between the Corporate Objectives and the Corporate Risk Register, to enable horizon scanning of risk movement and/or newly emergent risks and support continued consideration of risk appetite for the Board.

The Corporate Management Team (CMT) has reviewed the objectives and recommended that these should be submitted to the Board for its consideration

4 RECOMMENDATION

The Board is invited to review the draft Corporate Objectives and consider if these represent an accurate statement of its aims and objectives for 2026/27, and to recommend any amendments or additions to the existing document prior to final approval.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	To present the draft corporate objectives for discussion and decision for the coming financial year.
Corporate Objectives Please note which objective is linked to this paper.	This paper sets out a review of the Corporate Objectives for the coming year taking into account local, regional, and national developments and factors likely to have an impact within this period.
Workforce Implications	The Corporate Objectives detail the State Hospital's key strategic aims for a better workplace; providing a framework through which impacts on the workforce can be considered through any strategic planning for the year.
Financial Implications	To underpin the key aim of better value for the organisation, stating the intent that this will underpin strategic planning and financial management.
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Requested as part of the Board's workplan and requiring executive endorsement.
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk assessment made, this supports the organisational delivery of key objectives.
Assessment of Impact on Stakeholder Experience	Key stakeholders and the need to align the corporate objectives to these is outlined in the paper.
Equality Impact Assessment	Not required as part of reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This is not relevant
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA is 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

Appendix A

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

CORPORATE OBJECTIVES 2026/27

1. Better Care

a. Implement the Annual Delivery Plan 2026/27 and the Medium-Term Plan, aligning the organisational aims and direction to the health priorities set out in Scottish Government Policy, aligning to NHS Reform across NHSScotland.

b. Continue to tailor the Clinical Model to better reflect the graduated clinical and security steps for patient progression on their care and treatment pathway.

c. Implement refreshed operational structure for management of care delivery through the Senior Leadership Teams.

d. Eliminate the use of Day Time Confinement to all but very exceptional circumstances, managed through a prescribed Incident Control process.

e. Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk, across male services and the interim female service.

f. Ensure the principles of rehabilitative care are applied optimising opportunities for meaningful patient activities, educational development, and occupational development across all service areas.

g. Develop and implement an outreach service model for women from high security to medium security providers and the Scottish Prison Service, through a test of change pilot, stakeholder engagement, and evaluation process. 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. Develop a Strategic Assessment for capital development for a Medium-Longer Term Service Model, for submission to Scottish Government. 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.

i. Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events.

j. Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system.

k. Deliver a programme of Infection Control related activity in line with all national policy objectives.

l. Monitor the use and recording of restrictive practices (including seclusion practice and use of soft restraint kits) in accordance with Mental Health legislation and the definitions published by the Mental Welfare Commission.

m. Be accessible to patients, their family and visitors ensuring their views and experiences are reflected in service improvements, implementing the Carer Strategy 2025/28 and encompassing the best-practice framework of Triangle of Care.

n. Embed the principles of Realistic Medicine, through the Realistic Medicine Action Plan.

o. Work with stakeholders and Scottish Government representatives to enhance the reputation and healthcare ‘profile’ of the State Hospital.

p. Collaborate with the Forensic Network in the delivery of quality care guidance and standards applicable to the Forensic Mental Health Environment.

q. Take forward national collaboration and interface work with the Healthcare in Custody Network.

r. Support collaborative working for the delivery of forensic mental health services within the context of wider mental health services at regional and national levels, as part of the Health and Social Care Renewal Framework, and Population Health Framework, subnational planning structures, and Public Services Delivery Scotland (PSD).

s. Advance evidence-based practice through structured research and quality improvement initiatives across the organisation.

2. Better Health

a. Tackle and address the challenge of obesity, through delivery of the refreshed Supporting Healthy Choices programme, and performance metrics.

b. Continued improvement of the physical health opportunities for patients, implementing a Physical Health Strategy for the State Hospital.

c. Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient.

d. Address the overall social wellbeing issues for patients undergoing treatment.

e. Utilise connections with other health care systems to ensure patients receive a full range of healthcare support.

f. Ensure that patients have a seamless transition from the State Hospital to other care providers as part of their care pathway when clinically appropriate. This will align with the aims and ambitions of medium secure provision and other treatment pathways.

g. Ensure the organisation is aligned to the values and objectives of the wider mental health strategy and framework for NHSScotland.

3. Better Value

a. Meet the key finance targets set for the organisation and in line with Standard Financial Instructions.

b. Develop a sustainable finance model within the available finance allocation that supports the sustainability and growth of the organisation.

c. Deliver all Scottish Government financial budget and resource reporting and monitoring requirements for NHSScotland national matters, through Board Chief Executive, Director of Finance and Human Resource Director groups.

d. Work collaboratively across public sector bodies to ensure that best value is achieved in service planning, design, and delivery, including through National Board collaboration and the Anchors Strategy

e. Deliver programme of sustainable working and progress to net zero recognising the impacts of climate change and financial constraints.

f. Enhance and strengthen digital innovation for the organisation, and the digital inclusion programme for both staff and patients.

g. Ensure delivery of a cohesive approach to information governance and records management standards.

h. Deliver the actions identified by the NIS audit process and engage with the full review expected to be in 2026 or thereafter, to maintain cyber security and resilience.

i. Following completion of the Perimeter Security and Enhanced Internal Security Systems Project, implement and manage core security quality indicators to deliver a safe and secure environment.

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. Fully implement structured change to management groups within the State Hospital to support streamlined decision-making and leadership structures.

k. Support quality improvement approaches, embedding a cohesive approach.

l. Ensure the continued delivery and development of the organisation’s performance management framework, enhancing this through further strengthening of Directorate Performance Meetings within the management reporting structure.

4. Better Workforce

a. Delivery of the three-year Workforce Plan 2025-28 within the context of the planning framework and guidance from Scottish Government.

b. Continue to support and build partnership working so that this is embedded across the organisation.

c. Deliver and monitor staff resourcing aligning to the Health and Care (Staffing) (Scotland) Bill (2019) across the State Hospital, and in conjunction with the local delivery of the national e-rostering programme, through the Workforce Governance Group.

d. Maximise workforce sustainability through review of the State Hospital’s Recruitment and

Retention Strategy, delivering modern, inclusive recruitment practice and continued development of a supplementary workforce.

e. Implement the Organisational Development Strategy, and action plan, using an Organisational Health approach, focusing on creating healthy team cultures, improving communication loops, and strengthening leadership behaviours through a culture change programme.

f. Building on iMatter and staff governance principles to deliver an inclusive staff engagement programme in partnership to support the wellbeing of all employees.

g. Develop and Implement an Equalities Action Plan through the Workforce Equalities Group to mainstream equality in line with Scottish Government guidance for public bodies – as a means of ensuring equality is woven into all aspects of the organisation and by the development of specific equality outcomes.

h. Sustain a safe working environment for staff with a focus on risk management and health, safety, and wellbeing across all aspects of the organisation, to provide a continuously improving and safe working environment.

i. Implement the 'Once for Scotland' suite of Human Resources policy, aligning with the national rollout.

j. Ensure accessibility and support internal and external services for staff who require them, including a cohesive Occupational Health Service.

k. Continue to drive forward the Maximising Attendance approach to absence related issues and prioritise support mechanisms and staff wellbeing to provide staff and line managers with the support required. Where absence is required, support staff to return to work at the earliest opportunity. Support and strengthen management and leadership to develop positive culture.

l. Continue to support training and development for all staff at every level across the organisation.

m. Support the Independent National Whistleblowing Standards and support this workstream locally including promoting awareness for staff. Implement refreshed local approach to delivery of standards, and collaborative working where possible.

n. Maintain an appropriate Health and Safety governance framework that demonstrates continual improvements and a commitment to fulfil our compliance obligations.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 18
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning, Performance and Quality Corporate Planning, Performance and Quality Project Support Manager
Title of Report:	Quarterly Update Report Q3 Key Performance Indicator & Annual Delivery Plan Update
Purpose of Report:	For Noting

1 SITUATION

This report provides an overview of organisational performance for Quarter 3 (October–December 2025), summarising progress against Key Performance Indicators (KPIs) and the 2025/26 Annual Delivery Plan (ADP) commitments. It highlights performance against the two national standards relevant to the State Hospital these include Psychological Therapies Waiting Times and Sickness Absence alongside additional local KPIs monitored by the Board. Performance and delivery remain subject to oversight by Scottish Government through the 2025–26 Annual Delivery Plan, approved in June 2025.

2 BACKGROUND

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

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

3 ASSESSMENT

The following sections contain:

- Quarter 3 KPI data and highlight areas for improvement through an analysis of KPIs that have missed their targets.
- Quarter 3 ADP performance highlights.

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Monitoring of the State Hospital Key Performance Indicators links to both the State Hospital corporate objectives and the Annual Delivery Plan 2025-2026. The KPIs provide assurance to the State Hospital Board on key areas of performance. Some of the KPIs are national targets which the State Hospital is held accountable for performance nationally, others are local priorities for the State Hospital Board. The Annual Delivery Plan sets out in the State Hospital Board delivery commitments, these are monitored and reported to provide an overview of performance against plan. The State Hospital Performance Framework proves an overview of how performance is managed across the State Hospital. Scottish Government will receive this report following approval from the State Hospital Board as an indicator of the State Hospital performance.
Corporate Objectives **Please note which objective is linked to this paper**	**Better care:** a - Implement the Annual Delivery Plan and the Medium-Term Plan, aligning the organisational aims and direction to the health priorities set out in Scottish Government Policy, aligning to NHS Reform across NHS Scotland. e – Ensure the principles of the rehabilitative care are applied optimising opportunities for meaningful patient activities, educational development and occupational development across all service areas. **Better Health:** a - Tackle and address the challenge of obesity, through delivery of the Supporting Healthy Choices programme. b - Continued improvement of the physical health opportunities for patients. c, - Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient. e- Utilise connections with other health care systems to ensure patients receive a full range of healthcare support. **Better Value:** k - Support quality improvement approaches, embedding a cohesive approach. i - Ensure the continued delivery and development of the organisation's performance management framework. **Better Workforce:** M -Continue to support training and development for all staff at every level across the organisation.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.

Route to Board **Which groups were involved in contributing to the paper and recommendations.**	Via Strategic Planning and Performance Group
Risk Assessment **(Outline any significant risks and associated mitigation)**	If KPI's are off target the improvement plan to address this is detailed in the paper.
Assessment of Impact on Stakeholder Experience	Not formally assessed.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty **(The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).**	
Data Protection Impact Assessment (DPIA) See IG 16. **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 Hospital Board Corporate Performance

Quarterly Update Report
Q3 KPI Performance & Annual Delivery Plan Update

CONTENTS

1 OVERVIEW ... 6
2 CORPORATE KEY PERFORMANCE INDICATORS QUARTER THREE UPDATE ... 7
3 ANNUAL DELIVERY PLAN 2025/26 PERFORMANCE HIGHLIGHTS QUARTER ONE & TWO, QUARTER THREE ... 13

1 OVERVIEW

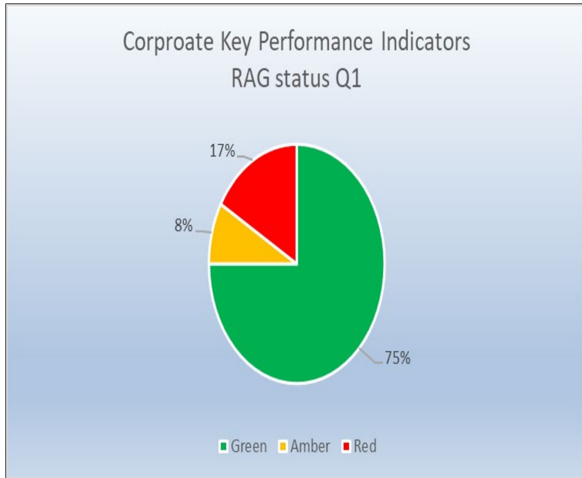
Overview	**Corporate Key Performance Indicators -** this report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPIs) for quarter three (October 2025 to December 2025). There is a total of twelve corporate KPIs. Analysis of the data using Red, Amber and Green RAG scale reveals that 67% (eight) have reached and / or exceeded their target this quarter and assessed as green, with 23% (four) KPI's off target, one in RAG status amber and three in RAG status red. The information provided within the reported by exception. The Planning, Performance, and Quality Team reviews all corporate KPIs data monthly, with areas to note highlighted in this report. All KPIs operational definitions are reviewed annually with data owners, all reviews were completed in July 2025. **Annual Delivery Plan 2025/26 -** meetings have taken place between the Corporate Planning and Performance Team and Directors to provide updates for quarter three. From the 83 Board actions identified in the Annual Delivery Plan 2025/26, fourteen actions have been completed. From the 63 recommendations are being actioned through quarter three, 92% (58) of these actions have been rated as RAG scale green and are completed or on track to be completed, 8% (5) have been rated as amber and no actions have been identified as red within the identified timescales. The remaining six actions identified timescales of quarter four 2025/26; therefore, no updates were requested at the time of meetings. One action moved from amber to green in this quarter. All updates on the Annual Delivery Plan 2025/26 are reported to the Strategic Planning and Performance Group and externally to Scottish Government Mental Health Directorate through the quarterly sponsorship meetings. Clinical delivery is monitored locally in Services with each of the Service Leadership Team having a range of indicators which are reviewed monthly by the Clinical Quality Team. Escalation of issues if required, is through the Board committee structure.

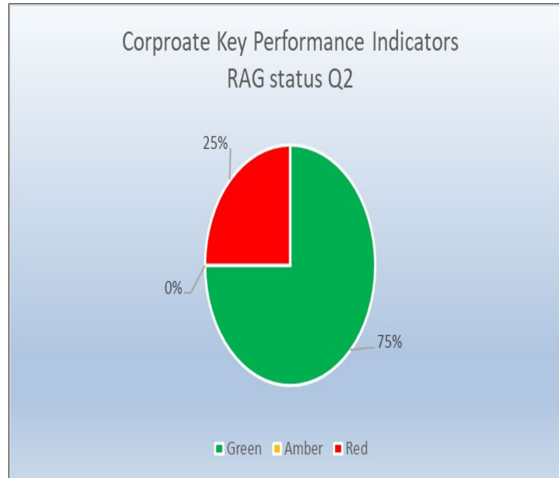
2 CORPORATE KEY PERFORMANCE INDICATORS QUARTER THREE UPDATE

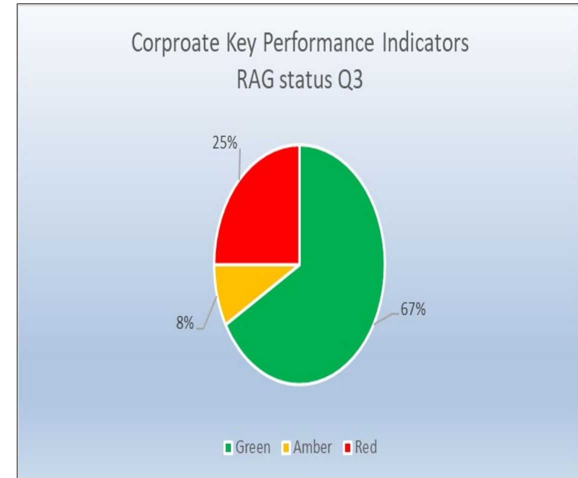
	Performance Indicator	Target	RAG Q4 24/25	RAG Q1 25/26	RAG Q2 25/26	RAG Q3 25/26	Actual Q3 25/26
1	Patients have their care and treatment plans reviewed at six monthly intervals.	100%	G	A	R	A	93.03%
2	Patients will be engaged in psychological treatment.	85%	G	G	G	G	84%
3	Patients will be engaged in off-hub activity centres. *(This includes drop-in sessions which take place in hubs, grounds, and Skye Centre*	90%	G	G	G	G	93.67%
4	Patients will undertake an annual physical health overview by the Practice Nurse.	100%	G	G	G	G	100%
5	Patients will undertake 150 minutes of moderate exercise each week.	70%	R	G	G	R	54.33%
6	Patients will have a healthier BMI.	25%	R	R	R	R	13.67%
7	Sickness absence rate.	5%	R	R	R	R	8.03%
8	Staff have an approved Personal Development & Planning Review.	80%	G	G	G	G	89.40%
9	Patients transferred / discharged using CPA.	100%	G	G	G	G	100%
10	Patients requiring primary care services will have access within 48 hours.	100%	G	G	G	G	100%
11	Patients will commence psychological therapies <18 weeks from referral date.	100%	G	G	G	G	100%
12	Patients have their clinical risk assessment reviewed annually.	100%	G	G	G	G	97.07%

Definitions for Red, Amber, and Green zones:

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

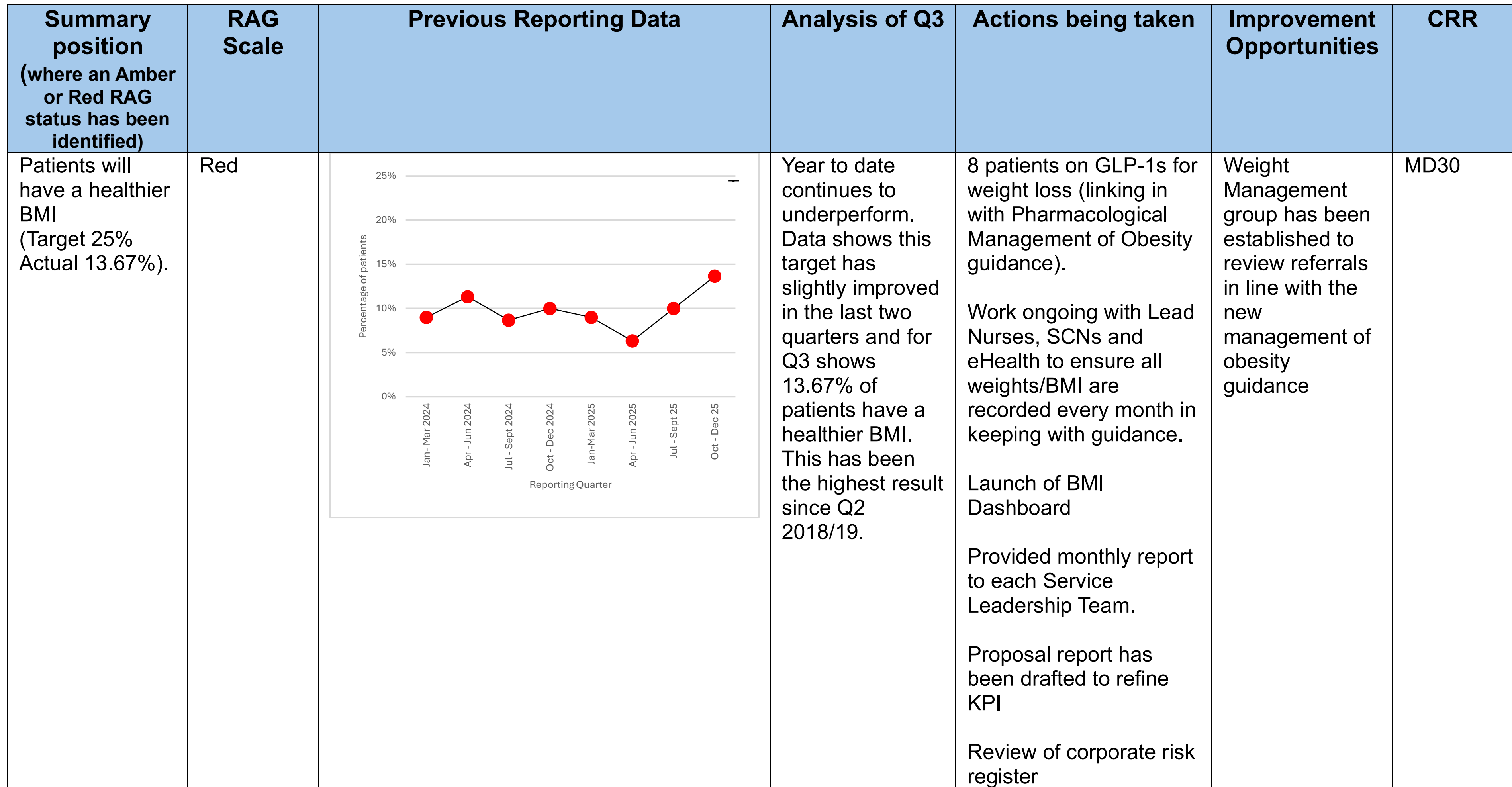






Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q3	Actions being taken	Improvement Opportunities	CRR
Patients have their care and treatment plans reviewed at six month intervals (Target 100% Actual 93.03%).	Amber (Improvement on Q2 red to Q3 amber)		Performance has improved this quarter, moving from Red to Amber. Work continues between Health Records and Clinical Administration teams to address outstanding issues related to the uploading and timely completion of documentation,	Responsibility for this KPI will transfer from Health Records to Clinical Administration in 2026, supporting more accurate monitoring and action as the new CPA reports begin to developed Until the handover Health Records will continue to retrospective analysis the data quality and verification processes and work with services to ensure all	Improvement activity includes reviewing the relevance and accuracy of the data being collected. Clinical Admin has updated the process map to reflect causes of delay.	No risk registered identified.

Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q3	Actions being taken	Improvement Opportunities	CRR
			overseen by the Corporate Planning, Performance and Quality Department.	risk assessments are appropriately signed off.		
Patients undertaken 150 minutes exercise each week (Target 70% Actual 54.33%)	Red (move from Q2 -green to Q3 - red)		During the review period there have continued to be various contributing factors and initiatives taking place which may have impacted patient uptake in physical activity such as the ongoing reduction of winter grounds access hours. All Service Leadership Teams implemented winter activity timetables to counteract any impact on physical activity	Continue to monitor the impact of the winter timetables Continue to utilise the activity coordinators to support activity	Proposal for a nighttime grounds access pilot	No risk identified

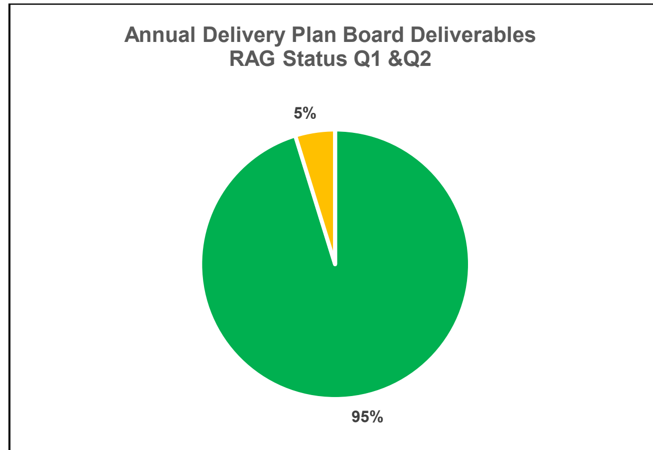


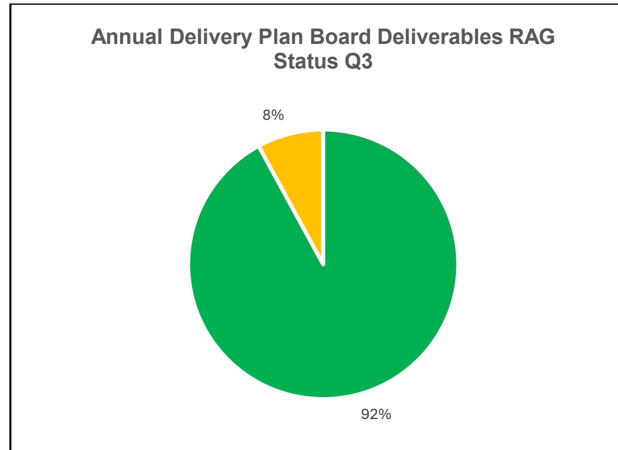
Summary position (where an Amber or Red RAG status has been identified)	**RAG Scale**	**Previous Reporting Data**	**Analysis of Q3**	**Actions being taken**	**Improvement Opportunities**	**CRR**
Patients will have a healthier BMI (Target 25% Actual 13.67%).	Red		Year to date continues to underperform. Data shows this target has slightly improved in the last two quarters and for Q3 shows 13.67% of patients have a healthier BMI. This has been the highest result since Q2 2018/19.	8 patients on GLP-1s for weight loss (linking in with Pharmacological Management of Obesity guidance). Work ongoing with Lead Nurses, SCNs and eHealth to ensure all weights/BMI are recorded every month in keeping with guidance. Launch of BMI Dashboard Provided monthly report to each Service Leadership Team. Proposal report has been drafted to refine KPI Review of corporate risk register	Weight Management group has been established to review referrals in line with the new management of obesity guidance	MD30

Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q3	Actions being taken	Improvement Opportunities	CRR
Sickness Absence rate (Target 5% Actual 8.03%)	Red		Year to date continues to underperform Anticipated spike in absence, particularly short term over winter, with close monitoring required over coming months to see levels reduce	Regular RAG Reviews for escalated areas. Continued partnership working with focus on providing a safe working environment. Recognition of departments with good attendance Encouragement and monitoring of consistent pathways usage & associated review of nursing reporting arrangements. Improved communication and awareness of impact of absence. Manager development. Accountability and performance management for areas which require additional support. Alternative duties and reasonable adjustments common practice to avoid absence.	OD strategy including culture assessment, bespoke wellbeing plans, line manager development and compassionate leadership will all have positive improvement on the working environment and staff experience which in turn should improve sickness absence rates. Local audit being undertaken in relation to absences which arise from stress & muscular skeletal reasons. To identify areas for improvement.	HRD116

Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q3	Actions being taken	Improvement Opportunities	CRR
				Dedicated case management support from HR and Occupational Health for a range of individuals examples provided below. Alignment across workforce directorate with support from wellbeing and OD colleagues where appropriate for individuals or teams. Frequent use of case reviews to meet with staff in a supported environment attended by HR, Occ Health and staff side to discuss and agree solutions. Absence information appraised in Chief Executive Performance Reviews. Audit undertaken of stress & muscular skeletal absences to consider areas for improvement.		

3 ANNUAL DELIVERY PLAN 2025/26 PERFORMANCE HIGHLIGHTS QUARTER ONE & TWO, QUARTER THREE





Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
Mental Health	**Deliverables: 3 of 3 actions being delivered** We are currently awaiting feedback from the Forensic Advisory Group regarding outcomes and recommendations. The State Hospital continues to actively support sub-national planning by participating in both East and West regional meetings as per DL 25 (2025), ensuring alignment with local service developments. Additionally, ongoing collaboration with national partners and the Scottish Government is underway to inform the establishment of a strategic framework for Mental Health Services.
Women's Service	**Deliverables: 1 of 5 actions completed, 3 actions being delivered, 1 remains an action for Q4 reporting** Further engagement is ongoing to develop the outreach service with the Scottish Prison Service and low/medium-secure female mental health service providers. There was an additional stakeholder session on 3 February 2026. Work to develop the Strategic Assessment continues in collaboration with relevant stakeholders. One action has been identified as amber with progress of the development of an outline business case being affected by nationally driven timescales DL (2025) 15, and the

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
	programme remains dependent on decisions from the Scottish Government Capital Investment Group.
Improving patient's outcomes from their clinical care experience	**Deliverables: 9 of 36 actions identified as completed, 25 actions being delivered, 2 remaining actions for Q4 reporting** A series of service development, clinical improvement and operational workstreams have progressed throughout the reporting period. Service Leadership Teams have presented their Year two plans at the Planning and Development event on 1 December 2025. Preparatory work for the revised Hub structures is ongoing and will require focus in Q4 for implementation in April 2026, with clinical guidance reviews and organisational development support continuing into 2026. Governance arrangements also continue to strengthen, with the updated Terms of Reference for the Service Leadership Group submitted to the CEO for further consideration. Across clinical practice, the majority of staff training has been completed, and work continues to finalise positive behavioural support plans. Psychology-led workstreams remain active to review the risk assessment process with Risk Clinics now well established and internal guidance on standards developed. The State Hospital continues to focus on exploration of Structured Clinical Care through the developed of a learn pro module, further work to progress this area will be identified following a needs analysis. There has been steady progress in CPA implementation, a Peer Review panel has met and reporting arrangements agreed with route through clinical governance. Quality improvement activity remains strong, with ongoing ScIL and QI training delivery, national relaunched programmes for realistic medicine, and active participation in local and national forums. Team Based Quality Review panels continue to develop, while the Quality Strategy action plan is regularly monitored and reported through the Clinical Governance Committee. Two actions have been identified as amber, the first being the elimination of daytime confinement (DTC). The introduction of the women's service has had a notable impact on resources, increased demand and higher acuity levels were observed across both women's and men's services. In response, strengthened oversight arrangements have been implemented, including meetings with key stakeholders and clearer reporting into clinical governance and operational management structures such as OMT. The State Hospital have escalated resource requirements to Scottish Government.

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
	The second amber relates to reducing weight gain through the TACKS project. Service progress continues and activities advancing despite some resourcing challenges. Oversight remains active through the SHC group. All admission areas are now equipped with exercise equipment, supporting the wider health improvement agenda. Work across the programme continues to be monitored to ensure delivery against agreed actions, with mitigations in place where delays or capacity issues arise.
Enhance Security, Reduce Risk and Harm	**Deliverables: 1 of 6 action have been identified as completed, 4 actions being delivered and 1 has been deferred until 2026/27** The organisation continues to strengthen its security and resilience arrangements, with Security Standards and Framework now developed, and all related processes and procedures reviewed and refined. A new Security Systems Manager has been recruited, while preparations are underway to transition from Datix to the new InPhase system, expected to go live by the end of quarter four. Business continuity arrangements continue with the continuity plan in place, monitored through Audit and Risk Committee and Scottish Government funding secured to support required improvements. Additional budget has been approved to progress key infrastructure projects in 2025/26, with work scheduled for quarter four including upgrades to the wander paths, rendering and roof repairs to the Islay Conference Centre, LED lighting replacement, and refurbishment of the animal sheds. These developments collectively strengthen organisational resilience and support the delivery of safe, effective, and sustainable service There is one action, the audit of security processes, procedures and practice against security standards, reported as amber and deferred to 2026/27.
Support Learning from the views of patients and carers	**Deliverables: 3 of 3 actions being delivered** The carers strategy action plan continues to progress well, with significant developments across key priority areas; Work on the Triangle of Care self-assessment, TSH3030 and a patient successfully presented their experience to the Board at the end of 2025. Regionally, the carers groups in the east and west are well-established and operating effectively, with further development planned for other parts of the country. Ongoing work includes updating and enhancing carers' information, developing the Forensic Network carers page, and integrating relevant toolkits. Child-friendly literature is currently undergoing peer review through the Communications Department. The wider group remains well established, with strong cross-hospital representation and continued progress across agreed priority areas.

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
Support the State Hospital workforce	**Deliverables: 2 of 12 actions have been identified as completed, 10 actions being delivered** The organisation continues to progress a wide range of workforce, culture, and development priorities. The Workforce Plan has been completed and is now in active use, with the associated action plan ongoing. Work continues to raise awareness of organisational health, which has seen positive engagement, including a second leadership, performance and organisational health event in December 2025 using the McKinsey 7-S model. Long-term absence remains a key focus, with audits underway to strengthen pathways that support effective management. Culture and leadership development activity remains central to improvement efforts. A culture assessment pilot within the workforce directorate took place in November 2025 and is now being evaluated for suitability, alongside the development of a draft leadership programme and targeted promotion of national training opportunities. Workforce development continues through the demonstrator programme and Modern Apprenticeships, with strong links to the Lanarkshire Employability Partnership. Efforts to enhance performance and organisational health reporting are progressing. Key programme updates were presented to Staff Governance in November 2025, with ongoing work to strengthen training plans and establish a clear calendar of events and activities. Resource management pilot in Mull Hub has been successful, with approval granted to extend the model across the site, subject to final partnership governance. A plan is in place to ensure all outstanding non-nursing rosters are onboarded by the end of quarter four moving this action from RAG amber to RAG green. The development of performance and health dashboards aimed at decreasing the need for manual data entry has been assessed as Amber with slippage in progress noted.
Finance and E-health/digital development	**Deliverables: 11 of 13 actions being delivered, 2 remaining actions for Q4 reporting** Several programmes continue to make steady progress, with oversight maintained through the SG Finance Delivery Unit and alignment to national timescales. Development work is ongoing across local delivery teams, while systems remain under review and will be progressed in line with funding availability. The electronic platform, Made Purple is currently in proof-of-concept evaluation to assess viability for full business cases, and national e-health updates confirm continued delivery against expected milestones. The 2025 NIS Audit review has been completed and shows marginal improvement on the previous year and currently awaiting timescales for the 2026 audit cycle.

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
Climate	**Deliverables: 5 of 5 actions being delivered** The State Hospital has progressed key sustainability and operational initiatives, including successful re-tendering with BIFFA for general waste and recyclates. TSH has continued transition to an electric fleet, and ongoing development of EMS and business-continuity systems. Grounds maintenance continues to support community access to grounds external to the perimeter. The internal audit recommendation, which was carried out by RSM are currently under review and all other associated actions reported as on track.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 19
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 new development of National High Secure Forensic Healthcare Services for Women in The State Hospital (TSH).

2 BACKGROUND

TSH was asked by Scottish Government to implement a proposal to deliver High Secure Services for Women in Scotland at TSH.

Strategically, this development supports 'The Independent Review into the Delivery of Forensic Mental Health Services in Scotland' published in 2021 (Recommendation 3); and 'The Mental Health and Wellbeing Delivery Plan 2023-25' published in November 2023 (Priority 8.1.2).

The proposal is in two phases:

i. develop and implement an **interim women's service model**,
ii. develop and implement an **outreach service model.**

Points i and ii above will be referred to as Phase 1, **The Interim and Outreach Service Model**. The Interim Womens Service attained 'patient ready' status on 21 July 2025.

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

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

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

In January 2025, funding was confirmed by Scottish Government to progress both Phase 1 and 2, thereafter a Core Project Team (CPT) has been established to take forward planning.

3 ASSESSMENT

3.1 GOVERNANCE

The establishment of a Womens Project Oversight Board (WPOB) is supported and agreed though the Corporate Management Team and The State Hospitals Board for Scotland. The WPOB is chaired by Mr. Stuart Currie, Non – Executive Director and meets bi-monthly. The last meeting was held on 15 January 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 – INTERIM AND OUTREACH WOMENS SERVICE

Interim Womens Service

As the current patient numbers for the service are below five, the update on the Interim Service will be reserved for the private session of the Board meeting. This is to ensure patient confidentiality is adhered to.

Outreach Service

Since the last update to the board consultation to develop the Women's Outreach Service has continued. To date in 2026 there have been two key consultation events:

Stakeholder Event HMP Stirling - 28th January 2026
Event hosted by HMP Stirling Governor Paula Arnold with attendance from senior SPS and NHS Staff. Discussion centered around current challenges and how an Outreach Service could support existing models of care to manage individuals with high mental health needs and associated risks.

Following this it was agreed to hold focus groups with officers working within Wintergreen Hall and the SRU. The first of these was held on the 12th February and there was a clear voice from officers that they would welcome additional training in how to interact with, and support prisoners, with significant mental health needs. They also highlighted the challenges of supporting women with different, and often competing needs, in one area.

NHS Stakeholders' Day: 3rd February 2026
Event held in Glasgow attended by nine external multi-disciplinary colleagues (psychiatry, clinical psychology, nursing) from medium and low secure care and representation from Intellectual Disability services. Colleagues from medium and low secure gave presentations about the female population they work with, and the obstacles they face. There was an open discussion about how best to operationalise an Outreach Service, and how any resource could best be used to support clinicians across the Forensic Network.

There was a view that there were three main areas where we could have a positive impact on the care women receive:

- Creating an established network of clinicians working with women who pose a risk of serious harm. This would include the coordination of specific training opportunities and a wider team in which challenging cases could be discussed and multi-disciplinary support offered.
- Stand-alone case consultation for specific services who are seeking input; predominantly based upon a psychological formulation but utilising multi-disciplinary expertise.

- Potentially, some ongoing case consultation for some women who require longer term indirect support via the different teams they interact with.

Next steps include:

- Further focus group with SPS officers planned for 26th Feb.
- Programme of 1 hour online CPD presentations to begin monthly from 4th March, Topics arranged to include Autism in Females, Risk Assessment in Women and Hormones and Mental Health.
- Service Evaluation Questionnaire "Working with Women who pose a risk of serious harm" to be sent to clinicians week commencing 16 Feb.

3.3 PHASE 2 UPDATE

Strategic Assessment Process

The proposal to further develop Option 3 with Thomson Gray commenced on 29 October 2025 and a draft report is expected prior to the end of February. The relevant outputs from the report will be included in the Strategic Assessment (SA) submission to SG.

A timeline for overall submission of the SA has been developed and remains on track with the aim of presenting a draft report to the TSH Board meeting in April 2026. As per DL (2025) 15, the deadline for final submission to the Capital Investment Group is March 2027.

3.4 FINANCIAL UPDATE

Phase 1
Included in the private session paper.

Phase 2
The allocation of £223,975k in 2024/5 for the Feasibility Study (Phase 2) includes:

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

The remaining allocation for Phase 2 is £59k. This allocation will be partly utilised to fund the development of Option 3 as agreed at TSH Board meeting in August 2025.

3.5 RISK REGISTER

A risk register has been developed jointly by the CPT and Risk department. Identified risks have been divided into the following themes:

- Workforce
- Finance
- Governance
- Clinical
- Environmental

Each risk is assessed fortnightly by the CPT and a report provided monthly to the WPOB. This process aligns itself to the TSH Risk Management Strategy and allows the WPOB to escalate any risk to the Corporate Risk Register if required.

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

3.6 STAKEHOLDER MAPPING AND COMMUNICATIONS PLAN

A comprehensive stakeholder mapping exercise and communications plan has been established by the CPT. Recent engagement has been with the following organisations:

- HMP Stirling.
- Forensic Network.
- NHS Ayrshire and Arran – Foxgrove Development.
- NHS Assure - development support for the SA submission.

4 RECOMMENDATION

The Board is invited to note the status of the National High Secure Forensic Healthcare Services for Women.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP	This paper outlines the strategic direction, as led through Scottish Government and being taken forward by The State Hospital's Board (TSH). The Corporate Objectives 2025/26 proposed include this as a key focus of work.
Corporate Objectives Please note which objective is linked to this paper	**1 Better Care** f) Develop and implement an interim women's service model, in line with the project initiation. g) Develop and implement an outreach service model for women from high security to medium security providers and the Scottish Prison Service. The aim of the outreach service is to work in partnership with service teams in the management of patients who may require admission, or who are displaying behaviours that could necessitate a high security referral. h) Oversee the development and implementation of a capital development following the outcome, and preferred option, from a professional design team feasibility report. This development will create a dedicated care and treatment centre for women with tailored person-centred care packages aligned to the three phases of the Clinical Care Model: Admissions, Treatment & Recovery, and Transitions.
Workforce Implications	There are considerable implications as set out in the paper, as this service requires staff with specific skills required for this service, and also to consider any impact on existing staff.
Financial Implications	The funding is outlined in detail within the paper, representing additional revenue and capital out with existing budget.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Womens Project Oversight Board (WPOB) to TSH Board (both public and private sessions).
Risk Assessment (Outline any significant risks and associated mitigation)	The report sets out the initiation of work to develop this service, and the risk framework for the project will be reported through the WPOB, and to TSH Board.
Assessment of Impact on Stakeholder Experience	Reporting confirmed that a Stakeholder engagement plan has been developed by the Core Project Team and endorsed by the WPOB who will be responsible for reporting in detail on impacts for all stakeholders, as the project develops.
Equality Impact Assessment	Equality Impact Assessments are in place for both phases of the project. Planned linkage with NHS Central Legal Office ensures compliance with Human Rights and Equality legislation.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce	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

Date of Meeting:	26 February 2026
Agenda Reference No:	Item No: 20
Sponsoring Director:	Interim 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 close to completion, with the majority of works complete and operational. The Securitas team are working on the completion of outstanding elements or getting those elements to a stage that would allow them to be completed during the two year defects and liability period.

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 4th December 2025. Weekly operational meetings continue.

3 ASSESSMENT

a) General Project Update:

The project is essentially complete and all systems are functioning. All quality targets have been met and the projected date for the award of Completion will be established through the ongoing discussions with Securitas. The projected final cost overspend is contained in Finance – Project Cost below. As above, at the time of writing works are ongoing to address final issues and the timing of those works relative to Contractual Completion. As these discussions are commercially sensitive and are potentially subject to change a full verbal update will be given to in the Board's Private Session.

b) Project Timescales

Revision 75 is the most recently accepted programme. It is now out of date as it forecasts completion in January. Revision 76 is in preparation and the completion date is dependent on the timing and result of the electrical investigations described below.

Works remaining to be addressed are:

- Works to take place in the Defects and Liability period following completion. These include:

- F2K 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
      These are almost complete to a degree that will allow contractual completion & require approximately two weeks of further work

    - Cameras affected by power fluctuations at generator tests
      An independent review has been commissioned to examine the power supply to and from the power supply units in the affected camera poles and establish, if possible, the likely cause. It is hoped that this will be complete in the near future. The timescale will likely be established by the time of the Board meeting and a verbal update will be available.

c) Progress

Contract Completion
Discussions with Securitas are ongoing. Due to the commercial sensitivity and fluid nature of these discussions a verbal update will be provided in the Board's private session.

d) Finance – Project cost

The contract with Securitas will underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by changes in the project timescale and the project has a projected final overspend (exclusive of VAT) of approximately £1,118k. This has increased by 20k since the December 2025 report to the Board. The increase is entirely composed of TSH costs for Lead Advisors, management and escort staff. Other than the contractual retention the remaining amount due to Securitas is currently a small negative.

The key project outline at 13th February 2026 is:

Project Start Date:	April 2020
Planned Completion Date (Estimate):	Jan 2026
Contract Completion Date:	May 2022
Main Contractor:	Securitas Technology Limited
Lead Advisor:	Thomson Gray
Programme Director:	Doug Irwin
Total Project Cost Projection (Exc. VAT) at 13/02/26:	£9,909,855
Total costs to date (exc. VAT & retention) at 13/02/26:	£9,897,370
Total costs to end of project (Exc. VAT & retention)	£ 12,485

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 13th February 2026 is:

Securitas	£ 7.299m
Thomson Gray	£ 1.343m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 1.175m
Miscellaneous	£ 0.002m
Income	-£ 0.122m
Total	**£ 9.897m**

VAT has been excluded from calculations of amounts paid due to the potential for final adjustments on project completion.

4 RECOMMENDATION

That the Board note the current status of the Project.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	Update paper on previously approved project
Corporate Objectives Please note which objective is linked to this paper	**3. Better Value** i) Complete the security upgrade and move towards the development of the core security quality indicators.
Workforce Implications	N/A
Financial Implications	The projected overspend is regularly communicated to Scottish Government and is an ongoing action at Project Oversight Board.
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	Previously reported, delays in completion incur additional capital cost
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Contract agreement stipulates compliance with Fairer Scotland Duty in respect of the remuneration of staff and contractors.
Data Protection Impact Assessment (DPIA) See IG 16. 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.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **ARC(M) 25/04**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 2 October 2025.

This meeting was conducted virtually by way of MS Teams and commenced at 2.00pm.

Chair:

Vice Board Chair	David McConnell

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Pam Radage

In Attendance:

Head of Estates and Facilities	Kenny Andress
External Auditor, KPMG	John Blewett
Risk Manager	Stewart Dick [Item 7]
Internal Auditor, RSMUK	Asam Hussain
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Head of Procurement	Stuart Paterson [Items 9-10]
Head of Corporate Governance	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting. Apologies were noted from Mr Allan Hardy, Acting Director of Security, Estates and Resilience and Mr Michael Wilkie, External Auditor, KPMG.

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 19 June 2025 were noted to be an accurate record of the meeting.

<u>The Committee</u>:

1. Approved the minute of the meeting held on 19 June 2025.

4 MATTERS ARISING – ROLLING ACTION LIST UPDATE

The Committee noted that actions had progressed or were on the agenda for today's meeting. In relation to Action No. 1, Fraud Update, Mr McNaught advised members that investigations were not yet at a stage where a pre-meeting would be arranged.

Ms Smith asked the Committee to note that further progress had been made on Action No. 2 in that she had discussed reporting arrangements with Ms Cathy Fallon Non-Executive Director, as Climate Emergency and Sustainability Champion who was in agreement with the proposal that the Committee receive annual reporting given the positive position of the Board in relation to climate and sustainability targets. The Committee agreed to this and the workplan would be updated in relation to the reporting frequency.

Action: Secretariat

The Committee:

1. Noted the updates from the Rolling Action List.
2. Agreed that the Committee would receive annual reporting on Climate Emergency and Sustainability.

5 INTERNAL AUDIT REPORTS

a) Use of Soft Restraint Kits

Mr Hussain provided the Committee with an update on the planned Internal Audit review of the Use of Soft Restraint Kits (SRKs) and noted that since the last Committee meeting a comprehensive internal piece of work had taken place in relation to SRKs and had been reported to the Clinical Governance Group. He was content that this piece of work offered relevant assurance around the current use of SRKs and proposed that the Use of SRKs Audit should be deferred until 2026/27 to avoid duplication of work. He further proposed that this audit should be replaced with a review of resilience planning and training.

Mr Jenkins commented that given a significant piece of work had already been undertaken to look at fluctuation and variation in the use of SRKs, it would be appropriate to defer the SRKs Audit to 2026 and replace this with a review of resilience planning and training, and there was agreement by the Committee to this position.

The Committee:

1. Agreed that the Use of SRKs Audit would be deferred until 2026 and would be replaced by a review of resilience planning and training.

b) Estates and Facilities Management

The Committee received the Internal Audit Report on Estates and Facilities Management presented by Mr Hussain who highlighted that this was the first time Estates and Facilities had been subject to a detailed internal audit process. He outlined the key aspects of the report including the agreed scope of the audit and the outcomes. He informed members that the audit had achieved 'Partial Assurance' with one high, three medium and two low priority actions, as detailed in the report. Given the outcome of the audit, he emphasised the importance of completing the suite of actions by 31 March 2026 as the result of this would be reflected in the Annual Internal Audit Opinion.

Mr Currie thanked Mr Hussain for the report and agreed that actions should be completed by the end of the financial year so that progress could be recognised within the Annual Internal Audit Opinion. He commented that the Audit Report would be helpful in effecting change as the recommendations were clear and there was an expectation that the actions would be completed within the defined timeframe.

Mr Jenkins noted that as an extra layer of assurance, any audit falling below the required level of

assurance would be reviewed at Directorate Performance Review meetings. He added that the frequency of review for the Estates and Facilities Management Audit would be increased to ensure that the actions were concluded.

Ms Radage thanked Mr Hussain for the report and noted that the actions related to systems, processes and skills, and she asked in which order these would be addressed. Mr Andress responded to this question and advised that the systems were already in place and would serve as a baseline for implementing the remaining actions. In relation to Ms Radage's point, Mr Jenkins proposed that a comprehensive action plan was developed to ensure that all necessary measures were undertaken to facilitate the timely conclusion of the identified priority actions.

Mr McConnell thanked Mr Hussain for the report, and the Committee were content to agree on actions as outlined in discussions under this agenda item.

The Committee:

1. Noted the outcome of Internal Audit Report on Estates and Facilities Management, which had an outcome of partial assurance.
2. Agreed that a comprehensive action plan would be developed to ensure that actions were progressed and concluded by the end of the financial year.

Action – Mr Hardy

c) Project Management Framework Review

The Committee received the Internal Audit Report on the Project Management Framework Advisory Review and Mr Hussain informed members that the review had highlighted that there were skilled project management personnel employed by TSH but there was no centralised Project Management Team and no overarching procedural guidance in place for project management. He advised members that there was one action point outlined in the report which had been discussed with Mr Jenkins and Ms Merson and it had been agreed that an Intranet page would be created with guidance on project management.

Mr Jenkins noted that using complex project management methodologies for all projects, regardless of their scale, could be discouraging and that it had been agreed that guidance on the intranet page would differentiate across requirements for Tier 1, 2 and 3 projects. Ms Merson echoed Mr Jenkins' comments and noted it was important to ensure consistency in all projects across the organisation however proportionality was essential, and staff should be able to access support and guidance while retaining ownership of their individual projects.

Ms Radage welcomed this approach and noted that having a centralised resource for project management would be useful.

Mr McConnell thanked Mr Hussain for the report, noting that the conclusions and key themes had been well received by the Committee.

The Committee:

1. Noted the Internal Audit Report on the Project Management Framework Review, and the proposed action on the Intranet guidance.

6 INTERNAL AUDIT

a) Audit Progress Report

The Committee received the Audit Progress Report presented by Mr Hussain who provided an update on progress against the Internal Audit Plan 2025/26. He noted that themes arising from control observations were being captured to identify any trends, however there were no concerns in respect of themes emerging that required escalation to the Committee.

b) Action Tracking Report

Committee members received the Action Tracking Report and Mr Hussain highlighted that there were nine actions on the tracker and provided a summary overview of the position as detailed within reporting.

He noted that the two actions relating to the roster compliance review were recorded as 'Being Implemented' but could not be recorded as fully completed as a national solution was awaited to address issues with the interface between Optima and the Scottish Standard Time System (SSTS). Mr Hussain asked if the Committee would be content to close these actions on the tracker and monitor them locally, or if they should remain on the tracker and be revisited at a later stage for an update. The Committee agreed that both actions would remain on the action tracker for the time being and this would be revisited at the next Committee meeting, particularly if there were any developments in relation to the Optima and SSTS interface issue in the meantime.

In relation to the narrative in roster compliance Action 2, where reference was made to SSTS being unable to document special leave, industrial injuries or union duties, Mr Connor clarified that these types of leave could be documented within SSTS. He expressed concerns around assurance of current processes for recording leave manually during the interim period while issues with the electronic interface were being addressed. There was discussion around the table on this matter and Ms Radage noted the need to retain oversight of any potential risk. Mr Jenkins agreed and suggested adding further assurance through conducting two randomised audits of existing practice, and providing reporting to the Staff Governance Committee in this respect. This would be in addition to the management action on the internal audit tracker. The Committee agreed to this way forward, and this was supported by Ms Radage as Chair of the Staff Governance Committee.

Action: Director of Nursing and Operations/Secretariat

Mr McConnell thanked Mr Hussain for the update and for the useful discussions this had generated.

<u>The Committee:</u>

1. Noted the Audit Progress Report.
2. Noted the Action Tracking Report.
3. The Committee agreed to share this discussion with the Director of Nursing and Operations to take forward randomised audit work as set out, as well as for the Secretariat to ensure that this was routed through the Staff Governance Committee

7 CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register presented by Mr Dick who highlighted the key aspects for the benefit of members. He noted that there were 24 risks and all were in date. He advised that risks CE12 and SD57 had been merged following review as similarities had been noted in that both risks were looking at timescales for review.

He noted that a new medical risk had been added which related to the impact on the female service if the long-term model was not implemented. In the Workforce Directorate the job evaluation risk had been transferred to the Local Risk Register.

As detailed in reporting, there were five high risks and Mr Dick advised that these risks would continue to be closely monitored.

Mr Connor referenced the narrative in the report relating to risk HRD114 – Reduction in Hours and asked that the report was amended to state that NHS Boards should have a final implementation plan for the Reduced Working Week in place by 1 October 2025, as the Reduced Working Week was not due to be fully implemented until 1 April 2026.

Mr Currie asked if the risk review process detailed how the residual risk level was determined, and put this in the context of how to assess whether the initial view of the risk and mitigations and controls put in place, did over time prove to be accurate. He though it important to consider whether this changed over time, and how this affected risk appetite.

Mr Dick confirmed that each risk is accompanied by a comprehensive risk assessment form, outlining the rationale behind the initial, current, and target risk ratings. Mr Jenkins also offered assurance that an auditable trail existed for each risk, enabling retrospective tracking of change points throughout the risk cycle.

The Committee:

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

8 FINANCIAL POSITION UPDATE

The Committee received the Finance Position Update to 31 August 2025 presented by Mr McNaught who highlighted a small adverse variance at this date, with a year-end break-even position anticipated. Monthly meetings continued to be held with each directorate to address the plans required to achieve and maintain break-even at year-end.

The main areas of pressure were noted in the report and Mr McNaught highlighted the improving position in nursing expenditure, which would continue to be monitored.

At the most recent finance meeting with the Scottish Government, they had indicated that they were content with the current position and forecast for 2025/26, with agreement of budgets and the savings target. The majority of planned savings had been agreed with budget holders, with the aim of having these substantially addressed in the third and fourth quarters.

He added that capital demands for 2025/26 had been fully allocated against the available budget and this included specific additional estate elements in the form of necessary repairs and upgrade works.

Mr Currie acknowledged the positive financial position and asked whether there was confidence that it would reach the anticipated position set at the beginning of the financial year. He also noted wider national considerations such as the tax reconciliation adjustment for the 2026/27 financial year and its potential impact on future budget allocations across NHS Scotland.

Mr McNaught stated that, based on the current position and the spending plans in place for the next six months, he anticipated that a break-even position would be achieved.

Mr Moore welcomed the allocation of capital funding asking whether there was confidence in committing the funds and delivering the associated projects by the end of the financial year. Mr McNaught advised that that the timing of current work was on track and noted that fortnightly capital meetings were held to monitor progress. He acknowledged that external factors such as supplier lead times and weather conditions could affect delivery, but assured that, at present, all projects remain on plan.

Mr McConnell thanked Mr McNaught for the reporting, and the continuing positive position demonstrated.

The Committee:

1. Noted the Financial Position Update to 31 August 2025

9 ANCHORS STRATEGY UPDATE

a) APPENDIX 1 – ANCHORS ACTION PLAN 6 MONTH UPDATE
b) APPENDIX 2 – DRAFT ANCHORS STRATEGY 2026-2028

The Committee received the Anchors Action Plan 6 Month Update and draft Anchors Strategy 2026-2028 presented by Ms Merson who outlined progress towards achievement of actions to September 2025 of the current Anchors Strategy 2023-2025.

Two Quick Quote processes had been carried out in this period and both contracts awarded to local ML postcode suppliers. She noted that the fair competent work assessment had been completed with TSH receiving a favourable score and some recommendations provided. The second cohort of the Demonstrator Programme would join in October 2025 for a five month period.

In relation to the draft Anchors Strategy 2026-2028 Ms Merson informed members that the focus would continue to be on progressive procurement, workforce and the sustainable use of land and assets. Each area would have clearly defined objectives, along with specific actions and progress measures to track what was being achieved.

Mr Currie asked if procurement decisions were based solely on achieving best value for money or if other considerations, such as sustainability, were also factored in. Mr Paterson explained that a range of award criteria would be taken into account, including sustainability and community benefits, and that cost was not the only determining factor.

Ms Radage asked if there was opportunity to accelerate the positive progress being made in initiatives such as the Demonstrator Programme and Modern Apprenticeships, to help build the workforce for the future and Mr Jenkins noted that this could be taken into account as part of the organisation's workforce pillars, particularly in relation to workforce impact, training and development, and career progression. Ms Merson added that, over the past year, guidance had been developed in collaboration with Human Resources to support younger employees. As part of the vacancy approval process, a prompt had now been included in the recruitment form asking if a Modern Apprentice could be considered for the role.

Mr McConnell noted that the Committee was being asked to approve the draft Anchors Strategy 2026-2028 and asked if Committee members would be content to approve this on behalf of the Board. Mr Moore said that he would be content with the strategy being approved by the Committee on the basis that the Board are cited on the strategy for the benefit of all Non-Executive Board members.

The Committee endorsed the draft Anchors Strategy 2025-2028 and agreed that the Board would be cited on this.

Action: M Merson/Secretariat

The Committee:

1. Noted the Anchors Strategy Update.
2. Endorsed the Anchors Strategy 2026-2028 on behalf of the Board.
3. Agreed that the Board would be provided with a copy of the Anchors Strategy 2026-2028.

10 PROCUREMENT ANNUAL REPORT 2024/25

The Committee received the Procurement Annual Report 2024/25 presented by Mr Paterson who highlighted the key achievements over 2024/25. He highlighted the regulated and non-regulated tenders that had been awarded as detailed in the report, and future regulated procurements. Of note, the contract with RSMUK would expire in March 2026 and Mr Paterson would meet with Mr McNaught to discuss the route to market.

Mr McConnell asked if agreements with other NHS Bodies over £50k would be considered as non-regulated and Mr Paterson clarified that Service Level Agreements with other NHS Boards are not formal contracts and therefore fall outside the scope of regulated procurement procedures.

Mr McConnell thanked Mr Paterson for the update.

The Committee:

1. Noted the Procurement Annual Report 2024/25

11 LEGAL CLAIMS ANNUAL REPORT 2024/25

Committee members received the Legal Claims Annual Report 2024/25 providing a summary of legal claims made against the Board for the financial year 2024/25. Ms Smith noted that that the report provided an overview of claims received, claims resolved, and financial settlements made over the last three years. She highlighted that four claims had been received in 2024/2025.

Ms Smith offered assurance that there were no areas of concern highlighted that required escalation to the Committee.

Mr McConnell thanked Ms Smith for the report.

The Committee:

1. Noted the Legal Claims Annual Report 2024/25

12 a) FRAUD UPDATE
b) FRAUD ACTION PLAN

The Committee received the Fraud Update and Fraud Action Plan presented by Mr McNaught who provided an update on fraud allegations and notifications received from Counter Fraud Services (CFS). He noted that two alerts had been notified to TSH in the last quarter and both were being investigated by the responsible directorates to report back to CFS. It was anticipated that investigations would be concluded and an update provided to the Committee at their next meeting in January 2026.

Mr McNaught informed members that the Fraud Action Plan was in place and had been agreed by CFS. A meeting with CFS had been arranged to provide an update on any key national matters currently ongoing.

Mr McConell thanked Mr McNaught for his update.

The Committee:

1. Noted the Fraud Update.
2. Noted the Fraud Action Plan.

13 CYBER CRIME UPDATE

Committee 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 and that any notified threats had been successfully quarantined. Cyber security training continued through mandatory training requirements and was currently at a satisfactory level.

Mr McConnell thanked Mr McNaught for the update.

The Committee:

1. Noted the Cyber Crime Update.

14 POLICY UPDATE

The Committee received the Policy Update and Mr McNaught reported that several policies were being reviewed for reclassification as procedures, where this would be more appropriate. He also noted that the Accountable Executive Directors responsible for policies due for review this quarter had been contacted to ensure they were informed and taking timely action.

As part of an organisational development session last week, the remit of the Policy Approval Group was being reviewed, and it was anticipated that an update would come to the Committee in regarding this.

Mr McConnell thanked Mr McNaught for the policy update.

The Committee:

1. Noted the Policy Update.

15 CLIMATE AND SUSTAINABILITY UPDATE

The Committee received the Climate and Sustainability Update and Mr Andress provided a summary overview of the progress on actions from the Climate and Sustainability Strategy and planned work in relation to the Net Zero Route Map. He noted that a mini-tender was carried out under the new National Framework for General Waste and Recyclates and contracts had been awarded to two suppliers.

Mr McConnell thanked Mr Andress for his update.

The Committee:

1. Noted the Climate and Sustainability Update.

16 AUDIT PLAN 2025/26

Mr Blewett of External Auditors KPMG provided a brief update on the Audit Plan for the 2025/26 Audit and informed the Committee that a planning call was scheduled for November 2025 with the intention of presenting the Audit Plan 2025/26 to the Committee in January 2026.

The Committee:

1. Noted the update on the Audit Plan 2025/26.

17 REVIEW OF EFFECTIVENESS OF AUDIT AND RISK COMMITTEE

a) COMMITTEE EFFECTIVENESS
b) CHECKLIST

The Committee received the Committee Effectiveness Report and Checklist presented by Ms Smith who provided an overview of feedback from the Audit Committee Self-Assessment Checklists as detailed in the report. Overall, it was agreed that the Committee contributed effectively to the overall control environment of the organisation and that feedback was sought appropriately through the Board and the Accountable Officer. Given the size of the Board the issue of cross-committee membership was highlighted, both in terms of the limits and potential benefits of a small Board membership.

Ms Smith indicated that Mr McConnell would be coming to the end of his final term as Non-Executive Director in 2026 and therefore a recruitment process would be taken forward through the Public Appointments, and there would be a need to identify the appropriate skills required.

Mr Currie highlighted the advantages of a smaller Board membership, noting that it allowed for a broader range of expertise and enhanced the Board's effectiveness to address diverse issues. Mr Jenkins echoed this point, noting that the composition of the Board enhanced connectivity across the governance structure.

Mr McConnell noted that this provided a good summary of effectiveness, and that this would be reflected in the Committee's annual report for 2025/26. He thanked Ms Smith for the update and summary of feedback provided.

The Committee:

1. Noted the Review of Committee Effectiveness.

18 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.

19 SECURITY, RESILIENCE, HEALTH AND SAFETY OVERSIGHT GROUP

The Committee received the Security, Resilience, H&S Oversight Group Update from Mr Andress who noted that there were no issues from the group that required to be highlighted to the Committee.

The Committee:

1. Noted the Security, Resilience, H&S Oversight Group Update.

20 DRAFT COMMITTEE WORKPLAN FOR 2026

Committee members reviewed the draft Committee Workplan for 2026 and the Committee was content to agree the proposed plan of work. It was noted that the frequency of Climate and Sustainability reporting would be reduced to annual reporting as was agreed by the Committee in previous discussions at this meeting.

The Committee:

1. Endorsed the Committee Workplan for 2026.

21 ANY RELEVANT ISSUES ARISING TO BE SHARED WITH OTHER GOVERNANCE COMMITTEES

Mr McConnell noted that the Use of SRKs Audit would be shared with the Clinical Governance Committee once completed, as well as noting that the Anchors Strategy 2026-2028 would be shared with the Board. The issue of roster compliance would be routed to the Staff Governance Committee for additional monitoring and assurance.

22 ANY OTHER BUSINESS

Mr Hussain noted that the RSMUK Risk Team conducted a survey every six months to identify emerging risks across the public sector and other industries to enable organisations to cross-check and evaluate their own risk and control environment. The Emerging Risk Radar report had been received by members and Mr Hussain highlighted that the three most prominent emerging risks identified in the Autumn 2025 exercise were geopolitical instability, a rise in cyber-attacks, and governance falling behind the rapid development of artificial intelligence (AI).

There was discussion around the table on the identified risks in the report, particularly the growing prevalence of AI and cyber risks. Mr Moore commented that the report was both informative and practical, and served as a useful reminder of the need for ongoing review of infrastructure capacity and reliability.

Mr McConnell thanked Mr Hussain for the report and noted that it would be useful to share this with other Non-Executive Board members.

Action: Secretariat

23 DATE OF NEXT MEETING

The next meeting would take place at 9.30am on Thursday 29 January 2026.

The meeting ended at 16.25pm.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 26 February 2026

Agenda Reference No: Item No: 21

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 29 January 2026.

1	Internal Audit	A finalised audit was reviewed relating to Absence, Disciplinary and Suspension Management covering practice over the past 18 month period. This received reasonable assurance, with general good practice noted. It was agreed that this report would be shared with the Staff Governance Committee. The Committee also received progress reporting on audit activity, including a review of the outstanding actions from previous audit reporting, and future planned audits.
2	External Audit	The External Auditors KMPG attended and provided an update on progress on the audit for the current financial year, including planning and risk assessments and process walkthroughs. A full and final plan would be provided to the next meeting of the Committee in March, and there were no areas of concern raised.
3	Corporate Risk Register	The Committee received a report on the position on the Corporate Risk Register, noting that all risks were up to date and that there were no proposed additions. No risks were assessed as very high, and five risks had been identified as being rated high. There was an update on the new electronic system being introduced in terms of its use in risk management and incident reporting. The Committee endorsed the register as an accurate statement of risk.
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. The Committee welcomed this as a positive position, and discussed the challenge presented by the interim women's service in terms of the current allocated budget. This was a key area of focus moving into the next financial year.
5	Audit Scotland National Reports	The Committee reviewed the report from Audit Scotland and discussed this in the context of reform required across NHS Scotland and the pressures being experienced in the financial

		landscape.
5	Counter Fraud	The Committee received a quarterly summary of alerts received from Counter Fraud Services (CFS) and noted this. Two new allegations had been received and were under investigation. Two closed cases had shown no requirement for any further action.
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 with any notified threats successfully quarantined.
7	Internal Updates	The Committee received updates from the Finance eHealth and Audit Group, and the Security, Resilience, Health and Safety Group.

RECOMMENDATION

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