THE STATE HOSPITALS BOARD FOR SCOTLAND
BOARD MEETING

12.30pm. Thursday 18 June 2026
On MS Teams

A G E N D A

12.30pm			
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 16 April 2026	For Approval	TSH(M)26/03
4.	**Matters Arising:** **Rolling Actions List: Updates**	For Noting	Paper No. 26/35
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
7.	**National High Secure Forensic Healthcare Services for Women in Scotland** Report by the Programme Director	For Decision	Paper No. 26/36
8.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Programme Director	For Noting	Paper No. 26/37
1.20pm	**RISK AND RESILIENCE**		
9.	**Corporate Risk Register** Report by the Acting Director of Security, Resilience and Estates	For Decision	Paper No. 26/38
10.	**Annual Report 2025/26: Risk and Resilience** Report by the Acting Director of Security, Resilience and Estates	For Noting	Paper No. 26/39
11.	**Finance Report** Report by the Director of Finance & eHealth	For Noting	Paper No. 26/40
2pm	**BREAK**		
2.10pm	**CLINICAL GOVERNANCE**		
12.	**Annual Report 2025/26:** **Clinical Governance Committee** Led by the Committee Chair	For Decision	Paper No. 26/41
13.	**Daytime Confinement (DTC) Report** Report by Director of Nursing and Operations	For Noting	Paper No. 26/42

14.	**Quality Assurance and Quality Improvement** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 26/43
15.	**Clinical Governance Committee:** - Approved Minutes 19 February 2026 - Report of Meeting 14 May 2026	For Noting	 CGC(M)26/01 Paper No. 26/44
16.	**Clinical Forum** - Approved minutes 10 March 2026	For Noting	CF(M)26/01
2.30pm	**STAFF GOVERNANCE**		
17.	**Annual Report 2025/26:** **Staff Governance Committee** Led by the Committee Chair	For Decision	Paper No. 26/45
18.	**Annual Report 2025/26:** **Remuneration Committee** Led by the Committee Chair	For Decision	Paper No. 26/46
19.	**Staff Governance Report** Report by the Director of Workforce	For Noting	Paper No. 26/47
20.	**Staff Governance Committee:** - Approved Minutes 12 February 2026 - Report of Meeting 21 May 2026	For Noting	 SGC(M)26/01 Paper No. 26/48
3pm	**CORPORATE GOVERNANCE**		
21.	**Annual Report 2025/26 – Audit and Risk Committee** Led by the Committee Chair	For Decision	Paper No. 26/49
22.	**Report on the Annual Accounts 2025/26** Report by the Director of Finance and eHealth	For Decision	Paper No. 26/50
23.	**Patients' Funds Accounts** Report by the Director of Finance and eHealth	For Decision	Paper No. 26/51
24.	**Performance and Annual Delivery Plan** - **Annual Report 2025/26** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 26/52
25.	**Annual and Medium-Term Planning** Report by the Head of Planning, Performance and Quality	For Noting	Paper No. 26/53
26.	**Board Improvement Plan** Report by the Head of Corporate Governance	For Noting	Paper No. 26/54
27.	**Audit and Risk Committee:** - Minutes 19 March 2026 - Verbal Update Meeting 18 June 2026	For Noting	ARC(M) 26/02
28.	**Any Other Business**		Verbal
29.	**Date of next meeting:** 9.30am on 27 August 2026		Verbal

29.	**Close of Session**	Verbal

Estimated end at 3.45pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 26/03**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 16 April 2026

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

Chair:	Brian Moore
Present:	
Non- Executive Director	Stuart Currie
Non- Executive Director	Cathy Fallon
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Finance and eHealth Director	Robin McNaught
Non- Executive Director	Pam Radage
Medical Director	Professor Lindsay Thomson
In attendance:	
Corporate Business Manager	Anne Donnelly
Consultant Psychiatrist/Clinical Lead	Dr Khuram Khan [Item 8]
Social Work Mental Health Manager	David Hamilton
Acting Director of Security, Estates & Resilience	Allan Hardy
Consultant Psychiatrist/Clinical Lead	Dr Sheila Howitt [Item 7]
Head of Communications	Caroline McCarron
Head of Corporate Governance/Board Secretary	Margaret Smith [Minute]
Programme Director	David Walker [Items 18 and 19]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone and noted apologies from Mr Jenkins, Chief Executive Officer: Ms Raghavan Non-Executive Director; Mr Connor, Employee Director; Mr Judge, Clinical Forum Chair and Ms Merson, Head of Planning, Performance and Quality.

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 26 February 2026 were noted to be an accurate record of the meeting, with a small amendment required in relation to attendance only.

The Board:

1. Approved the minutes of the meeting held on 26 February, subject to the amendment noted.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the rolling action list (Paper No. 26/22) and were content with the updates

provided.

The Board:

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

5 CHAIR'S REPORT

Mr Moore reported that the Excellence Awards had taken place in early March, with over 50 finalists, and had provided a positive and uplifting experience for those involved. He conveyed his thanks to staff and noted that the planning, preparation, and participation on the day had been reflected well in a Special Bulletin circulated by the Communications Team, which he considered to have captured the events effectively.

Mr Moore also advised that a Board Development Session had been held in early March, during which the reform agenda and financial planning from a State Hospital perspective had been considered, alongside the ongoing delivery of the women's service and current and future digital development opportunities. He further noted that a celebration of patients' learning achievements had taken place in an event with patients and some family members in attendance. He highlighted that over 80 formal qualifications had been recognised; and patients had spoken about the importance of learning. It had been a very positive occasion for everyone involved.

Finally, he noted national and sub-national planning workstreams with plans being submitted to Scottish Government at the end of March, aligning to DL 2025/25. In view of the current electoral period, it was expected that a response would follow the formation of the new government. At this stage, the key priority areas were orthopaedics, business systems, emergency care, and the digital front door.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Ms McCaffrey provided an update of organisational activity, in the absence of Mr Jenkins at the meeting.

Ms McCaffrey reported that the new Chief Nursing Officer, Ms Aisha Holloway, had visited the State Hospital as part of her tour of NHS Boards across Scotland and had been impressed by the facilities. She attended a Patient Partnership Group session and recognised the level of patient engagement. Ms Holloway had met a range of staff during the visit and had indicated she would return to take part in the Couch to 5K event in June. Ms McCaffrey noted that this visit had provided a valuable opportunity to showcase the work undertaken at the hospital.

Ms McCaffrey also advised that she had held the first in a series of in-person engagement sessions with frontline staff on 14 March, which had been well attended and had covered a range of topics. She explained that the engagement approach would be tested and refined, with a planned monthly schedule whereby she would be available for a full week each month for staff to ensure access while minimising impact on services.

She further noted that the Mental Welfare Commission had visited the Lewis Hub and Mull Wards 1 and 2 on 26 March. Although the draft report had not yet been received, the initial verbal feedback had been positive, with good practice and patient feedback identified; she added that a recommendation regarding Daytime Confinement (DTC) was anticipated. Ms McCaffrey confirmed that the published report from the Commission's previous visit on 22 January had been very positive, highlighting the quality and standard of care, strong leadership, and staff commitment, and that no recommendations had been made following the visit to the women's service.

The Board:

1. Noted the update from the Director of Nursing and Operations.

7 PATIENT STORY: WOMEN'S SERVICE

Dr Howitt, Consultant Forensic Psychiatrist and Clinical Lead for the Women's Service, introduced a short patient story relating to the women's service.

Dr Howitt advised that the patient story had been gathered with support from the Patient's Advocacy Service. The patient had spoken of feelings of nervousness prior to admission, challenges relating to restrictions, and difficulties arising from the patient mix within the six-bedded women's service, where women at different stages of recovery and with varying diagnoses had shared the same environment. She reported that the patient had felt isolated, had found frequent alarms and activity unsettling, and had found it daunting to attend activities in the Skye Centre as one of a small number of female patients within a predominantly male hospital. Dr Howitt also noted concerns regarding equality in relation to potential progression to grounds access for female patients. She further described the patient's emphasis on the importance of meaningful activity, including placements and SVQ modules, particularly at weekends when time within the ward could feel long and unstructured.

Dr Howitt also outlined key current challenges within the women's service and advised that clinical activity and incident levels had been high, with ongoing resource pressures, particularly for nursing staff, requiring baseline staffing levels to be exceeded each shift. She reported that this had contributed to fatigue and burnout for staff undertaking additional shifts and had also affected continuity for patients, as reliance on changing staff teams had reduced consistency of care. Dr Howitt further noted that staffing constraints had hindered the routine embedding of planned clinical supports, including regular psychology formulation and reflective practice sessions. At the same time, she emphasised the positive and innovative approach taken by staff delivering the service.

Mr Moore thanked Dr Howitt for her presentation which provided valuable insight into the patient perspective, as well the issue of equality of care across patient cohorts. Mr McConnell then asked about how a transitions service could be implemented with such a small patient cohort, and how this would be considered in terms of Phase 2 which would bring into being a full service. Dr Howitt referred to the limited space and capacity of the interim service, and the way in which care was tailored to individual patient needs as appropriate. However, this was limited given the small patient cohort e.g. group therapeutic sessions and building peer support. She supported the view that Phase 2 may bring additional opportunity to offer a wider range of therapeutic care for patients in the service.

Ms Fallon noted how powerful the patient reflections were, as this added the human element which should be at the core of patient care, and she emphasised the feelings of isolation reported within the limited care on offer at present. Mr Currie agreed with this sentiment, and noted that this had been considered when the service had been stood up, and would form part of the Strategic Assessment for Phase 2. However, in terms of the present interim service, it was only possible to deliver within the current funding framework, and it should be recognised that this may not deliver optimal clinical outcomes which may bring potential challenge. Professor Thomson echoed this point, and noted the review of referral admission criteria to the service and related guidance. In terms of the current service, although three of the six beds were occupied, it was not possible to consider any further admissions at this point due to the additional resource that would be required. Ms McCaffrey paid tribute to the staff within the service, as well as the wider staff groups across the hospital helping to deliver care, and the essential value of their efforts to do so.

Mr Moore brought the discussion to a close, summarising the key points, and noting that this was a key area of importance that would be discussed across several papers in today's meeting.

The Board:

1. Noted the content of the presentation.

8 GLOBAL CITIZENSHIP

Professor Lindsay Thomson advised that the work had been undertaken by Dr Khan in his role as the Board's Global Citizenship Ambassador, noting that each NHS Board had been asked to appoint an ambassador. She explained that the work had been undertaken in partnership with the School of Forensic Mental Health to support educational collaboration with colleagues in Pakistan and that the initiative represented the latest development within a programme that had progressed over several years.

Dr Khan outlined the international educational project supported by the State Hospital, which he considered to have delivered added value beyond its educational aims. Dr Khan explained that the "New to Forensic Mental Health: Let's Work Together" programme had been delivered through the School of Forensic Mental Health as a structured six-month course for clinicians and professionals working within the criminal justice system. He reported that the course had been developed collaboratively with partners in Pakistan and had focused on forensic mental health, law, ethics and human rights through online teaching, mentored learning, and supervision, promoting a human-rights-based approach. He noted that the first cohort had completed the course in January and that participant blogs had demonstrated engagement across a range of professional groups and topics.

Dr Khan advised that the project had delivered three principal benefits: it had enhanced the organisation's national and international profile by demonstrating the State Hospital's transferable expertise in ethical and human-rights-based forensic care. It had achieved meaningful educational impact overseas; and it had generated practical learning for those involved in programme design, governance, and supervision. He stated that the programme had been subject to audit through attendance data and qualitative feedback.

Mr Moore thanked Dr Khan for his presentation and asked about the wider potential of the programme going forward, noting that it was sponsored by Scottish Government. Dr Khan described the plans to extend the programme throughout Pakistan's four provinces in the future. Professor Thomson advised that the programme covered five countries, of which Pakistan was one. The focus had been on Pakistan to date due to the valuable local links in place through Dr Khan. Any future potential for expansion and to share teaching would be considered positively if possible.

The Board:

1. Noted the content of the presentation.

9 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 26/22) from the Acting Director of Security, Resilience and Estates in respect of the Corporate Risk Register. Mr Hardy provided a summary overview of the report, noting that there had been no change from the previous quarter with 23 risks remaining on the Corporate Risk Register. Further, there had been no changes to the five risks which were graded as 'High'.

He highlighted that in relation to Risk MD30, the obesity KPI had been revised with work underway to revise the associated risk assessment. Professor Thomson advised that, from 1 April 2026, the organisation had moved to formal reporting against the new obesity KPI. She explained that a suite of supporting measures had been progressed to ensure access to physical health interventions, including a newly introduced protocol for medicines to manage and prevent obesity, psychological treatments, and established activity measures. She confirmed that reporting would continue through Clinical Governance Committee and onward to the Board as part of routine performance reporting.

Mr Hardy advised that, within his directorate, Risk SD57 (serious adverse events) would be reviewed with the expectation of a reduction in grading by the next quarter following good progress in the management of this process. He also noted that FD90 (financial risk) continued to reflect the prevailing financial challenges and did not anticipate significant movement in that risk. Mr Hardy reported that HRD115 (relating to workforce sickness absence) had continued to show significant improvement but remained above the target level. He also highlighted ND70 (resourcing and staffing challenges) and noted the sustained operational impact of staffing pressures across the

hospital.

Mr Hardy advised that, in respect of risk distribution, this was being reviewed within the department to better understand the reasons for slippage in respect of risks not meeting their target level, and to agree a more focused and timebound approach to realignment. Lastly, He noted that development work had continued to implement the new incident management system (InPhase), which had gone live and was performing well in tested areas, with positive staff feedback. This incorporated incident reporting, risk registers, and risk management, alongside aspects of legal claims, complaints, and feedback. He stated that, by May 2026, the next phase would commence to migrate corporate and local risks into the system.

Ms Fallon commented positively on the impact demonstrated in relation to SD57, asking how it could be demonstrated to the Board the ways through which the management of reviews had become more efficient. Mr Hardy advised that this work was currently underway, and the revised risk assessment would describe the changes made, based on the data set measuring the timescale for reviews. He further confirmed in answer to a query from Mr Moore, that the Corporate Management Team (CMT) maintained oversight receiving quarterly reporting in this regard.

The Board:

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. 26/23) from the Director of Finance and eHealth, presenting the financial position to 28 February 2026 (Month 11). He advised that a year-end break-even position was anticipated, although month 12 remained subject to final year-end adjustments. He reported that the draft closing position due to be reported to the Scottish Government that week had shown a small underspend of around £200k, noting that this position remained subject to external audit, which was due to commence in the following weeks. Mr McNaught advised that meetings had been held with individual directorates to agree budgets and savings plans for 2026–27, with the main areas of pressure noted within the paper. He reported that nursing spend had improved but would continue to be closely monitored, particularly in relation to staffing within the women's service, and he advised that further discussions had been held with the Scottish Government regarding required funding. He noted that additional information had been provided and that confirmation of the Scottish Government's response remained awaited, and he stated that the most recent allocation communicated for 2026–27 had replicated the previous year's allocation, which the Board had indicated was insufficient for the ongoing service.

Mr McNaught also updated on charges for Northern Ireland and advised that a draft service level agreement, agreed with the Scottish Government and the Central legal Office (CLO) had been issued to Northern Ireland in early March, with a response awaited. He reported that the most recent finance meeting with the Scottish Government had confirmed that they had been content with the year-end forecast position and the approach to budget setting for 2026/27. He further advised that the 2025/26 capital allocation had been fully utilised, with additional estates work progressed using extra funding made available in the final quarter, and he noted that work had been under way to set capital priorities for 2026/27.

Mr McConnell asked about the underspend reported in respect of the women's service, and if this was being reported as part of the overall underspend to date or if it would be carried over into the next year. He also asked if the remainder of the additional funding under capital received would be utilised in full by year-end. In response, Mr McNaught confirmed the underspend relating to the women's service was due to it being stood up in year, meaning that unused funding would be returned to government as appropriate. In relation to capital funding, the monies would be spent or the requisite materials purchased in year.

Ms Fallon referred to how the State Hospital position compared to that of other NHS Boards, and Mr McNaught spoke to the difficulty of providing this insight, but would do so whenever possible. He added that work had progressed well across directorates in conjunction with the Finance Team, to

continue to identify recurring savings wherever possible. Engagement was positive and this served to build increasing benefit into the process.

Ms Radage noted the positive position, and asked for further clarification on whether there was continued government support for expenditure on the security project; as well as the likely timing of government response relating to funding within the reduced working week framework. Mr McNaught advised that the majority of costs relating the security project were capable of being met within existing budgets, and that it was not possible to comment further in relation to reduced working week funding as this was still under consideration by government following what were broad estimates made initially across all NHS Boards.

Mr Currie spoke to the continuing financial costs of sickness absence, and that this was likely to continue to be a feature in the future meaning that the ability to reduce these costs would bring enormous benefit. He also referred to the potential benefit of renewable energy projects in the context of rising energy costs. He raised the issue of continuing to wait for government response to the re-basing of costs for the women's service given the experience to date which had demonstrated the need for increased funding. He pointed to the continued difficulty of service delivery within an inadequate funding package at the present time, and potentially in the coming year, and the risks presented to the Board if baseline funding was not increased.

Mr McNaught also commented on this being a very pressing matter – the existing funding level (£3.1m) had been confirmed, but not the required uplift, and in the absence of this it may be that service delivery within the hospital would require to be re-considered. He confirmed that this was being continually highlighted in discussion and correspondence with Scottish Government to ensure that there was full awareness of this situation. Mr Moore added his agreement and underlined the role of the Project Oversight Board in reporting to Scottish Government as well. He emphasised Mr Jenkins' role as Chief Executive Officer as well as Accountable Officer in the context of the need for full funding in order to deliver services as required. Professor Thomson underlined the clinical aspect, with the potential for detriment to patients across the hospital.

Mr Moore summarised the discussion for the Board, noting the positive position at present as well as the key risks highlighted in relation to the women's service which meant that the Board would move to an overspend position in the coming year if the additional funding was not made available. This was noted as a key risk for the Board, and that detailed reporting would continue on this aspect.

The Board:

1. Noted the content of the report.
2. Noted and underlined the key risk reported in relation to future funding of the women's service and that the Scottish Government response was currently awaited.

11 DAYTIME CONFINEMENT (DTC) REPORT

The Board received a paper from the Director of Nursing and Operations (Paper No. 26/24) summarising levels of DTC and the mitigating actions taken in response. Ms McCaffrey advised that the report covered the position to the end of March and that February and March had continued to show fluctuations in the level of DTC, with the contributing factors unchanged from previous reports. She reported that extensive work had continued to recover the whole-time equivalent capacity lost as a result of the introduction of the women's service and the reduced working week. She noted positive progress in recruitment, including the introduction of on-the-day interviews at the recruitment fair, which had resulted in 11 offers from 15 interview slots. She added that further interviews were planned and confirmed that efforts would continue to reach the over-establishment position agreed by the Board, with progress updates to be provided.

Ms McCaffrey also provided further detail on the bespoke incident command process, which had been introduced to support decision-making in relation to DTC and had been operating effectively, and which would support scrutiny of decision-making.

Mr McConnell referred to the focused work underway, as detailed in the report, and how the

outcome of this would return to the Board. Ms McCaffrey described this work as helping to identify resourcing requirements and costs both in relation to the requirements of women's service and across the hospital more widely as this would inform the most optimal way to direct additional staffing resources. This work was ongoing, and would be brought back to the Board.

Ms Fallon asked about the impacts on the Skye Centre activity in particular, and whether it was possible to track any subsequent correlation with patient incidents. Ms McCaffrey confirmed that the Skye Centre was continuing to deliver a high level of patient activity and services were being delivered innovatively. At the same time, resourcing challenges did have an impact, and this was monitored through the Patient Safety Group with no significant concerns highlighted to date. There was agreement around the table that the activity levels being delivered during difficult circumstances was to be commended. It was also noted that it may be valuable to consider the balance in activity levels from the start to the end of each month and whether this also had any impact.

Professor Thomson referred to the deleterious clinical impact of DTC, within the context of uncertainty on the financial position of the women's service as previously discussed. Mr Moore acknowledged these clinical concerns and strongly underlined the importance of this issue for the Board as a whole. He also noted the mitigations in place presently to meet this challenge, including agreeing recruitment to 105% level, saying that this was within a potentially high-risk situation wherein the Board could not go into deficit as a result. Ms McCaffrey added that reporting fed through the Board was transparent in describing the challenge being faced, as well as the full range of actions taken to manage delivery of services across the hospital. This was to seek improvement in delivery as well as to engage with both patients and staff to help build understanding of the current challenges.

Mr Moore summed up, saying that the Board should continue to be kept advised of the work being progressed as discussed. He also referred specifically to a letter he had received from the Clinical Forum which had expressed concern at levels of DTC in the hospital and the impact on patients, including ability to attend CPAs. The correspondence provided some detailed clinical reflections, and Mr Moore was considering this with Executive Leads in order to be in a position to respond in full.

The Board:

1. Noted the Daytime Confinement Report.
2. Noted the letter received from the Clinical Forum, and that the Chair would respond.

12 QUALITY ASSURANCE AND QUALITY IMPROVEMENT REPORT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 26/25) summarising quality activity over the past two months. Ms Tait attended to present the report, in the absence of Ms Merson. She advised that, during the reporting period, four local audits had been completed within the agreed timescales, with significant assurance reported for the controlled drugs and diabetes audits. She reported that moderate assurance had been provided for the PMVA seclusion and mechanical restraints audits, with improvement plans agreed with relevant commissioning groups.

Ms Tait also noted that CPA oversight and monitoring had continued, and that data had shown some random variation. She advised that work had been under way to improve data quality and strengthen reporting, including the development of task-flow Tableau dashboards to provide teams with easier access to performance information.

She reported that quality improvement activity had continued to grow, with 10 active QI projects being led across interdisciplinary teams, and that registrations for the TSH 30/30 programme had closed with 15 teams signed up, nearly half of which had included patient involvement. She noted that participating teams would be supported by the QI Forum. Ms Tait also provided an update on review of new guidance, with 35 guidance documents reviewed during the period. She noted that progress against the new HIS Clinical Governance Standard would be monitored through the Clinical Governance Committee.
Ms Fallon asked about the need to review the Clinical Quality Strategy following the publication of

new Clinical Governance Standards, and Ms Tait agreed that this would be entirely appropriate and would be led by the Head of Clinical Quality.

Mr Moore thought that the report was very helpful, and that there may be areas within it that could provide opportunities to promote the work of the State Hospital at the upcoming NHS Scotland event.

The Board:

1. Noted the Quality Assurance and Quality Improvement Report.

13 HEALTH AND CARE STAFFING ANNUAL REPORT

The Board received a paper from the Director of Nursing and Operations (Paper No. 26/26) relating to Health and Care Staffing. Ms McCaffrey advised that the organisation was required to submit an annual report and that this had been the second iteration of this process, brought to the Board for approval prior to submission. She reported that quarterly engagement with Healthcare Improvement Scotland (HIS) had continued and that the feedback received had informed assessment of compliance with the standards. She said that the submission provided substantial assurance for all applicable standards; and that the previous year's reasonable assurance for the training and consultation standard had improved following delivery of planned actions.

Ms McCaffrey highlighted the work undertaken to support compliance, including the rollout of training, progress with eRostering, developments in Optima and the introduction of Loop. She emphasised that the report had focused on the robustness of systems and processes, and on the mechanisms in place to identify issues and respond appropriately, notwithstanding the acknowledged staffing challenges. She also referred to issues previously raised through internal audit, and the actions taken to strengthen the process, noting that the full benefits of the Optima system had not yet been realised.

Ms Fallon commended the detailed nature of the work as evidenced in reporting, and asked about the focus on nursing as compared to other clinical professions. She also asked about the references to non-clinical staff groups within the planning and procurement given that this workstream related to clinical staffing only. Ms McCaffrey said that the volume of the nursing cohort compared to the other clinical professions would always lend more weight to that group but that it was important to note that the level of training and support was provided across all groups. She also confirmed that she would check the detail in terms of inclusion of non-clinical staff.

Action – Karen McCaffrey

Mr Currie thought that the report was helpful, especially the level of detail provided, which was evidence of a comprehensive piece of work. He asked about the wider helpfulness of this evidence, and the additionality this provided, comparing it to internal audit work. Ms McCaffrey agreed saying that the work was in place and this exercise was focused on capturing that position. The need to think through this process helped to review and strengthen existing practices.

Mr Moore asked about whether there was a national update in terms of business systems linkage which would prevent the need for "double keying" for rostering; and also about the pilot within the Supplementary staff Register (SSR). Mr Wallace confirmed that the Optima link to payroll was being tested in some Boards presently, and he hoped that the State Hospital could be included in this cohort by the end of the year. Further, he confirmed that the SSR pilot was going ahead.

Mr Moore also commented on the wider organisational re-structure and management redesign taking place this year, and how this may impact, as well as considering how staff could raise any concerns. Ms McCaffrey thought that a strengthen operational structure and management roles would help to support this framework further, and adherence to these standards, as well as addressing any concerns in a constructive way.

Mr Moore echoed this point and that it would be helpful to see the benefits of new systems and processes over time as they were adopted, as this should lead to streamlining of practice so that

front line staff could focus on delivery of patient care.

The Board:

1. Approved the annual Health and Care Staffing Report, for onward submission to HIS.

14a WHISTLEBLOWING

a) Annual Report
b) Advice to Cabinet Secretary

The Board received a paper (Paper No. 26/27) from the Director of Workforce and Mr Wallace presented a high-level overview of the content. He advised that the whistleblowing paper covered three areas, including the routine quarterly update, and he reported that no formal whistleblowing cases had been raised during the fourth quarter and that no cases had been raised during 2025/26.

He also confirmed that the annual report set out the work undertaken to strengthen implementation of the whistleblowing standards. Mr Wallace stated that the key focus had been on creating a positive “speak up” culture, including increased visibility of the Whistleblowing Champion through on-site sessions, and he emphasised that the work had extended beyond whistleblowing to wider culture. He also noted that letters seeking assurance on implementation of the standards had been prepared for issue to the Cabinet Secretary for Health and Socia Care, from the Whistleblowing Champion and from the Chief Executive Officer, and these were appended for information.

Ms Fallon thought it was helpful to see the letters prepared for the Cabinet Sectary and that the commonality between the letter showed the cohesiveness of the approach taken. Ms Radage added that the information provided about a concern raised, which did not meet the criteria for whistleblowing but which was reviewed nonetheless, was positive. She also thought that the mix of face-to-face staff engagement sessions and the online contact route was a good mix of opportunities through which staff could raise concerns. Mr Wallace noted that the key to this was ensuring that there was a culture of safety through which staff could be confident to speak up. The most direct route to do so was through their line manager, as a means to early resolution. Ms McCaffrey added that the provision of various strands to this was beneficial as a whole – for example, the face-to face sessions she had taken forward was well received and further sessions were being arranged.

Mr Moore commented that it was important to put whistleblowing in the context of the culture change programme that was underway, led through Organisational Development. There had been a new intake of staff, especially within nursing, and it would be important to support them so that they had the confidence to raise concerns should they wish to do so. It was disappointing that there had been no new cases throughout the past year, and progressing the culture change programme should have an impact on this in the coming period.

The Board:

1. Approved the content of the annual report, for onward submission.
2. Noted and discussed the content of the letters prepared for issue to the Cabinet Secretary.

15 STAFF GOVERNANCE REPORT

The Board received a paper (Paper No 26/28) from the Director of Workforce which provided an overview of the content workforce performance and assurance across key staff governance indicators.

Mr Wallace reported that sickness absence had continued to reduce, falling from a peak of 8.93% in December to 6.78% in March, with the 2025–26 year-to-date position at 6.89% compared with 7.69% in the previous year. He advised that a downward trend had continued for long-term absence across the service and within nursing, while short-term absence had remained more variable around the end of the leave year. He noted that early April data suggested potential emerging pressures

which would require proactive management. Mr Wallace also referred to areas of concern, and which would be a focus for improvement, as well as placing the Hospital in the national context. He reported that a new Staff Care Specialist had started the previous week and stated that the post had been expected to strengthen proactive support for staff.

Mr Wallace noted that recruitment activity had remained high, including attendance at careers fairs and events, and that work had continued to restore staffing to the agreed 105% establishment, with retention still stable. He advised that Employee Relations (ER) activity had been limited, although work on lessons learned from recent complex cases had been progressed through the Staff Governance Committee with an action plan to follow. He also reported an increase over the previous four months in staff breaching the Working Time Directive, which had been associated with overtime and resourcing pressures, and which was expected to reduce as the staffing position stabilised. He added that PDP completion had remained just below 90% and was expected to return above 90% as operational pressures eased.

Mr Currie picked up on this last point, and said that this was an excellent result especially in comparison to levels within NHS Scotland as a whole. He asked if it would be practicable to ploy some future predictions, especially for absence levels, as this may assist in comparison of the actual outturn at that point and compare this to initial expectations. Essentially the focus should be on getting staff back to work in a supportive and sustainable way, and there would be a positive impact on the budgetary position as well. In terms of turnover, he commented that the best position was to be able to retain staff even when there were other options available to them in the job market. Mr Wallace noted the point on predictive work, saying that this additional detail would be routed through the more detailed reporting submitted to the Staff Governance Committee. This would involve looking at trends over the past four years, as a baseline.

Ms Fallon asked for more details about the recent recruitment fair and also about the work underway to take learning from ER cases. Mr Wallace described the success of the recent event as an effective recruiting route and that additional capacity would be in place for future such events. For ER cases, the focus was on improving timelines and better supporting individuals. Further, to build staff training and embedding checklists throughout the process. He advised that he had linked directly with joint staff side colleagues in this regard, and that the overall aim was to bring forward a more supportive process.

Mr Moore summed up the discussion, noting the slight increase in short term absence rates had contributed to the total figure for the past month in the context of the decrease in long term absence.

The Board:

1. Noted the content of reporting.

16 ANNUAL REVIEW OF STANDING DOCUMENTATION

c) Scheme of Delegation and Standing Financial Instructions
d) Standing Orders and Members Code of Conduct

The Board received a paper (Paper No. 26/29) from the Director of Finance and eHealth providing a review of standing documentation in terms of the Scheme of Delegation and the Standing Financial Instructions.

Mr McNaught advised that the standing documentation had been included for the Board's annual review and that no significant changes were required. He noted that, although inflation had increased prices by around 25% since approval levels had last been revised in 2022/23, the Scottish Government procurement thresholds had been under review and would require parliamentary approval, and it had therefore been considered preferable to align any changes with those revised thresholds next year. He confirmed that only minor amendments had been made, including updates to role and committee titles and revised delegations for corporate governance as set out in the schedule. The paper had been endorsed by the Audit and Risk Committee in March, with Board approval now sought for adoption.

The Board received a paper (Paper No. 25/30) from the Head of Corporate Governance, encompassing a review of the Board Standing Orders and Members Code of Conduct. Ms Smith highlighted that there were no proposed amendments to the Standing Orders or Members Code of Conduct. These had also been reviewed and endorsed by the Audit and Risk Committee, for onward submission to the Board.

As Committee Chair, Mr McConnell confirmed that the Audit and Risk Committee had reviewed all aspects of these papers and were content to recommend that the Board endorsed these.

The Board:

1. Approved the Scheme of Delegation and the Standing Financial Instructions, as set out.
1. Approved the Board Standing Orders and Members Code of Conduct, as submitted.

17 COMMUNICATIONS ANNUAL REPORT 2025/26

The Board received a paper (Paper No. 26/31) which included the Communications Annual Report for 2025/26 from the Head of Communications, and Ms McCarron provided a high-level summary overview of the content.

Ms McCarron reported that the annual report provided assurance on the performance and effectiveness of the communications service during the previous financial year and confirmed that all core communications objectives and statutory requirements had been met. She advised that communications had remained embedded in governance and planning activity and had supported the Board, Executive Team, and services across a range of areas, including workforce initiatives, statutory reporting, organisational change, and engagement. She noted that internal communications channels had continued to perform well, with a review of the Board Bulletin confirming it had remained an effective means of communicating Board business aligned with national practice.

Ms McCarron stated that external communications activity had supported transparency, recruitment and public and political confidence. She reported on the increase in social media posts during the year, with Facebook achieving over two million views, which had demonstrated strong engagement. She advised that the team had since been restored to full capacity and that a new communications strategy had been put in place, meaning that the service was well positioned to continue supporting the Board's strategic ambitions.

Ms Radage welcomed the report which demonstrated the work undertaken by the team. She thought it was positive to see the social media presence which had galvanised quickly, especially to support recruitment initiatives. She asked about when video production would be available, especially when other NHS Boards were using vlogs as a means of communication from senior leaders, and also if there was a greater role for AI in communications. Ms McCarron confirmed that some work had been progressed on short videos and animations to date, with planning in place to develop this further in the coming year. She spoke to the complexity in the use of AI, and the need to ensure that all aspects of this were considered including information governance aspects.

Mr Currie commented that it was positive to see changes in the approach taken, including use of social media. He thought it would be helpful to explore wider opportunities in this respect to help showcase the rehabilitative care provided by the hospital. Ms McCarron echoed this point, noting that social media posts linked directly to key pieces of work.

Ms Fallon noted that this was a small team, and although the report produced was comprehensive, the full background details included were not necessarily required in reporting to the Board, and this may help support team capacity. She referenced the details behind each KPI as an example.

Mr McConnell asked about the balance of reporting about the hospital within mainstream media, and in response, Ms McCarron said that often local news sources were a helpful way of promoting the positive aspects of care at the hospital.

Mr Moore summed up for the Board, with appreciation of the work taken forward and captured within the report. He noted that there was an opportunity for the Board to link with the service to help support its own visibility and that this would be taken forward in the coming year.

The Board:

1. Noted the content of reporting.

18 NATIONAL HIGH SECURE FORENSIC HEALTHCARE SERVICE FOR WOMEN IN SCOTLAND

The Board received a paper (Paper No. 26/32) from the Programme Director providing the updated position. Mr Walker joined the meeting and summarised the detail. He advised that the Women's Project Oversight Board had last met on 2 April.

He highlighted that that the Phase 1 update focused on the women's outreach service and had demonstrated positive levels of engagement across services in relation to women at risk of harm to others, with sustained attendance at training events and constructive engagement with NHS colleagues and the Scottish Prison Service. Mr Walker advised that the next steps for the outreach team had included development of a full-service proposal, incorporating the findings from the now-closed survey and feedback from stakeholder events, recognising that requirements had varied between NHS services and the Scottish Prison Service and across different geographic areas. He reported that the team had also been planning to pilot a limited number of case discussions to capture learning to inform the proposal, and that webinars and continuing professional development sessions would continue in the interim. He noted that the full proposal was expected to be presented to the Women's Project Oversight Board at the end of May, in time for consideration by the State Hospitals Board in June.

Mr Walker reported that the Phase 2 feasibility study had been completed and that the Strategic Assessment was nearing completion, with work progressing in this regard, anticipating submission to the Board in June. He stated that the financial position had remained challenging for the interim service and noted that the Phase 2 allocation had been almost fully utilised, with a small underspend to be returned to the Scottish Government and not carried forward. He also highlighted the stakeholder mapping and communications activity taken forward.

There was agreement around the table on the comprehensive nature of reporting, and that the ongoing development of the outreach service was welcomed. It was noted that the full feasibility report with related appendices would be distributed to the Board.

Action – Mr Walker

The Board:

1. Noted the content of reporting.
2. Noted that the feasibility report with related appendices would be circulated.

19 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report (Paper No. 26/33) which provided the updated position on the project, with Mr Walker presenting a summary of the key points. He advised that the Project Oversight Board had not met since December, as the only outstanding matter related to camera dropouts related to surges in power supply units. He noted that the expert report in this respect was expected by the end of that week, and that once the report had been received, the position would be assessed to determine whether the issue fell within the Defects and Liability period or whether further work would be required. He also drew attention to the updated financial position, which had increased as set out in the report.

Mr Currie noted the need to start to anticipate future risks to existing technology given the speed of developments in this field, and to align this to a schedule of maintenance. Mr Walker referred to the two-year Defects and Liability phase, during which each component could be tested and maintenance

planning put in place. The Systems Manager role within the hospital would be key to this process.

Mr Moore noted that the framework for post-completion reporting would need to be considered, as it may be that the final project report would be submitted to the next meeting of the Board in June.

The Board:

1. Noted this update in relation to the Perimeter Security and Enhanced Internal Security Systems Project.

20 AUDIT AND RISK COMMITTEE

The Board received the approved minute of the meeting that took place on 29 January 2026; as well as a summary report (Paper No 26/34) of the key areas of reporting and discussion at the meeting which had taken place on 19 March 26.

Mr McConnell reported that the Audit and Risk Committee meeting on 29 January had received internal audit reports on absence management which had provided reasonable assurance, and had also considered the initial external auditors' plan for the 2025/26 audit. He advised that the Committee had received the second standard set of reports across areas including risk, finance, and fraud, and had also addressed the arrangements for continuing internal audit provision for the hospital, which had subsequently been progressed to the Board.

Mr McConnell advised that the Audit and Risk Committee meeting on 19 March had considered internal audit reports on resilience planning and training, which had again provided reasonable assurance, and had received the draft Internal Audit Annual Report, with these and other reports contributing to a positive overall internal audit opinion. He also noted that the updated external auditors' plan had been received, alongside items supporting year-end audit work, including the draft governance statement.

The Board:

1. Noted the content of the approved minutes of the meeting on 29 January 2026.
2. Noted the update from the meeting held on 19 March 2026.

21 ANY OTHER BUSINESS

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

22 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 12.30pm on Thursday 18 June 2026.

23 CLOSE OF MEETING

Mr Moore brought the session to a close, thanking colleagues for their contributions to a full meeting, including consideration of important issues for the Board.

The meeting ended at 12.50pm

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	June 26	**December Update:** This will be reviewed fully on completion of the project to understand risk/ requirements to mitigate system failure. To return to Board in June. **June Update:** Project Update on agenda, with expectation of final reporting in August 2025. **August Update:** Reporting in terms of final elements due in October, and to be actioned on that basis. **October Update:** Update reporting on agenda which reflected that the project is not yet into final completion and further update at next meeting. **December Update:** Reporting within meeting, and confirmation that project nearing completion so action will be considered further at that point. **February Update:** project still ongoing and progress and action to be considered at completion. **April Update:** project completion is imminent and action to be completed thereafter. **June Update:** Await practical completion – anticipated late June.
2	December 2025	Patient Advisory (PAS) 12 Month Report	Provide feedback if possible on how advocacy services operate at other UK Sites	K McCaffrey	August 2026	**February Update:** PAS have started the process and have identified 6 key points for comparison. The next stage is to gather the necessary information and analyse the data prior to collating an overview. **April Update:** Work progressing as outlined. **June Update:** To return once finalised

3	February 2026	Corporate Risk Register	Alignment of each risk in terms of governance at Board and Committee level for oversight, and wider work on risk management structure – review within next BDS.	A Hardy	August 2026	**April Update:** Discussed at Board Development Session in March 26, with further areas of review outlined, going forward.
4	April 2026	HCSA	Point raised for clarity in respect of why there is inclusion of non-clinical cohorts within reporting under Planning and Procuring services, rather than being clinical staff only.	K McCaffrey	June 2026	**June Update:** Clarification provided by Director of Nursing and Operations: Every Health Board must demonstrate a regard to the guiding principles for the Health and Care of all staff cohorts. This duty relates to those staff whose services are procured from external providers and in most cases under an SLA. Within the hospital, procurement have also provided assurance re governance in place for compliance with Scottish Government guidelines when Service Level Agreements (or similar) are signed. **CLOSE ACTION**
5	April 2026	Women's Service	To ensure recirculation of the feasibility report along with related appendices when finalised.	D Walker	June 2026	**June Update:** Programme Director confirmed the full report and apprentices not finalised hence not circulated at April meeting. Strategic Assessment on June agenda.

Last updated – 02.06.26 MS

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 7
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 Decision

1 SITUATION

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

2 BACKGROUND

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

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

The proposal is in two phases:

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

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

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

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

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

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

3 ASSESSMENT

3.1 GOVERNANCE

The establishment of a Womens Project Oversight Board (WPOB) is supported and agreed though the Corporate Management Team 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 28 May 2026.

The CPT meets on a fortnightly basis and is chaired by the Programme Director.

The latest updates on progress of both phases are as follows:

3.2 PHASE 1 UPDATE – OUTREACH WOMEN'S SERVICE

The proposal for the outreach service was approved at the WPOB meeting on 28 May subject to a review of the resource profile. This element has now concluded and the proposal is attached in Appendix 'A'. The proposal is designed to support women at risk of harm to others and is designed to provide support in the following areas:

- Training to support and strengthen systems and practice.
- Complex case discussions.
- Support to professionals working with women who are in the Community or a Custodial Setting.

The annual cost profile for the service based on current salary levels and including additional costs for IT, travel and accommodation is £632,816 per annum.

If approved, the proposal will be submitted to the Mental Health Directorate at Scottish Government for consideration.

3.3 PHASE 2 UPDATE

Feasibility Study

The final report on the Feasibility Study has been completed and now includes the attachments which were not available at the last Board meeting in April 2026. The final report outlines that the proposal can be accommodated on the land currently utilised by the management centre. The relevant details and cost have been incorporated into the final draft of the Strategic Assessment. The Feasibility Study report is attached in Appendix 'B' however due to the size of the attachments, these are not included but can be made available to the Board.

Strategic Assessment

The Strategic Assessment was subjected to a final review with NHS Assure and a number of amendments made to strengthen the proposal. The final draft was subsequently approved by the WPOB on 28 May and is attached in 'Appendix 'C' for TSH Board approval and onward submission to the Scottish Capital Investment Group.

3.4 FINANCIAL UPDATE

Phase 1

The allocation of £3.1m for 2025/6 was underspent by £674k. An allocation of £71k has been carried over into the current financial year to fund an additional training proposal and the Garden Enhancement project.

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 £138k)
Travel/Expenses Allocation	£6k	(spend £0)

The remaining allocation is £18k is not eligible to be carried forward and has been included in the overall underspend for financial year 2025/6.

3.5 RISK REGISTER

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

- Workforce
- Finance
- Governance
- Clinical
- Environmental

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

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

3.6 STAKEHOLDER MAPPING AND COMMUNICATIONS PLAN

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

- HMP Stirling.
- Forensic Network – Womens Forensic Services Planning Group.
- NHS Assure - development support for the SA submission.
- NHS Nottingham – Rampton.

The communications plan has been updated accordingly.

4 RECOMMENDATION

The Board is invited to **note** the status of the National High Secure Forensic Healthcare Services for Women and **approve** the Outreach Service Proposal and the Strategic Assessment.

MONITORING FORM

How does the proposal support current Policy / Strategy /ADP	This paper outlines the strategic direction, as led through Scottish Government and being taken forward by The State Hospital's Board (TSH). The Corporate Objectives 2026/27 proposed include this as a key focus of work.
Corporate Objectives Please note which objective is linked to this paper	**1 Better Care** f) Develop and implement an interim women's service model, in line with the project initiation. g) Develop and implement an outreach service model for women from high security to medium security providers and the Scottish Prison Service. The aim of the outreach service is to work in partnership with service teams in the management of patients who may require admission, or who are displaying behaviours that could necessitate a high security referral. h) Oversee the development and implementation of a capital development following the outcome, and preferred option, from a professional design team feasibility report. This development will create a dedicated care and treatment centre for women with tailored person-centred care packages aligned to the three phases of the Clinical Care Model: Admissions, Treatment & Recovery, and Transitions.
Workforce Implications	There are considerable implications as set out in the paper, as this service requires staff with specific skills required for this service, and also to consider any impact on existing staff.
Financial Implications	The funding is outlined in detail within the paper, representing additional revenue and capital out with existing budget.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Womens Project Oversight Board (WPOB) to TSH Board.
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

WOMEN'S SERVICE OUTREACH MODEL PROPOSAL

1 SITUATION

The State Hospital (TSH) was asked by the Scottish Government to implement a proposal to deliver a high secure service for women in Scotland at TSH. As part of this, the Core Project Team (CPT) were asked to scope out the need for a psychology-led outreach service and develop a proposal for what would meet the needs identified. This was to be developed in collaboration with representatives of the Scottish Prison Service and NHS medium secure services and take account of "*any system deficits*" relevant to women who pose a high risk of harm.

2 BACKGROUND

Further background information is provided in Appendix '1', but key points are summarised below (all references contain hyperlinks to the original documents in the footnotes).

Female Offending

Rates of female offending are lower than those of men, and women are less likely to commit violent offences. Comparatively, we know less about all aspects of offending by women (e.g. prevalence and drivers). However, women do engage in a range of types of offending that cause harm to others.

Over 2023/4, 4 women per 1000 of the population were convicted of an offence (compared to 21 males) and 17% of all convictions in Scotland were committed by women[1]. One in five violent crimes involve female offenders[2]. One in six incidents of domestic abuse and approximately one in ten homicides involve a female accused[2]. 71% of offences related to "*cruelty and unnatural treatment of children*" were perpetrated by women. In addition, the number of women receiving custodial sentences for non-sexual violent offences has increased. Importantly, the Criminal Proceedings in Scotland 2023-24[1] report highlights that the longer-term fall in convictions (over the last ten years), is driven by a reduction in convictions of men with minimal decline to the rates of conviction for women.

Since the Angiolini report in 2012[3], Scottish Government policy has highlighted the role of diversion from custody and specialist women's justice services, as well as community-based sentences for female offenders and efforts to avoid imprisonment where possible.

Multiple papers have highlighted the need to recognise the role of trauma and mental health in female offending and in sentencing practices. The needs of these women are diverse. Their difficulties will be present in community as well as custodial settings (prior and post custody) and consequently difficulties also pose challenges to risk management.

Prison Population

[1] Scottish Government (2025) Criminal Proceedings in Scotland, 2023-2024
[2] The Scottish Government (2022) Women in the Justice System
[3] Angiolini, E. (2012) Commission on Women Offenders: Final Report; Edinburgh: Scottish Government

We know that people in prison experience a higher rate of complex mental health and behavioural difficulties compared to those in the community; and that "*women in prison have a greater mental health burden compared to men"*[4]. The needs are diverse and include self-harm, childhood and adult trauma, personality disorder, neuro divergence, and intellectual disability; co-morbidities are prevalent.

In prison, mental health teams have continued to develop, broadly following community-based models in terms of service structure, though there have been calls for this to be reconsidered[8]. However, since 2019, multiple reviews [4,5] have expressed concern about the mental health care of women in Segregation and Reintegration Units, with addressing this being considered an NHS responsibility[6].

SRU (Segregation and Reintegration Unit) staff reported that the complex issues and needs of segregated prisoners were often labelled as "*behavioural*" (as opposed to a "*mental illness*") by either the mental health teams or external psychiatric services, resulting in limited mental health interventions being available to them, and no access to a bed in a secure mental health facility[7]. They have shared that that they felt ill-equipped to manage this group.

Throughout the documents reviewed, consistent recommendations for training in relation to mental health generally for prison officers and further training for those working in SRUs have been made[8,12,] and that a model of care with the needs of those in custody at its centre is developed.

Forensic Mental Health

In terms of forensic mental health provision, it has been highlighted that the needs of female patients in secure services are characterised by different and more complex presentations than men. There is variability in the provision for women requiring secure psychiatric care, and in those areas where there is less forensic provision generally, women are cared for in services that are meeting a mixed range of needs. The necessity of a workforce who have expertise and experience in working with this patient group has been emphasised[8].

The Barron report also highlighted that the care needs of the group of women "*who may not meet the definition of 'forensic', but who are subject to conditions of security as their behaviour has not been able to be safely managed by generic services*" should be considered and that more coordinated and strategic approaches to sharing forensic expertise with partners is required.

Contextual Factors

Scottish Government[9] has committed to "*support the justice system to work effectively with local partners to improve outcomes for people with mental health problems*". This Mental Health Strategy highlights that continuity of care is of importance due to points of transition being times of high risk in terms of mental health. The Scottish Government's Justice Strategy highlights a

---

[4] Report to the UK Government by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, October 2018

[5] MWC: Mental health support in Scotland's prisons 2021: under-served and under-resourced; themed visit report, April 2022

[6] Response of the UK Government to the report of the European Committee for the Prevention or Torture and Inhuman or Degrading Treatment or Punishment, October 2019

[7] HMIPS (2023) A Thematic Review of Segregation in Scottish Prisons

[8] The Forensic Network (2019) Women's Service and Pathways across the Forensic Mental Health Estate.

[9] The Scottish Government (2017) Mental Health Strategy: 2017-2027

requirement to ensure that women (and children) are "*better serviced by our approaches to justice*". The strategy also highlights the need for "*a person-centred approach to rehabilitation where people are supported in the most appropriate and effective setting*"[10]. Any interventions should be trauma informed[10,11], and that includes our shared understanding of risk and risk management.

In addition, at a national level, reviews[12,13] have highlighted the need for the use of appropriate risk assessment tools as well as co-ordinated multi-agency risk management practices for those who pose a risk of serious harm to others. Psychological and clinical expertise are central to such assessments and the absence of understanding of mental disorder has been highlighted. The RMA (Risk Management Authority) guidance[14] is that we should use a structured professional judgement approach to risk using appropriate tools as well as a formulation-based approach to the assessment and management of those who pose a high risk of harm to others. However, we are lacking female-specific risk assessment tools, and so understanding, assessing and managing the risk posed by women is considered specialist knowledge.

In recent years in Scotland, there has been a move towards considering how we ensure that there is equal access to expertise across the country rather than it being predominantly located in the Central Belt within specific geographical locations. In terms of health and forensic expertise, there are established precedents of services based in one part of the country which offer services at a national level (e.g. IVY: Interventions for Vulnerable Youth; F-CAMHS: Forensic Child and Adolescent Mental Health Services and the Forensic Network); particularly in relation to highly specialist services where needs may seem too infrequent to warrant local services throughout the country.

3 ASSESSMENT

Early on in the consultation process it was evident that services and professionals in Scotland did not want a replication of the outreach service based at Rampton (NWOS – National Women's Outreach Service) and that any outreach service should be developed in conjunction with Scottish stakeholders and in recognition of the Scottish landscape. The CPT (Core Project Team) therefore undertook an extensive scoping exercise to inform this paper:

- We directly discussed the potential needs with multi-disciplinary colleagues in low and medium secure (psychiatry, nursing, occupational therapy and clinical psychology) across the country in the form of meetings and stakeholder events.
- We met with SPS management, prison officers and the mental health team in HMP Stirling.
- We held initial consultations with clinicians who work in HMPYOI Grampian.
- We consulted with wide range of colleagues in connected services and bodies including outreach services in England and Australia. In addition, sought information from what equivalent services that exist in Scotland (e.g. IVY; STAR: Specialist Treatments Addressing

[10] The Scottish Government (2022) The Vision for Justice in Scotland
[11] NHS Education for Scotland: National Trauma Transformation Programme
[12] The Southport Inquiry Report, 13.04.2026
[13] Inquests Arising from the Deaths in the Fishmongers' Hall Terror Attack; Regulation 28 Report on Action to Prevent Future Deaths
[14] RMA (2018) Standards and Guidelines: Risk Assessment Report Writing; RMA Scotland

Risk, NHS Greater Glasgow and Clyde; SOLS: Serious Offender Liaison Service, NHS Lothian and F-CAMHS).

- In conjunction with the RMA, we constructed a survey completed by colleagues in police, social work, general adult and forensic mental health services that allowed professionals to respond as individuals or on behalf of their service.
- Finally, the paper and its recommendations have been presented to and discussed at the Womens Project Oversight Board, and we have held additional consultations with some members of this group.

This extensive consultation process, as a whole, has led to the identification of the following themes and considerations:

1. In terms of the response to the survey, it was acknowledged that the numbers of women compared to men are small, particularly at a local health board or council area level. However, higher clinical and psychological complexity in presentation was highlighted as a significant issue in the field when compared to men in both justice and health settings. Professionals from community services have found that the increased complexity of the women they are working with contribute to difficulties in risk management.
2. The types of risk perpetrated by women that are being managed by respondents generally related to violence, sexual violence and intimate partner violence. When provided with a definition of serious harm[15], responders to the survey identified that 80% of the women being managed were considered to meet this definition. This equates to approximately 214 women. Further exploration of this could be useful, both in terms of understanding of the offence histories of the women in question and the extent to which their conviction(s) reflects the risk posed, as well as whether the ratings may reflect the challenges professionals have identified in the assessment and management of female offenders.
3. The NHS services that women who pose a risk of harm to others are likely to come into contact with (e.g. community mental health teams, trauma services, addictions teams) are unlikely to have expertise related to risk to others and those justice agencies with whom they may be working do not necessarily have expertise related to mental disorder.
    a. It was queried whether a reduced understanding of violence posed by women may ultimately do women a disservice because their risk needs are not fully understood or responded to. It was suggested that this may contribute to exclusion from services and social isolation.
4. In terms of FMH settings, there are fewer services for women and fewer women needing the services compared to men. Networks for sharing advice and expertise predominantly exist within psychiatry, but less so in other disciplines. This may mean that, in terms of understanding the link between mental disorder and offending, there is an implicit bias to those disorders characterised by psychosis.
    a. Within FMH settings, one consequence of the combination of the national nursing shortage and fewer numbers of female patients is that it is becoming increasingly difficult to develop and deliver in-house training specifically related to the care of women. Such needs therefore need to be considered a national level.

[15] The Risk Management Authority (2018) define "*serious harm*" as "*harmful behaviour of a violent or sexual nature which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible*".

   b. Colleagues in women’s secure services were keen to explore potential shared training and research objectives. However, when collaboratively discussing options in relation to the interim high secure service being at capacity, those in medium security did not feel that a service offering in-reach to them for women who may either be on a waiting list for high secure care, or whose referrals had been declined, would be beneficial.

5. Professionals reported concern about different types of mental health presentations in this group of women. As well as access to assessment and intervention for them, they shared concern about a lack of access, for professionals, to expertise in relation to the needs associated with specific disorders (e.g. autism, ADHD, trauma) and how such difficulties relate to the understanding and management of risk in women.

6. Within prisons, complex case discussions that focus on mental health / trauma are available from the mental health team in HMYOI Stirling if a person appears to meet their referral criteria. However, it seems that there can be differing views about the appropriateness of some women’s placement (i.e. hospital vs prison) and a consequent misalignment in the expectations from such discussions; this, and the limited extent to which the whole SRU team can attend these discussions or access follow-ups can act as barriers to recommendations being put into practice.

   a. Prison officers felt that they were working with increasing numbers of women with overt mental health difficulties. Officers shared that they have valued the training that they have received but can find it hard to implement into their practice unless it is revisited or there is a chance to discuss how that training relates to specific cases. In addition to training, they requested the chance to discuss and better understand specific cases not accepted by the mental health team, those women who have been returned to custody from hospital or how a woman’s mental disorder could affect the risks they are managing. Much of what they spoke of mapped on to a model of working typically found within forensic mental health services.

7. Compared to men, the pathways for women moving on from custody or hospital are less clear and less well established. There is concern in the field that this may contribute to delays in progression, more opportunity to fall between services and a lack of service provision tailored to their needs. It was felt that those women that services are trying to support seem likely to fall between the gaps in services – e.g. due to difficulties engaging in mainstream services or their presentations not meeting the criteria for services.

8. Across all the services and professionals we spoke to, it was consistently stated that further opportunities to learn about how we recognise, assess and respond women who pose a risk of harm to others is essential. Currently, obstacles to accessing such CPD (Continuous Professional Development) include the lack of availability of it and limited budgets.

9. Mental health needs (e.g. autism, psychosis) can look different in women; across services we need to increase our skills in identifying and responding to such needs. Awareness of personality disorder, neurodevelopmental disorder and impact of trauma upon risk were key areas that professionals wanted to know more about, but there currently is not service which consistently provides this across the country.

   a. Working with the trans population in justice settings was also highlighted as an area where further CPD (Continuous Professional Development) is required.

   b. The CPD sought is varied in terms of the topics to be covered. For example, the needs of prison officers are different to those of Social Workers, Psychiatrists and Applied Psychologists. However, there is also overlap between professional groups.

In order to be able to contribute to addressing the training needs of SRU prison officers in SRUs in a sustainable manner, we would recommend broadening this training to other professional groups who have expressed an interest (e.g. social work, third sector, police).

c. In recognition of this feedback, we have begun to organise a series of webinars focusing on issues of relevance to working with women who pose a risk of harm to others. These have been delivered in conjunction with the School of Forensic Mental Health, and attended by a range of professionals from health, social work and justice services. Over 450 people signed up for the first webinar about offending by women with autism (242 attended) and over 300 people registered for the following event about the impact of reproductive hormones on mental health. These have been received very positively, with requests for more webinars about other topics of relevance as well as more in-depth training about those already covered.

10. The different prosecution and sentencing practices for women, mean that women who pose a risk of harm to others may not be found in the same places as their male counterparts and this has a bearing upon the assessment and management of their risk.

11. The population of female high-risk offenders is spread across diverse services.

12. Not all women who pose a risk of harm to others and have a mental disorder are cared for by specialist forensic services, the criteria for which often require a major mental illness as a primary diagnosis.

13. Low secure inpatient care for women is concentrated in the independent sector in the west of Scotland, which creates challenges in terms of transitioning women back to their local communities

14. Shorter sentences and more complex presentations may contribute to more points of transition for those women who pose a risk of harm to others. This can interfere with access and provision of treatment, e.g. due to an individual moving between custody and community before referral can be actioned, reduced continuity of care or because there are not clear pathways for the mental health support of those women who pose a risk of harm to others. As well as disrupting care and treatment, it could also disrupt or interfere with risk management and the ability of services to uphold principles of trauma informed care.

15. Almost every respondent raised concerns about the limitations of the risk assessment tools available to them for assessing the risk posed by women in their services and management of it. The tools available and current practice is predominantly based around the risk assessment and risk management of men. Many identified risk assessment practice as an area where further support, training and research is required.

    a. When working with women who pose a risk of harm to others, our practice is predominately informed by research and guidance developed for men. This may lead to bias and over/under estimations of risk. Given that women are less likely to receive custodial sentences, there is a need for gender informed risk assessment and management that is cognisant of the risks posed to others whilst holding an awareness of the increased likelihood of women being the victims of violent crime.

    b. Developing our understanding of the risk assessment and risk management needs is a priority identified by professionals in health and justice settings.

    c. Services and clinicians from each discipline and geographical area who responded to the survey requested access to expertise in the assessment and management of

women's risk and individualised psychological formulations of complex women that incorporates an understanding of their risk; with a request that delivery had the option of being in person. Many also highlighted a lack of access to a multi-disciplinary team.

16. That a Scottish outreach service should contribute to the development of the evidence base as well as disseminate current knowledge and best practice.
17. Burnout and vicarious traumatisation are key considerations in services which emphasises the need for peer support, clinical supervision and psychologically informed care, reflective practice centred around psychological formulation. Professionals are keen to develop collaborative peer networks in relation to working with women who pose a risk to others.

In summary, services are managing women who pose a risk of violence. We learned that there are both overlapping and different needs in services across the country which would be of relevance to the development of an outreach service specific to women who pose a risk of harm to others, and that there are geographical differences in access to additional specialist expertise. Overall, there was significant demand for access to consultation, support and training in relation to working with women who pose a risk of harm to others and who have difficulties with their mental health that recognises both factors.

4 RECOMMENDATIONS

Reliably estimating the demand for an Outreach Service in Scotland is challenging. Although we know that this group of women have high levels of complexity, pose a risk of harm to others and are more likely than their male counterparts to be in the community, data specific to female offenders is not routinely published in Scotland. The responses to the webinars have demonstrated the demand and interest in CPD opportunities and the survey has demonstrated that complex case consultations that can factor in an understanding of risk is a need that professionals in the field have identified.

The data we do have highlights that the numbers in each local area are too small for specialist local services throughout the country, and so centralising this expertise and making it available to all relevant services makes sense.

We are therefore proposing a three-year pilot of a new service that is tailored to the Scottish landscape and has arisen from extensive consultation with professionals in the field.

Given that this would be a new service, specific to Scotland, ongoing evaluation would be essential. Integral to this will be gaining a clearer picture of the need across the country and the resources required to meet it.

Our recommendation is that the service is hosted within the State Hospital but has a distinct identity.

Three years has been chosen as the length of time required to allow the service to become established, for all aspects of it to be delivered and refined and for evaluation. The Outreach Service which would be responsive to a Scottish landscape would be one that offers the following:

Tier 1: Training focused on three main areas initially to support and strengthen systems and practice:

1. Training for non-mental health clinicians (e.g. prison officers, social workers) focused on understanding the mental health needs of the women they work with. Examples of topics include understanding psychosis and how to work with someone experiencing a psychotic episode; how to support those with anxiety; how to manage disclosures of trauma. Delivery would be both remote and in person, aiming to deliver four days per month (with the option for one event, or two consecutive events, per month to be outside of the Central Belt).
2. Co-ordinating training specifically for women's FMH services whereby local expertise is utilised and external training is sought if this is not possible. Examples of topics include systemic approaches and managing self-harm in inpatient environments. Our role in this would be in co-ordination rather than direct delivery.
3. Continuation of short CPD events that are open to those from a range of professions.

Potential topics would be reviewed and developed in response to feedback from participants and in conjunction with representatives from related services.

As a service, we would intend to move towards the delivery of training specific to the risk assessment and risk management of women that would be applicable to those working in justice and FMH settings.

In addition, our service would take on an administrative role with organizing peer networks for different professional groups working in forensic mental health services and a "clinical escalation group" which would exist for multi-disciplinary teams to discuss challenging cases as peers. Leadership of this group would rotate between services, but this service would hold an organisational role. These were requested in the course of the stakeholder events held.

Tier 2: Complex case discussions regarding women who pose a risk of harm to others:

- For those women in the community who pose a risk of serious harm[16] to others, the provision of ongoing support to the professionals working with her regarding an individualised psychological formulation of her presentation and how this informs risk management. This would be based on a structured professional judgement risk assessment undertaken collaboratively with her if she consents, and so would require in-person assessments to be undertaken.
- They would focus on developing an individualised psychological understanding of complex presentations that incorporates an understanding of the risk posed and actively contributes to risk management with multidisciplinary and multi-agency case discussions regarding adult women in (or returning to) Scotland who are involved with a public agency or SPS and who pose a risk of harm to others / or whose behaviour challenges the system caring for them and have recognised difficulties with their mental health.
- At this stage, it is proposed that the referral criteria remain relatively open to allow the service to develop in line with the needs of women offenders and those working with them. We would accept referrals from colleagues in health, SPS, Police Scotland and Social Work services. Following a case discussion, informed informal support could be offered to

[16] The Risk Management Authority (2018) define "*serious harm*" as "*harmful behaviour of a violent or sexual nature which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible*".

colleagues or an additional case discussion arranged if required either in-person or remotely.

- Estimating the number of case discussions required is challenging for the reasons stated above and the requirement to be able to provide consultation in a short timeframe that is responsive to the needs of services.
- IVY is the service most similar to this proposed one, and they aim to offer 80 case discussions per year; this is the same amount that was offered by SOLS in NHS Lothian. We would suggest that a capacity equivalent to IVY is required, in recognition that our model includes the need for follow-up consultations and the provision of consultation to custodial settings as well as community. We have built in capacity for one case discussion per month to occur in the North of Scotland. All would be facilitated by two senior clinicians. To achieve this goal three are required. In the earlier phase of the service, we would increase the amount of training offered to other services, whilst making stakeholders aware that a new service exists.

Tier 3: There would be two parts to tier 3 depending on whether a woman is in the community or custody (or equivalent).

Community

For those women in the community who pose a risk of serious harm[17] to others, the provision of ongoing support to the professionals working with her regarding an individualised psychological formulation of her presentation and how this informs risk management. This would be based on a structured professional judgement risk assessment undertaken collaboratively with her if she consents, and so would require in-person assessments to be undertaken.

- Risk assessments would only be undertaken if the case discussion highlighted that this was necessary and capacity allowed.
- In terms of staffing, we have conservatively allowed for four per year but would keep this under review.

This type of consultancy could also be available for women returning to Scotland from adolescent units in England or low secure services in other health boards if they are not transferred to a forensic mental health team. It is assumed that these women will have existing risk assessments written about them, and so a case discussion would be the primary method by which we would offer this support.

For those leaving custody, some may warrant assessment of risks; others may benefit from case discussions with those working with them in the community. We recognise this may be more than one if she moves between care settings. However, if the risk posed is not of serious harm to others, we would need referring agencies to obtain her consent for any case discussion (or assessment) which could occur.

[17] The Risk Management Authority (2018) define "*serious harm*" as "*harmful behaviour of a violent or sexual nature which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible*".

Custodial Settings

In terms of custodial settings, we would provide a regular and consistent time to meet with officers in the SRU and high needs hall at HMYOI Stirling that would support them to put learning into action, develop their psychological understanding of the women in their custody and increase psychologically informed working practices. We would ensure that this occurs whilst developing and maintaining links with the local mental health team.

Costs

The majority of what would be delivered would be by two clinicians at a time. Therefore, in order to reduce the costs associated with staffing, we would propose that this service operates on a three-day week. This would allow all staff to overlap in terms of their working days, which then allows us to ensure we have sufficient personnel to cover our commitments. This would be very difficult to achieve over a five-day week with the proposed staffing.

In order to deliver the proposed model, the following **resource profile** would be required:

WTE	Profession	Cost with high secure environmental allowance.
0.8	B5 Admin	£ 44,806
0.8	B5 Assistant Psychologist	£ 44,806
0.5	B7 Nurse	£ 36,984
1	B8A Applied Psychologist	£ 90,408
1	B8B Clinical Psychologist	£ 109,985
1	B8D Consultant Clinical Psychologist	£ 152,714
0.5	Consultant Forensic Psychiatrist	£ 129,228
	Total	**£608,931**

This resource profile is in line with other services of a similar nature. The seniority of roles reflects the specialist knowledge, expertise and experience required to offer support to other professionals and services. It also reflects the requirement for case discussions and risk assessments to be undertaken by those professionals who can autonomously assess risk and mental disorder as well as undertake structured professional judgement risk assessment tools.

Within the costs, we have assumed use of the State Hospital infrastructure (e.g. in terms of data storage, IT support, HR Support) as well as access to limited office space; although much of the work would be undertaken outside of the hospital grounds, it would be important for there to be a physical base.

Consequently, the staffing costs include the high secure environmental allowance, but not the clinical responsibility allowance.

We would suggest that the Consultant Clinical Psychologist and administrator be recruited first, as the lead for the service, followed by the Consultant Forensic Psychiatrist and the Band 7 nurse. This would allow development of the operating procedures and would also allow the advertisement of the service and training to begin early on whilst awareness of the other tiers builds.

Additional costs, related to CPD events, travel, accommodation, IT equipment and room hire:

	Yearly costs (excluding VAT)		Set up costs (Excluding VAT)
Travel	£5097	IT equipment (lap tops, iPad, 5 Mobile telephones)	£5530
Accommodation	£3600	Incidentals (e.g. stationery, risk assessment manuals, psychometrics).	£1500
Room hire	£6000		
CPD budget	£5000		
IT costs (line rental, remote access)	£2268		
Rio License (if required)	£1920		
Total	**£23,885**		**£7030**

The annual costs for the service in total is **£632,816** with initial funding of **£7030** required for the material and equipment.

Summary

Within the original request, the need to work with those services we generally admit from and discharge to was highlighted. The Rampton model incorporates multi-disciplinary outreach for women waiting for admission and leaving their service. Whilst this was not currently thought to be required in Scotland, this likely reflects several factors: the forensic estate is still to "recalibrate" now that there is a high secure women's service, we do not currently have a waiting list, and we are some time away from discharging patients to conditions of lower security. In addition, the service is an interim one with plans being made for a larger, established service.

We envisage that there may be a need for such a service in the future, but the extent and nature of that need will evolve as the inpatient service does and we move beyond an interim high secure service. The nature of this form of outreach would likely be very different as it will involve supporting women to move to and from inpatient settings of lesser security, and the skill mix required to ease such transitions will be different. We therefore propose that the composition of such a service is considered at a later date.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Objectives include development of an outreach service and support TSH and Scottish Government objectives.
Workforce Implications	Yet to be fully determined but expected to be managed by the Interim Women's Service team.
Financial Implications	Funding from Scottish Government is provided until March 2026.
Route to Women's Project Oversight Board Which groups were involved in contributing to the paper and recommendations.	Core Project Team meetings.
Risk Assessment (Outline any significant risks and associated mitigation)	Risks are yet to be fully determined.
Assessment of Impact on Stakeholder Experience	Once established the service should improve stakeholder experience. determined
Equality Impact Assessment	EQIA has been established for Phase 1 which includes the Outreach 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 establishment of this pilot should assist in reducing inequalities for service users.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ☐ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ✓ There are privacy implications, full DPIA included

Appendix 1: Background Information

Women who pose a risk to others in Scotland

2. Rates of female offending are lower than those of men, and women are less likely to commit violent offences. Comparatively, we know less about all aspects of offending by women (e.g. prevalence and drivers). However, women do engage in a range of types of offending that cause harm to others.

3. In terms of female offending, data from England and Wales is more detailed[18] than what exists in Scotland. There, 56% of female arrests were related to violence. 22% of offences related to violence against another is committed by women. 20% of men are imprisoned after conviction for this type of offence, whereas 7% of women are

4. Ministry of Justice (2025) figures report that approximately 7% of those subject to MAPPA are female[19]. Research indicates that in 2010, the re-offending of women within one year of being subject to MAPPA had slightly increased to 27%, bringing them in line with the reoffending rates of men (which had decreased)[20]. However, overall, female re-offenders have a higher rate of reoffending than male re-offenders[19].

5. Similarly to England and Wales[19], in Scotland, one in five violent crimes involve female offenders. One in six incidents of domestic abuse and approximately one in ten homicides involve a female accused[21]. 71% of offences related to "*cruelty and unnatural treatment of children*" were perpetrated by women. In addition, there has been some increase in the number of women receiving custodial sentences for non-sexual violent offences.

6. Over 2023/4, 4 women per 1000 of the population have been convicted of an offence (compared to 21 males) and 17% of all convictions in Scotland were committed by women[22]. The data used to inform the government's report allows for more detailed information to be extracted. Between 2023 and 2024, 10,983 women received criminal convictions compared to 52,503 men. Women were convicted of 19.62% of non-sexual crimes of violence (women:2,267, men: 9,286); 4.11% of sexual crimes were perpetrated by a woman (65, compared to 1518 male perpetrators), and 14.58% of fire-raising offences were committed by women (21 compared to 123 men).

7. In Scotland there are 8182 Registered Sex Offenders, 88 of whom are women. We do not have data about how many women overall are subject to MAPPA in Scotland.

---

[18] Ministry of Justice (2023) Accredited Official Statistics: Statistics on Women and the Criminal Justice System 2023; published 30.01.2026

[19] Ministry of Justice (2025) Multi-Agency Public Protection Arrangements (MAPPA) Annual Report 2024/5

[20] Bryant, S. Peck., Lovbakke, J. (2015) Reoffending Analysis of MAPPA Eligible Offenders; Ministry of Justice.

[21] The Scottish Government (2022) Women in the Justice System

[22] Scottish Government (2025) Criminal Proceedings in Scotland, 2023-2024

8. Importantly, the Criminal Proceedings in Scotland 2023-24 report highlights that the longer-term fall in convictions (over the last ten years), is driven by a reduction in convictions of men with minimal decline to the rates of conviction for women[23]. As has been observed elsewhere in the country, the gap between male and female reoffending has closed in recent years[24].

9. Since the Angiolini report in 2012[24], compared to the sentencing of men, Scottish Government policy highlights the role of diversion from custody and specialist women's justice services, as well as community-based sentences for female offenders and efforts to avoid imprisonment where possible.

10. When women do receive custodial sentences, the sentence tends to be shorter. When comparing females and males by the severity of the crime, males tend to receive a higher tariff[24]. For example, between 2010/1 and 2019/20, 46% of females convicted of homicide or culpable homicide received a life-sentence; compared to 66% of men[24]. Whether this latter statistic reflects a greater likelihood of women being convicted of culpable homicide than men is unclear from the data reviewed.

11. Scottish Government[25] has committed to "*support the justice system to work effectively with local partners to improve outcomes for people with mental health problems*". This Mental Health Strategy highlights that continuity of care is of importance due to points of transition being times of high risk in terms of mental health.

12. The Scottish Government's Justice Strategy highlights a requirement to ensure that women (and children) are "*better serviced by our approaches to justice*". The strategy also highlights the need for "*a person-centred approach to rehabilitation where people are supported in the most appropriate and effective setting*"[26]. Any interventions should be trauma informed[27,27], and that includes our shared understanding of risk and risk management.

13. In recent years, there has been a move towards considering how we ensure that there is equal access to expertise across the country rather than it being predominantly located in the Central Belt within specific geographical locations. In terms of health, there are established precedents of services based in one part of the country which offer services at a national level; particularly in relation to highly specialist services where needs may seem too infrequent to warrant local services throughout the country.

[23] The Scottish Government (2022) Women in the Justice System
[24] Angiolini, E. (2012) Commission on Women Offenders: Final Report; Edinburgh: Scottish Government
[25] The Scottish Government (2017) Mental Health Strategy: 2017-2027
[26] The Scottish Government (2022) The Vision for Justice in Scotland
[27] NHS Education for Scotland: National Trauma Transformation Programme

14. In terms of forensic issues, IVY (Interventions for Vulnerable Youth) exists, and it is our understanding that a model whereby F-CAMHS (Forensic Child and Adolescent Mental Health Services) expertise based in NHS Greater Glasgow and Clyde will be shared across Scotland. The Forensic Network, and its role in service and contingency planning, referral guidance to each level of security and conflict resolution as well as education, is another example of a national resource that influences practice and service delivery across the country.

2. Needs of female offenders
    1. Multiple papers have highlighted the need to recognise the role of trauma and mental health in female offending and in sentencing practices.
    2. Professionals in MAPPA (Multi-Agency Public Protection Arrangements) and the Police have highlighted that female offenders in the community frequently present with mental health conditions which do not meet the criteria for NHS services but nonetheless present challenges for both the individual and those working with them to manage risk.[28]
    3. The SPS (Scottish Prison Service) Strategy for Women in Custody[29] highlights the broad needs of women in Scottish custodial settings. Almost all are considered to have problems with their mental health, and 58% have engaged in self-harm. There are high levels of cognitive impairment; 78% have had a significant head injury and 51% have possible learning difficulties or intellectual disability. Eighty-three percent have a history of childhood trauma and 92% have a history of adult trauma. Difficulties they have are exacerbated by substance use, poverty, unstable accommodation and ongoing victimisation. The strategy highlights the need for SPS to have "*the right people with the right skills and knowledge at the right time and that they are supported through reflection and supervision*".
    4. In 2019, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) [30] recommended that alternatives were required for those women who had personality or behavioural disorders and were not eligible for transfer to hospital. In their view, a multifaceted approach which included the recruitment of clinical psychologists to design programmes for persons with behavioural disorders was required. The National Preventative Mechanism (NPM) shared the CPT's concerns[31]. In their responses, the UK government referred to initiatives such as trauma informed practice and highlighted that any intervention for those in SRU due to mental health difficulties is the responsibility of NHS rather than SPS to address[32].and mental health teams in the prison have continued to develop, broadly following community-based models in terms of service structure, though there have been calls for this to be reconsidered[33].

---

[28] Darling et al. (2023) Learning for the Police from Multi Agency Public Protection Arrangements (MAPPA) Serious Case Reviews; National Police Chief's Council: Vulnerability Knowledge and Practice Programme.
[29] Scottish Prison Service (2021) Strategy for Women in Custody: 2021-2025
[30] Report to the UK Government by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, October 2018
[31] Statement from NPM on Committee for the Prevention of Torture's report on Scotland.
[32] Response of the UK Government to the report of the European Committee for the Prevention or Torture and Inhuman or Degrading Treatment or Punishment, October 2019
[33] Gilling-McIntosh, L et al. (2022) Understanding the Mental Health Needs of Scotland's Prison Population

5. In 2021, the Commission followed up on the CPT concerns about women who were mentally unwell in Cornton Vale prison. Their findings raised specific areas of concern, including the use of segregation for women who were mentally unwell and unacceptable delays in transferring individual women who were acutely mentally ill to hospital care[34].

6. There has been concern about the availability of mental health support in prisons generally[35]. SRU (Segregation and Reintegration Unit) staff report that they felt ill-equipped to manage severely mentally unwell prisoners, within this group they include those with a greater range of mental health difficulties than those which would lead to hospital admission. Eighty-nine percent of SPS staff stated that they would like more training in mental health.

7. SRU staff reported that the complex issues and needs of segregated prisoners were often labelled as "*behavioural*" (as opposed to a "*mental illness*") by either the mental health teams or external psychiatric services, resulting in limited mental health interventions being available to them, and no access to a bed in a secure mental health facility[35].

8. We know that people in prison experience a higher rate of complex mental health and behavioural difficulties compared to people in the community. Overall, in Scotland, "*women in prison have a greater mental health burden compared to men*": female prisoners have high rates of long-term mental health conditions, history of self-harm, alcohol use disorder, anxiety and depression; with the prevalence rates in the remand population being slightly higher than in the convicted population[36].Women offenders do not necessarily have the same diagnoses as men prison (e.g. schizophrenia is more common in male prisoners and affective disorders are more common in female prisoners) [37].Their difficulties will be present in community as well as custodial settings.

9. Whilst there are multi-disciplinary mental health teams in prisons, there continue to be challenges in recruiting to them[35] which have been exacerbated by the impact of the pandemic[37]. In addition, the NHS staffing resources do not appear to be closely linked to the size and characteristics of individual prisons and members of the mental health team can be pulled away to support other parts of healthcare delivery[37]. Cumulatively, such difficulties would likely impact upon consistency of care and relationships with SPS colleagues.

10. Throughout the documents reviewed, consistent recommendations for training in relation to mental health generally and further training for those working in SRUs have been made[37,38] and that a model of care with the needs of those in custody at its centre is developed.

---

[34] MWC: Mental health support in Scotland's prisons 2021: under-served and under-resourced; themed visit report, April 2022
[35] HMIPS (2023) A Thematic Review of Segregation in Scottish Prisons
[36] Gilling-McIntosh, L et al. (2022) Understanding the Mental Health Needs of Scotland's Prison Population
[37] HMIPS (2023) A Thematic Review of Segregation in Scottish Prisons
[38] Gilling-McIntosh, L et al. (2022) Understanding the Mental Health Needs of Scotland's Prison Population

11. In terms of the Scottish Prison Service, although women are held in five prisons, the Segregation and Reintegration Units for women are in HMYOI Stirling and HMPYOI Grampian. Complex case discussions that focus on mental health / trauma are available from the mental health team in HMYOI Stirling if a person appears to meet their referral criteria. However, it seems that there can be differing views about the appropriateness of some women's placement (i.e. hospital vs prison) and a consequent misalignment in the expectations from such discussions; this, and the limited extent to which the whole SRU team can attend these discussions or access follow-ups can act as barriers to recommendations being put into practice.

12. In terms of forensic mental health provision, it has been highlighted that the needs of female patients in secure services tend to be characterised by different and more complex presentations than men. In addition, there is variability in the provision for women requiring secure psychiatric care, and in those areas where there is less forensic provision generally, women are cared for in services that are meeting a mixed range of needs. The review also highlights the necessity of a workforce who have expertise and experience in working with this patient group[39].

13. The subsequent Barron report[40] identified the need for coordinated forensic mental healthcare for women. It highlighted that women may be disproportionately affected by the ambiguities around the remit of FMH (Forensic Mental Health) services.

14. Until the interim women's high secure service at the State Hospital opened in July 2025, those female FMH patients considered to pose the greatest risk of harm to others could only be cared for either in medium secure services or secure units in England and Wales.

15. The Barron report also highlighted that the care needs of the group of women "*who may not meet the definition of 'forensic', but who are subject to conditions of security as their behaviour has not been able to be safely managed by generic services*" should be considered and that there is a need for more coordinated or strategic approaches to sharing forensic expertise with partners.

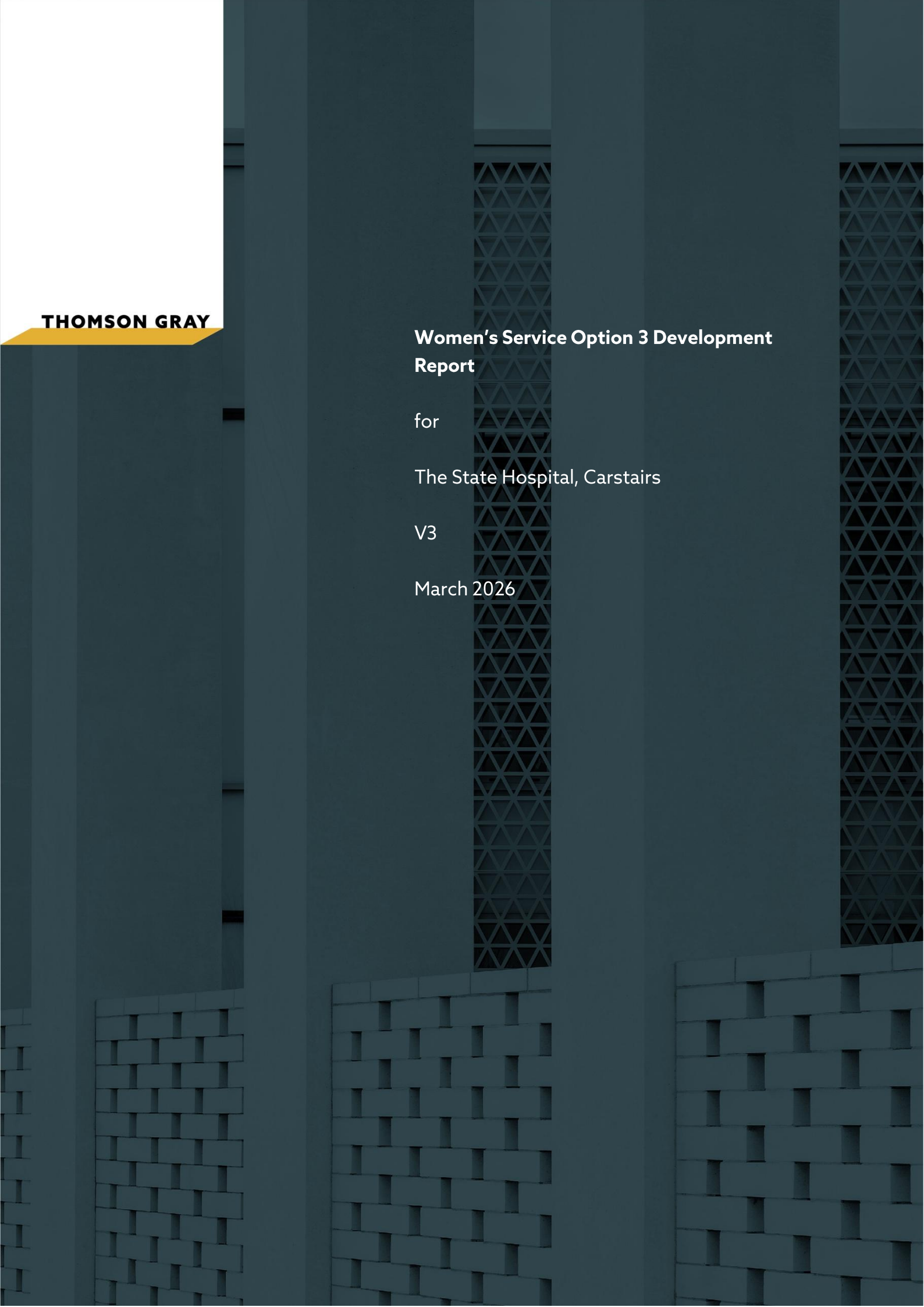
16. Whilst the Forensic Network, and particularly the Women's Forensic Services Planning Group, is focused on developing the forensic mental health services available for women, it is recognised that there is a significant level of mental health need in this population that is of a nature that would not meet the criteria for inpatient treatment or the majority of community forensic mental health teams.

17. Finally, multiple reviews[41][42] have highlighted the need for the use of appropriate risk assessment tools as well as co-ordinated multi-agency risk management practices for those who pose a risk of serious harm to others. Psychological and clinical expertise are central to such assessments and the absence of understanding of mental disorder has been highlighted. The RMA (Risk Management Authority) guidance[43] is that we should use a structured professional judgement approach to risk using appropriate

---

[39] The Forensic Network (2019) Women's Service and Pathways across the Forensic Mental Health Estate.
[40] The Scottish Government (2021) Independent review into the delivery of forensic mental health services: what we think should happen.
[41] The Southport Inquiry Report, 13.04.2026
[42] Inquests Arising from the Deaths in the Fishmongers' Hall Terror Attack; Regulation 28 Report on Action to Prevent Future Deaths
[43] RMA (2018) Standards and Guidelines: Risk Assessment Report Writing; RMA Scotland

tools as well as a formulation-based approach to the assessment and management of those who pose a high risk of harm to others. However, we are lacking female-specific risk assessment tools.



THOMSON GRAY

Women's Service Option 3 Development Report

for

The State Hospital, Carstairs

V3

March 2026

CONTENTS

1.0 Introduction

Following the Feasibility Study produced in 2025, Thomson Gray have been appointed by The State Hospital (TSH) to further develop Option 3 (new facility on location of the management centre) to support an enhanced clinical model for a larger patient population.

There is currently no provision for high secure forensic mental health care and treatment for women in Scotland. Female patients are currently treated at the National High Secure Healthcare Service at Rampton Hospital, Nottinghamshire. 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) which states 'During the lifespan of this Delivery Plan, develop a plan with stakeholders to deliver services in Scotland for women who need high secure care and treatment in the short and longer-term'. The stakeholders involved in the development of this plan are Scottish Government Ministers, Mental Health Directorate, NHS Chief Executives and the Forensic Network for Scotland.

TSH intend to operate a Women's Service within the perimeter grounds of the existing site.

Further guidance from NHS Assure identified the need to ensure that any new development provided sufficient capacity for changing patient demands. A review was carried out of potential patient numbers based on previous and current referrals for high secure care which highlighted that a six bedded unit would not meet current demand and that a twelve bedded service would provide sufficient capacity for forensic patients in Scotland. The modelling exercise was based on current Out of Area patients (five) and patients admitted to the Interim Service (three) since opening in July 2025. Due to the complex nature of managing women in High Secure care some of whom require to be nursed separately from others, the TSH Board supported the proposal to increase the bed numbers for the service from six to twelve.

HLIP Option 3 selected by TSH in 2025:

- **Option 3** - Leave the extant building in place (Harris), retain its current functions and develop a new building utilising existing ground within TSH (or potentially extending part of the existing high secure perimeter to accommodate new build).

Refreshed Option 3 February 2026:

- **Option 3** - To demolish the Management Centre and re-use the space for a new build Female Service. Any displaced services currently within the space to be re-provided in a new facility either within or out with the High Secure Perimeter.

This report seeks to determine the space required to support a larger clinical model and if this size of building can be located within the previously selected Option 3 – demolished Management Centre area.

2.0 Guidance Documents

Relevant SHTM's / HTM's, Building Standards and best practice were considered during development of Option 3. The existing Feasibility Study has been retained to support the development of Option 3 along with current learning from the Interim Women's Service. A full list of guidance documents and information can be found at Appendix A.

3.0 Clinical Requirements

3.1 Women Service Priority

TSH wish to provide a fully inclusive women's service where female patients can be nursed separately from male patients. The service will accommodate 12 No. bedrooms, flexible and multi-use therapy / day rooms as well as separate admission rooms and seclusion suites. The service will also benefit from a Surgery (enhanced treatment space) for the mental and physical care of patients. Staff areas are included to ensure that there are adequate areas for interview, consultation, administration and general staff wellbeing. Dedicated external areas are required to provide secure and segregated space for patients, in addition to the potential introduction of mixed ground access where appropriate.

3.2 Clinical Requirement

Through extensive stakeholder engagement the Schedule of Accommodation (SoA) was further developed to support the larger patient model of 12 bedrooms and requirements of the service. The SoA was developed through a series of workshops covering the following:

- Patient / staff daily routines
- Lessons Learnt from the current Interim Women's Service
- Patient care models

TSH is a specialist environment and requires enhancement to the standard SHTM guidance in order to accommodate higher staff to patient ratios in areas such as Patient Bedrooms, Day Spaces and the Surgery (Enhanced Treatment Rooms). Room adjacencies are also critical to overall service delivery and the daily flows for staff and patients.

4.0 Option C Development

4.1 Schedule of Accommodation

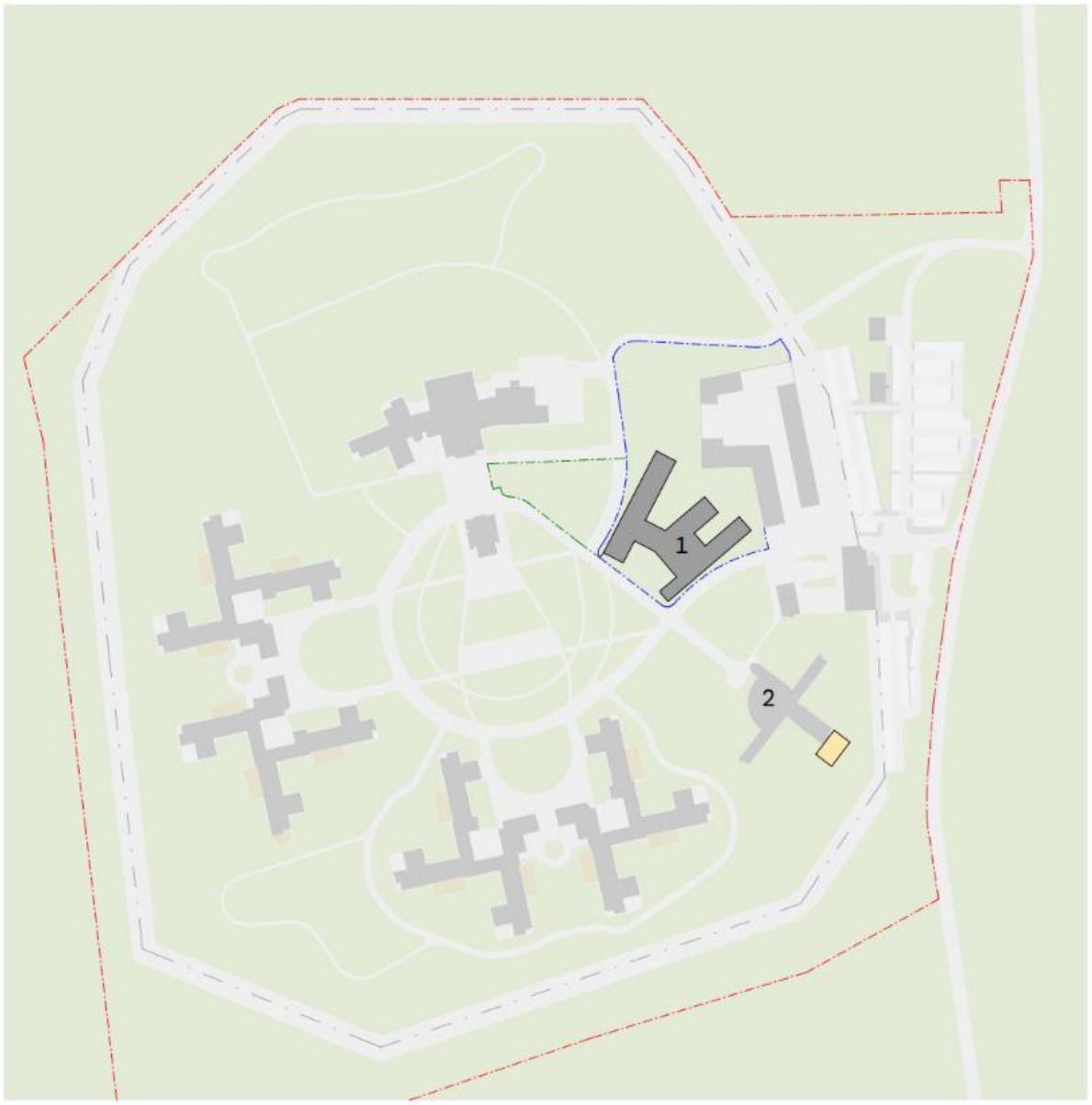
The increase from the original 6 to 12 bedrooms has resulted in an increase in area from 1,534.61m2 to 2,897.15m2 (increase of 89%).

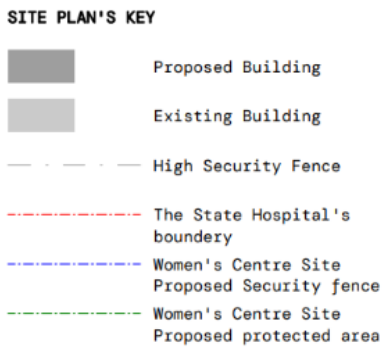
Main areas / spaces of change are listed below :

- Increased number of bedrooms (6 to 12)
- New central open 'Living Space'
- New larger, flexible Day Room Spaces
- New larger, flexible Interview Room Spaces

The Service requires highly flexible space, to be able to cater for changing behavioral demands and accommodate the therapeutic model anticipated to support productive patient pathways. This has shaped the revised SoA with the introduction of the new central Living Space, and adjacent flexible Day and Interview spaces. This allows for patient disassociation where required, options for the use of space for different therapeutic care and quieter spaces to be included as part of future design stages.

4.2 Site Location Plan – External areas





The proposed site boundary follows the surrounding internal roads and is constrained by the Contingency Road to the top of the site. The increased building footprint maximises the available land but reduces the privacy line between the Men's and Women's Services.

The green line is a 'protected' area of ground within the existing site to support and enhance the privacy between the Men's and Women's Services. A fence with privacy mesh is proposed to help with the segregation of services. The protected area means that the existing road and pathways, with associated infrastructure, can remain unchanged. The introduction of the protected area could help with the layout and orientation of departments and bedrooms, along with the protection of external views into these spaces.

The remaining grounds surrounding the building are limited for use by patients and constrained by surrounding buildings. The land towards the Contingency Road rises sharply further limiting use for patients.

This space is further constrained by the requirement for access to be maintained to the envelope of both the new building and existing Essential Services building for future Planned Preventative Maintenance.

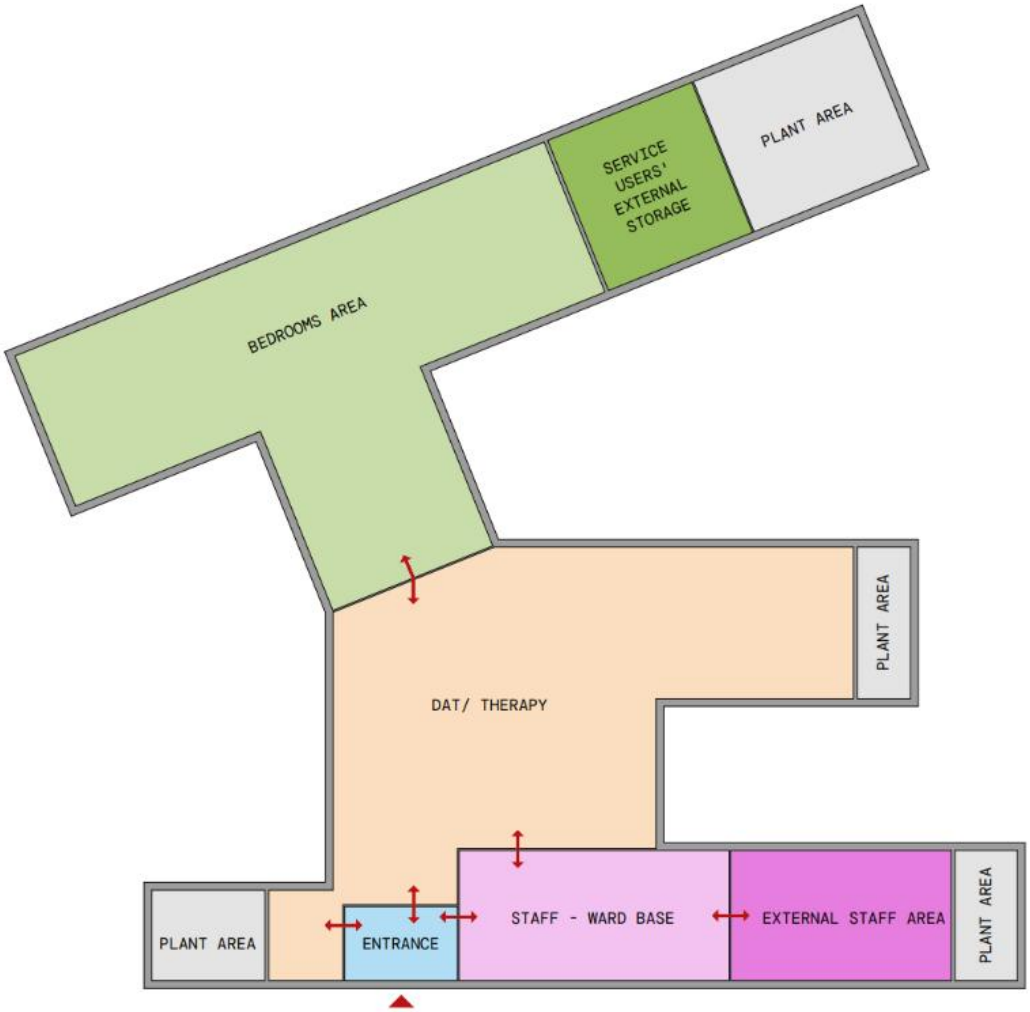
4.3 Site Location Plan – block diagram

The site plan shows the location and orientation of a single storey building and limits the adaptation of any of the existing roads, pathways or associated CCTV camera infrastructure.

A number of observations have been raised by Stakeholders in relation to the orientation of the building and departments located within for consideration at the next stage of design :

- Entrance to the Service should not be located close to the main secure entrance to the site
- Position of bedrooms towards the Skye Centre offers little privacy for the Women's Service
- Position of the building provides little opportunity for 'long perspective' views that are enjoyed by the Men's Service.

4.4 Departmental Adjacencies and Flow



The block plan outlines a possible shape for the Women's Service building, with all departments on a single ground floor level, indicating a 'worse case scenario' for the footprint. The shape is dictated by the available land and without causing major disruption to existing roads, pathways and associated infrastructure. Departmental adjacencies are indicated following discussion with Stakeholder.

Given the 'standalone' nature of the Women's Service, space has been allowed for any secure air-lock requirements between internal and external spaces as discussed with Stakeholders.

The bedroom area is designed to allow all rooms to be kept in close proximity for staff observation purposes however consideration should be given to shaping this area to introduce 2 wards to help with patient disassociation.

The Day / Therapy rooms are kept together and away from the bedroom areas to reduce noise transfer and protect flow for day / evening use.

An Admission Room continues to be proposed to remain located close to the secure entrance for initial patient assessment, acknowledging that a patient may not wish to return to this room.

Staff offices, administration and welfare areas are separated from the Day / Therapy areas, however located close by to allow for ease of access to patient spaces, and to monitor the pedestrian travel / visitors through the main entrance.

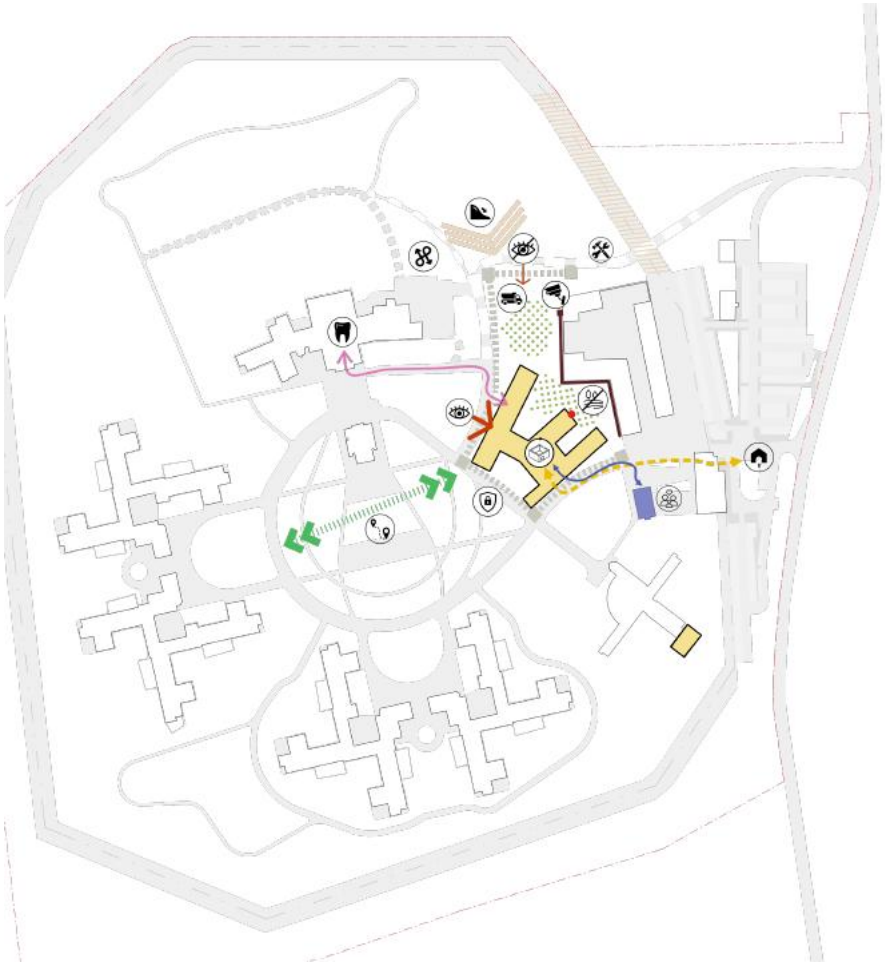
Several plant rooms are located throughout the building for ease of service distribution; an IT room would be located close to the secure entrance to reduce the need for IT staff to enter patient areas.

4.5 Future Design Considerations

There is an opportunity for a 2 storey building to provide more external space for patients, similar to the current Male Wards. The following accommodation could be located on the first floor subject to stakeholder agreement:

- External Staff Area / Offices
- Service Users External Storage
- A plant room space

4.6 Strengths & Weaknesses



The site location and new building size were assessed against the strengths and constraints detailed below :

- **Location to services** - proximity to services that the patient group would require access to
- **General location** - location of the new service on the site and proximity to existing men's service, site entrance, etc.
- **Privacy** – separation from the men's service, surrounding buildings and any external influences such as members of the public, media, etc.
- **Construction** - considerations for building the new facility
- **Building** - building design and considerations
- **Cost** - outline cost for provision of a new female service
- **Utilities** – impact on providing mechanical and electrical services
- **Timeline** - consideration of movement / decants required
- **Operational** - clinical considerations for the provision of the service
- **Security** - considerations both in infrastructure, CCTV and segregation of services

Further considerations for the larger service are noted below:

The new building is close to the secure entrance for ease of patient transfer without crossing the grounds. Consideration will need to be given to the location of the entrance to the Women's Service building to mitigate against patient interaction for those with general grounds access.

The larger building footprint means there are limited grounds available for patients around the building, exacerbated with further reduced long range views or nature aspects.

Ensuring the privacy of the Women's Service building and associated grounds may require the introduction of a 'protected' area, potentially increasing fencing to the inner site boundary and changing Men's Service walking routes without disrupting associated roads or infrastructure.

Working space within the segregated construction site may be constrained by the larger building footprint impacting on vehicular movement, working / lay down spaces and areas for welfare.

5.0 Site Utilities

An existing power load assessment has been undertaken for the 12-bed option with the incoming supply having sufficient capacity (at present) to accommodate the 12-bed option.

TSH has a site wide standby generator in the event of mains power loss. At present the effective output of the generator is set at 534kVa. The new projected peak demand would be 570kVa, over the threshold of the current generator, therefore a new generator is required to support the new, larger building with a model that can provide an effective output of 750kVa (say 1MVA genset).

It is anticipated that the peak heat load would rise from 1.511kWth to circa 1,727kWth to accommodate the new building. This remains within the capacity of the existing plant capacity; however new utility connections will be required to serve the new Women's Service.

As the design develops, regular assessment of all demands on existing infrastructure and utilities should be undertaken to ensure that no changes to supply are required.

6.0 Programme

A high-level programme has been produced as part of the Feasibility Study to help inform the Business Case Stage, TSH governance and Scottish Government approvals. The key milestones are noted below:

Stage	Dates	Duration
Option 3 Development	January 2026 – March 2026	3 months
Initial Agreement	March 2026 – May 2027	14 months
Outline Business Case	May 2027 – December 2027	7 months
Full Business Case	January 2028 – August 2028	8 months
Construction	August 2028 – January 2031	28 months

The programme dates assume each Business Case stage progresses at pace with short governance approval and achieving NHS Assure Key Stage Assurance Review (KSAR) supported status at each stage. The timescales for the construction period are estimated against experience of similar sized projects within secure environments, with contingency allowed for items such as weather and security events.

7.0 Cost Estimate

An Option 3 Development Cost Estimate (Appendix F) of £32.1m + VAT has been prepared based on m2 rates benchmarked against recently tendered projects with uplifts for the secure environment, construction complexities and inflation. The anticipated period of construction is between 2028 – 2030.

8.0 Lead Advisor Opinion

A larger building footprint to accommodate a 12-bed Women's Service and associated spaces is possible on the location of the existing Management Centre, however some constraints have been identified.

The building location remains close to the secure entrance, Family Centre and the Skye Centre with transportation between these areas requiring minimal movement of female patients through male patient areas, however consideration needs to be given to orientating the building entrance away from the secure entrance to the site.

The new building will enable all the required services to be provided without compromise or derogation (to be assessed during the design stage) and allow for greater energy efficiency and sustainability measures to be implemented. The building design and location presents an opportunity for some natural segregation between male and female patients.

The grounds and external areas are limited by the increased building footprint which may impact on patient enjoyment of external spaces.

Patient privacy becomes an issue as the building size starts to closely follow the surrounding roads. A proposed mitigation would be the introduction of a 'protected' area, however this may mean the introduction of fencing into the central site area, impacting on the open aesthetic of the site. Design development of the building to explore a multi-storey building may mitigate this requirement and should be explored further.

There is no change to the proposal for site segregation from the previous Feasibility Study and access via the Contingency Gate, however the segregation line may need to be increased to allow for working space around the larger build during construction and would impact on the wider site.

The relocation of the existing Management Centre to a new building within the site remains part of the proposal to support the new Service.

The preferred option needs to be developed in greater detail during the IA and following design stages.

Appendix A – Guidance, Documents and Reports

Appendix B – Oberlander Architects Drawings

Appendix C – Hulley & Kirkwood Report

Appendix D – Programme

Appendix E – Schedule of Accommodation

Appendix F – Cost Estimate

Strategic Assessment

1. **Please provide the email address of at least one individual as the lead contact person for this proposal: (Senior Manager / Director)**

   Programme Director: david.walker2@nhs.scot

2. **What is the Proposal Scope? (15 words or less)**

   Implement a National High Secure Forensic Mental Healthcare inpatient service for Women at The State Hospital (TSH).

3. **To what extent is the core driver for this proposal aligned to the focus areas below?** (Provide a score which totals 10 across all three drivers, where 0 is not at all relevant, and 10 is the sole focus of the investment)

   Driver: Improve Infrastructure and/or service resilience
   2
   Driver: Service modernisation and/or renewal
   6
   Driver: Create additional capacity
   2

4. **Describe the strategic planning content behind this proposal, giving details of how it is aligned with the Scottish Government's Health and Social Care Service Renewal Framework 2025-2035 and Scotland's Population Health Framework 2025-2035. Reference to local strategy or policy may also be made.** *(250 words)*

   Prior to the introduction of medium secure provision for women in 2000, TSH was the sole provider of high secure services for women in Scotland. Subsequent low demand (0-4 patients over 10 years) led to the creation of a referral route to the sole UK provider of high secure services for women at Rampton Hospital, England.

   In 2019 the Forensic Network published its report on best options for high secure women, which concluded the best option for was a co-located unit with high and medium secure services on the NHS Lothian Royal Edinburgh site. However, following the COVID pandemic and the 2021 '*The Independent Review into the Delivery of Forensic Mental Health Services in Scotland*' recommendation that a dedicated female high secure service should be developed at TSH, the site was redesignated.

   In November 2023, the *Mental Health and Wellbeing Delivery Plan 2023–25* (Priority 8.1.2) committed to developing, with stakeholders, a short and long term plan for delivering high secure services for women within Scotland.

   In November 2024, on instruction from the Lord Advocate and Minister for Mental Health and Wellbeing, TSH was required to establish an Interim Service to ensure compliance with the Equality Act 2010. The Interim Service went live in July 2025 with capacity for six beds. While it supports NHS Scotland's 'Right Care, Right Place' approach, it has recognised clinical limitations that will only be addressed through the development of an equitable high secure women's service. This service was designated a ministerial priority with an estimated delivery timescale of around 36 months.
   (257)

5. **Describe the current service arrangements and then detail how the proposed service arrangements will differ.** (250 words e.g. **what** services and settings, **how** services are accessed, delivered and distributed).

In January 2025, Scottish Government revenue and capital funding enabled the development of the Interim High Secure Service for Women at TSH. Adapting an existing ward, this six-bedded service opened in July 2025 and has recognised clinical limitations due to space, layout and staffing. The service is co-located with two male high secure wards and key therapeutic areas including the gym, therapeutic kitchen and multifunction room are shared. This arrangement restricts access, impacts staffing flexibility and affects the overall therapeutic environment for all patients. The current layout also limits the ability to meet the needs of women at different stages of recovery and managing mixed-gender proximity requires additional risk management and increased wellbeing support for staff. While operational, the interim model is not a sustainable long term solution for providing safe and equitable access to therapeutic care for women.

The proposed service is a purpose built unit for female patients, designed to meet identified national demand. It will include twelve bedrooms, dedicated day spaces, dining areas and seclusion suites, enabling clinicians to better manage complex interpersonal dynamics without compromising care quality. Therapeutic spaces will be located within the service, allowing patients to access them without requiring additional staffing resources or reliance on shared facilities. The design ensures that women can be cared for separately from male patients where appropriate, while achieving parity of access to therapeutic, clinical and recovery focused interventions available elsewhere in the national high secure estate. This model supports a safer, more consistent, equitable and resilient recovery oriented service for women requiring high secure care.
(259)

6. **Describe the anticipated impact of the proposed service model if implemented.** (what opportunity for improvement is there to service performance and outcomes to the current arrangements? *(250 words)*

The proposed service will be able to provide a fully equitable range of therapeutic activities for women who require High Secure care and treatment. The model will be based upon the therapeutic journey from Admission and Assessment, Treatment and Recovery and finally Transitions, with the aim to move patients on to lower levels of security. The service will provide beds for patients with Mental Illness and Intellectual Disabilities and will be designed to maximise opportunities for recovery. It should be noted that rates of trauma, personality disorder and complex needs are significant in female forensic patients.

The proposed service will provide therapeutic spaces and facilities for the exclusive use of female patients. This will be of significant benefit for staff experience and patients who may be traumatised in a mixed-gender environment. It will improve peer and social relationships and group psychological interventions can be configured for those at similar stages of recovery.

The build itself will maximise light, space and therapeutic opportunities which have been shown to improve mental health outcomes. It will allow all Scottish women who require high secure care to be cared for within one service and assist with patient flow within Medium and Low secure settings.

The service will maximise modern digital opportunities to support patients' pathways and will include appropriately secure internet access, shopping and entertainment. Patients will also benefit from video visiting with family and carers. By accessing digital services, patients will not experience digital

deprivation typical with traditional high secure facilities and will keep them current with the digital advancements.
(257)

7. **Provide quantitative data on volume / throughput for current state service arrangements and proposed service arrangements.**

Metric	Current	Current Year	Projection	Projected Year
Patients currently Out Of Area (OOA)	5	2025/6	Zero	2032/33
High Secure Services for Women: Annual Costs: OOA Patients (5 patients): + Interim Service (6 beds)	 £2.2m + £5.2m = £7.4m	 2025/6	TSH:12 Bedded Service: £7.3m (estimated resource profile)	 2032/33
Current TSH Beds in use -v- capacity	4 out of 6	2025/6	9 out of 12 beds in use	2032/33

8. **Describe the patient / user / item profile for the current state and identify whether this will likely change as part of this proposal or remain consistent**. (250 words)

Currently, TSH Interim service has four patients, two of which have been admitted from Medium Secure Forensic Services and two from the Scottish Prison Service. None of these patients are likely to be admitted to levels of lower security in the medium to short term and two of these patients have long histories of inpatient secure stays and require intensive nursing.

There are currently five patients in Out of Area (OOA) placements, four patients are placed within the High Secure Services at Rampton and a further patient placed within a specialist private care provider in Wales. The Interim Service does not currently have capacity to be able to repatriate all of these patients, and this would require careful consideration as it may adversely impact on a patient's clinical recovery and create future capacity issues.

Research informs that Women requiring high secure care have difficulties which begin in childhood or adolescence and may stem from traumatic experiences. For these patients' mental health recovery takes time, consistency and multifaceted treatment including intensive nursing support, medications, psychological interventions and rehabilitation. Patient stays are likely to be lengthy and turnover slow, therefore it is important there is adequate service capacity. Annual census data shows in recent years that the number of women requiring high secure care has increased. Currently a total of nine patients (5-OOA and 4-Interim Service) require such care and demand is likely to remain constant for the foreseeable future. Given the likely prolonged length of stay, any further cases will add to this identified need.
(254)

8b. Record the name here of any supporting data file submitted to evidence this:

Note: There is no data file available; data collated from emails from NSS and medium secure providers.

9. Where relevant, provide quantitative data on waiting time and volumes for those potentially affected, for current and proposed arrangements.

Metric	Current	Current Year	Projection	Projected Year
Average waiting time between referral and admission to an OOA Care provider.	37 weeks	2021-24	6 weeks	2025 onwards
Travelling Distance in miles (m) for OOA families and carers. (using Stirling as a starting point).	To Wales – 760m round trip. To Rampton – 560m round trip	2025-6	Stirling to TSH – 76m round trip	2032/3

9b. or indicate the file name here if data is included, which shows this:

09b - Referral Timescales 290426.xls

10. Optional: Provide additional quantitative data relevant to supporting this proposal's case for change. Appropriate metrics will vary by proposal. (Indicate date range and scope or N/A where not applicable).

Metric	Current	Current Year	Projection	Projected Year
Number of Patients where Scottish High Secure Criteria met and did not meet referral criteria for Rampton Hospital	4	2018-2022	0	2032/3
Number of Patients where Scottish High Secure criteria met and declined by Rampton	10	2014-2025	0	2032/3
Number of Medium Secure beds for Women in Scotland	8 – NHS GG&C: reduced from 10 due to clinical acuity pressures) 3 - NHS Lothian	2018 -2025	10 – NHS GG&C: (capacity increased by 2 since opening of Interim Service) 3 - NHS Lothian	2026/7

Daytime Confinement: Number of hours patients require to spend in room (see Section 14)	3 months prior to Interim Service opening: 1536 hours 3 months post Interim Service opening. 6543 hours	2025	0	2032/3

10b. **Record the name here of any supporting data files submitted to evidence these metrics:**
Note: There is no data file available; data collated from emails from Clinicians across services.

11. Optional: Describe a maximum of 2 further relevant metrics for current and proposed service arrangements where appropriate. (indicate date range and scope – *max 250 words*)

There is complexity in comparing the Interim Service and other service models such as Rampton High Secure Service which caters for a wide range of clinical diagnoses. It is however important to highlight the 'Value for Money' and 'Therapeutic Environment' aspects of the Interim Service and OOA patients against this proposal.

Since opening, the Interim Service has faced challenges in managing patients with high degrees of clinical acuity. Following the admission of the second and third patients in late 2025, the resource allocation for the service was well above the budgeted establishment and annual costs have risen from £3.1m (initial allocation) to £5.2m. The current annual cost for OOA patients is £2.2m. A new modern and efficient twelve bed service has an indicative resource profile of £7.3m. Whilst costs comparisons are broadly similar, future costs and resilience for OOA patients are out with Scotland's control. The overall OOA 'value for money' must also include the current inequitable service provided to patients and their families.

The therapeutic environment of the Interim Service as highlighted in previous sections is suboptimal. The average length of stay for women in high secure care in England is five years therefore an environment that enables female patients to feel safe and engage in their treatment and therapeutic journey is vital. It also supports staff wellbeing, who have a higher risk of 'burn out' compared to those working within the male service. This proposal will be designed to maximise therapeutic space and support individualised equitable care plans thereby making best use of space available to support patients.
(261)

11b **and indicate the file names here if further data included which shows this:**
Please refer to Table within Question 7 – costs obtained from National Services Division.

12. Describe current infrastructure arrangements for providing these services and how proposed infrastructure arrangements will be different *(250 words)*

The Interim Service became operational in July 2025 and provides six bedrooms, including three low stimulus rooms (LSRs) for patients requiring enhanced care. The need to use LSRs for longer term care reduces overall bed availability. Therapeutic facilities such as the gym, kitchen and multifunction room are located off the ward and shared, requiring additional staffing to facilitate access.

Current infrastructure challenges include:

- LSRs are too small for longer term management and do not accommodate the increased staffing

levels needed for managing patients who pose a threat of violence or aggression.
- Only one communal area is available, making it impossible to safely manage patients who require disassociation; this extends to limited dining space.
- Patients unable to attend the main activity centre for clinical reasons cannot access equivalent therapeutic activities, resulting in inequitable care.
- Higher than planned staffing ratios are required due to limited space in bedrooms and communal areas, which constrains therapeutic engagement.
- The environment does not fit with the expectations of managing female patients such as key therapeutic and biophilic interventions.
- Noise levels can become extremely high, and distress in one patient can significantly disrupt therapeutic work for others.

The proposed infrastructure will provide twelve bedrooms and dedicated therapeutic spaces within the unit, ensuring that complex clinical needs can be met safely, are equitable and provide best value. Additional day rooms and dining rooms will allow patients requiring separation to be supported appropriately. Locating therapeutic spaces inside the ward will improve accessibility for high risk patients and optimise staffing resource currently needed to support off ward activities.
(255)

13. Describe current infrastructure issues or challenges with the physical estate and how this is affecting service performance and/or patient safety/dignity *(250 words)*

The identified needs of women requiring High Secure Care cannot be fully met within the existing ward environment which can only be marginally improved. Patients currently require protracted periods of enhanced care within LSRs. As each ward was originally designed with only one LSR, two additional bedrooms have since been converted. These refurbished rooms are suboptimal: they are too small to safely accommodate the number of staff required during interventions and lack the space and layout to safely deliver therapeutic activities for patients unable to use communal areas.

The interim interior design is not tailored toward female patients who require psychologically supportive environments that are trauma informed and biophilic in design. Many spaces are small, and natural light is limited particularly in the newly created LSRs. Female patients also face restrictions in accessing the Health Centre and other therapeutic spaces without encountering male patients, which may cause fear or distress for individuals with trauma histories. The absence of a dedicated treatment room within the ward adds further inequitable risk and discomfort, particularly when physical health care requires intimate examinations or procedures.

Externally, the service offers only a small single garden area, whereas male patients with grounds access can use wider unescorted outdoor spaces at designated times. Female patients must be escorted at all times, which affects dignity, therapeutic opportunity and parity of experience. These combined limitations significantly impact service performance, restrict therapeutic progress and present avoidable risks to patient safety and wellbeing. The potential for increased lengths of stay could create capacity issues across the forensic estate requiring further use of OOA placements.
(259)

14. Provide quantitative data on the state of the existing infrastructure and the potential for improvement e.g. with reference to a SAMS data report which can be referenced in the next question. Summarise the highlights / comment here. *(250 words)*

Whilst the SAMS data for Mull 3 (Interim Service) indicates that the building, built in 2011, last surveyed in May 2022 is in a good state of repair, this does not reflect the fact that the building was designed around the needs of male patients.

The current infrastructure challenges outlined in Sections twelve and thirteen results in a sub optimal level of care being provided for patients and requires additional staffing to be drawn from the male service. The funded establishment of ten staff per day required to safely operate has increased to twenty-seven per day. The impact of this has seen a significant rise in daytime confinement (DTC) for male patients where due to resourcing shortages, patients are required to spend time within their rooms. (Table 10 – DTC).

The needs of women at different stages of recovery requires careful clinical risk management and a therapeutic environment designed to support recovery and the wellbeing of staff and patients. This proposal will maximise biophilic design ensuring that internally and externally components such as space, acoustics, quality of light and views of nature amongst others are all incorporated.

In considering the future design and layout of this proposal, through feedback from staff and patients there are a number of lessons learned on the current design of the ward and clinical areas within TSH as well as further learning from recently developed services such as HMP Stirling, Foxgrove in Ayrshire and the National Forensic Service at Portraine, Ireland. (254)

14b. and indicate the file name here which supports this:

14b.xlsx

15. Considering the Infrastructure Investment Hierarchy, describe current thinking around utilisation of existing infrastructure or alternate solutions less reliant on a new build solution. (250 words)

A previous review of High Secure Services for Women considered developing the service at the Orchard Clinic as highlighted in Section four. In 2024, following agreement with SG, TSH commissioned a Feasibility Study to explore options for delivering a service for women. Four options were identified.

Option One converting or demolishing the Harris building to create a Women's Centre, with displaced functions moved to a new build within the high-secure perimeter.

Option Two proposed the same redevelopment of Harris with displaced functions moved to a new build out with the high-secure perimeter.

Option Three retained the existing Harris building, with a new Women's Centre constructed on available land within TSH. (Preferred option.)

Option Four Develop an extension or new accommodation attached to Arran 2 or Mull 2 to provide women-only facilities.

Option Three emerged as the preferred option with least challenges and most benefits due the proposed location close to the Secure Entrance, Family Centre and Skye Centre. The building design and location also gives natural segregation and privacy between male and female patients. The building would be designed to suit the clinical requirements for a female service. The build area can also be segregated with the use of temporary secure fencing to mitigate the impact on existing operations and reduce construction traffic. Its proximity to the breakthrough gate reduces operational impact and overall cost. The building will enable all the required services to be provided without compromise or derogation and allow for greater energy efficiency and sustainability measures to be implemented. *(252)*

16. **Describe early thinking on how this proposal will have a positive impact on the community it will serve and / or the locality it sits within.** *(250 words)*

From 2008 until July 2025, there was no high secure forensic provision for women in Scotland. During this period, eligible patients were transferred to Rampton Hospital; however, this option was not available for pre-trial and remand patients. As a result, some women spent prolonged periods inappropriately placed in prison custody or in medium secure care. In several cases, medium secure units were required to temporarily reduce bed capacity to safely manage these patients and staff (Table 10).

Establishing an adequate high secure service for women in Scotland will increase capacity across the national forensic estate and strengthen resilience and business continuity. Similar to the arrangements for male patients, having a service within Scotland will enable pre-transfer visits and smoother transitions between levels of security something that is difficult to achieve when patients are placed OOA.

This service will significantly improve opportunities for family and carers to visit patients, enhancing their involvement in care and recovery. The Independent Forensic Mental Health Review and Scottish Human Rights commission highlighted this lack of access as a major inequality, reinforcing the importance of creating a service for women in Scotland.

In addition, the development of the service will bring positive local benefits, including economically, the recruitment of additional staff in Scotland to support the enhanced model. This increase in local employment and professional opportunities aligns with sustainability and workforce development priorities, contributing positively to the surrounding community. This approach compliments TSH Anchors Strategic Plan. The plan sets out to prioritise progressive procurement, employment and the sustainable use of land and property. (257)

17. **Describe any conversations with other agencies already taken place, or opportunities to do so in the future, about the opportunity for infrastructure collaboration while taking a place-based approach to planning**. *(250 words)*

In 2024, the development of a medium to long term Womens Service at TSH was deemed a ministerial priority and supported by NHS Chief Executives. Detailed debate and discussions have taken place with Scottish Ministers and CEO's across Scotland exploring a range of options for a Womens Service incorporating a place based approach. In 2018, following an options appraisal process, a proposal to create High Secure beds at the Orchard Clinic in Edinburgh was debated and supported. However following the Covid pandemic, plans were paused and the redesignated of the Edinburgh Royal Campus removed the Orchard Clinic as a viable high secure option.

In February 2021, *The Independent Review into the Delivery of Forensic Mental Health Services in Scotland* was published. Recommendation three stated that a dedicated female high secure service should be developed at TSH. In November 2023, the *Mental Health and Wellbeing Delivery Plan 2023–25* was published. Priority 8.1.2 committed to developing, with stakeholders, a short and long term plan for delivering high secure services for women within Scotland.

In deciding to develop a High Secure Service at TSH, it limits opportunities for a place-based approach due to the unique nature and location of the services provided. However, place-based opportunities for workforce planning and digital integration exist with other providers of services for women to ensure that a whole systems approach is created that improves service delivery and efficiency.

A collaborative approach to delivering forensic services for Women in Scotland is currently being discussed and debated through the Forensic Network's 'Womens Services Planning' group. (257)

18. **Provide quantitative data on population demographic analysis for the impacted service catchment area** (indicate the changes in volume and over which timeframe). **Describe the highlights here** (250 words)

The Scottish Prison Service data drawn from the 'Strategy For Women In Custody: 2021-2025' indicates that the numbers of women receiving a custodial sentence in Scotland decreased by 27% between 2010-20. There was a broadly downward trend until 2016 followed by a period of relative stability until the Pandemic in 2020. Since 2020, numbers have increased by 22% from 282 in 2022/3 to 345 in 2024/5. In a study of 109 women across four prisons in Scotland, 90% (98 of 107) reported mental health anxiety, depression, or combination of both.

The November 2025 Forensic Network Census indicates that the overall forensic population or Scotland was 469 patients, 27 of these were females with the majority having a primary diagnosis of mental illness (18 females). Only two patients were catered for at that time in a high secure setting with a further eight patients in medium security. The average length of stay for female patients was 1389.4 days (3.8 years). In comparison to the previous two years the total number of female forensic patients remains constant at 29 and 30. It should be noted that above 2025 data does not include women placed in secure settings for therapeutic security who have not been admitted there because of forensic issues.

Between 2008 and 2020, the numbers of female patients requiring high secure care has been historically low (zero-two patients). Since 2020, these numbers have increased and currently five patients require OOA High Secure Care with a further three patients in the Interim Service at TSH. (253)

18b. and indicate the name of any data file submitted which supports this:

18b1 - Census-Paper-for-We

18b2 - 2025 Census Analysis paper.pdf

19. **Describe early thoughts on how the proposed investment might impact both positively and negatively upon the environment and the community it will serve. This should also include any actions already being considered to improve such an impact**. (250 words)

This proposal is strongly linked to DL (2021) 38, a policy statement on 'Policy for NHS Scotland on Global Climate Emergency and Sustainable Development.' In terms of sustainable development, current buildings are fifteen years old, having been established in 2011. Potential negative impacts of a new build on site would be additional energy demand, adding to current infrastructure (reference NHS Scotland Sustainable Design and Construction (SDaC) Guide (SHTN 02-01)) and a loss of 'green space'. TSH currently has 67.5% green space against buildings. Using an approximation of 2800m2 as the footprint for Option three; green space figure against buildings would reduce to approximately 64%. The new building would connect directly to the current district heating system and will be energy efficient to reduce the impact of additional energy costs.

Positively, a new build would specifically be designed to suit the needs of women's high secure forensic services, as well as improving environmental performance. It would offer a more sustainable approach and build, including longevity, as well as up to date modern technology. The existing Interim Service

would return to the male bed estate and restore the resilience arrangements to the previously held position of two decant wards which support business continuity arrangements not just internally but across the Forensic Estate.

Travel and transport links would also be greatly improved, ensuring Scottish families and carers spend less time and costs travelling to OOA settings. This will provide carbon benefits with mileage at less than a sixth and days of travel reduced to one day for family and carer visits.
(258)

20. **Provide an estimate of the projects full capital budget. This should be a proportionate and reasoned, cautious estimate that fully captures the potential scale of investment required**. (indicate and appropriate range).

    The development of a medium to long term service for women is supported by Scottish Government. In 2024 funding was allocated to TSH to carry out a feasibility study as described in section 15.

    Option three details the development of a standalone twelve bedded service for women within the grounds of TSH. A schedule of accommodation was established by a core project team of multi-disciplinary experts and working with architects and specialist advisors, an efficient, compliant and equitable design for a modernised Womens Service at 2,897.15m2 was developed. The cost estimate of £32m has been prepared based on m2 rates benchmarked against recently tendered projects with uplifts for the secure environment, construction complexities and inflation. The anticipated period of construction is between two to three years.

    The block plan tested the layout and outlines a possible shape for the Women's Service building, with all departments on a single ground floor level, indicating a 'worst case scenario' for the footprint. The shape is dictated by the available land and without causing major disruption to existing roads, pathways and associated infrastructure. There is an opportunity for a two-story building to provide more external space for patients, similar to the current male wards with staff areas, offices and plant room located on the first floor reducing the overall footprint. The layout will be further tested in the next stage to ensure best 'Value for Money'. (232)

21. **Provide an indication of the likelihood of the proposal having additional revenue implications, including an early assessment of any additional impact on costs proportionate to current budgets**. (Consider workforce and facilities)

    An indicative resource profile for the twelve bedded service has been collated based upon current experience and comparison to broadly similar services in England and Ireland and is estimated at £7.3m per annum using current pay scales. The Interim Service operating costs with the current staffing levels are £5.2m per annum and this may increase if there are further admissions to the service. The additional revenue implications above the initial agreed £3.1m allocation for 2025/6 are highlighted in previous sections and relate to clinical acuity and environmental constraints, with these staffing levels likely to remain high in the medium to long term.

    The new modernised Womens Service design maximises clinical observation and the adaptable spaces and quieter areas will improve safety, enhance therapeutic outcomes for patients and support staff wellbeing. Resources can be deployed flexibly across the service and each department has indicated their desired resource profile and includes additional facilities costs for support services such as security, catering, estates and e-health. (162)

22. **Optional: Describe any other factors that you believe to be part of the essential considerations of why this is an important investment proposal** (250 words)

Although an Interim Women's Service has been established at TSH, it does not fully address current clinical demands, nor does its infrastructure support trauma-informed, recovery-focused care nor is it autism / neuro-diverse responsive. With a single ward, there is an added complexity of mixing patients on the basis of gender rather than clinical needs, risk and/or presentation.

Considering the needs of both current and future patients particularly given the gradual nature of recovery the service is likely to become oversubscribed in the near future, posing a risk that acutely unwell patients may not be admitted promptly. Additionally, the limited space, including small low-stimulus rooms and inadequate soundproofing, creates an environment where patients who are more settled become disturbed by those who are acutely unwell and detrimentally impacts their recovery. This also presents a risk to staff who are managing patients in this environment and the service has seen a significant increase in incidents, some of these involving serious injury to staff. The present model is resource intensive, and a lack of therapeutic spaces exacerbates this challenge. Patient consultation during the hospital redesign emphasised the importance of peer support and progression in care and treatment; unfortunately, these aspects cannot be adequately delivered within the Interim Women's Service.

This investment is aligned to ministerial priorities and will allow patients to be repatriated sooner if appropriate, improve bed capacity and resilience across the forensic network and improve the care and treatment outcomes for patients, letting them progress safely and more efficiently through their clinical journey to lower levels of security.
(257)

23. **Describe who has been involved in developing the Strategic Assessment and the local Board governance arrangements for approval**. (250 words)

Reporting to the Corporate Management Team and Womens Project Oversight Board, a Core Project Team was established to oversee the development of this Strategic Assessment. The team comprises of Programme Director, Acting Director of Security, Estates and Resilience, and senior management leads from Nursing, Finance, eHealth, Risk Planning, Prevention and Management of Violence and Aggression, Estates, and Security. Clinical input has been provided by clinical colleagues from Psychiatry, Psychology, Occupational Health and Rehabilitation as well as representation from Joint Staff Side.

Governance is continued via reporting to The State Hospitals Board for Scotland, Corporate Management Team and Womens Project Oversight Board.

Externally, the core project team have engaged with NHS Ayrshire and Arran (Foxgrove Development), HMP Stirling, Mental Welfare Commission, The National Forensic Mental Health Service, Portraine Co. Dublin, Ireland, the Scottish Human Rights Commission and the Forensic Network Womens Services Planning Group (incorporating Low and Medium secure providers). Engagement has also taken place with Healthcare Improvement Scotland on 'major service change' and this process is ongoing and will develop further as the project progresses.

This collaborative approach ensures that the Strategic Assessment is grounded in clinical, operational, and financial realities, while also reflecting broader system ambitions for sustainable, integrated, and future-ready service delivery. (204)

24. Please confirm this project Strategic Assessment has received NHS Board approval for submission to Scottish Government. (Yes/No)

The Strategic Assessment for a National High Secure Forensic Mental Healthcare inpatient service for Women was approved at The State Hospitals Board Meeting on 18 June 2026.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 8
Sponsoring Director:	Acting Director of Security, Resilience and Estates
Author(s):	Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1 SITUATION

The project is approaching a close, with completion planned for late June. A survey of the electrical supply quality has now been undertaken, and a report received. Some other works have been moved to the two-year Defects and Liability period following completion. Further information regarding this is provided at 3b and 3c. (A verbal update will be provided.)

2 BACKGROUND

As previously reported, governance arrangements have been tailored to match the stage of the project and the amount of outstanding works. The Project Oversight Board plans to meet monthly and the last meeting took place on 23 April 2026. The next meeting is to be scheduled on receiving a plan to address the issues identified by the electrical supply quality report. 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 completion is projected for late June. The projected final cost overspend is contained in Finance – Project Cost below.

b) Project Timescales

Revision 77 is the most recently accepted programme. The programme projects completion on 12 June, though the programme precedes decisions regarding the electrical supply and a programme revision is being prepared. It includes a two-week period to establish and implement a solution to the electrical supply problems.

Works remaining to be addressed are:

- F2K camera issues
  This issue is known to the Board, and work is planned to take place during the Defects and Liability period following completion.

- Works to investigate and address water ingress to cable ducts.
  This issue is known to the Board, and work is planned to take place during the Defects and Liability period following completion.

- Cameras affected by power fluctuations at generator tests
  The independent review that examined the power supply to and from the Power Supply Units in the affected camera poles established that the cause of the problems is within the Power Supply Units supplied by Securitas. A potential solution has been suggested. that would involve Securitas, at their cost, replacing Power Supply Units with Uninterruptable Power Supplies in the affected columns. At the time of writing the detail of the proposal is being worked up by Securitas prior to assessment by TSH. Depending on agreement regarding the nature and duration of the potential solution the works are likely to be considered suitable for moving into the Defects and Liability period.

c) Progress

Completion is imminent subject to the agreement on the proposed solution following the electrical investigations. Communication continues between the State Hospital Chief Executive and the Securitas UK General Manager as required.

d) Finance – Project cost

The contract with Securitas will underspend against budget, including available contingencies. Project management costs and associated contingencies have been affected by changes in the project timescale, and the project has a projected final overspend (exclusive of VAT) of approximately £1,181k. This has increased by 16k since the April 2026 report to the Board. The overspend 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 due to estimated escort recharges continuing up to completion. Any overpayments will be recovered from the retention.

The key project outline at 04 June 2026 is:

Project Start Date:	April 2020
Planned Completion Date:	June 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 04/06/26:	£9,970,862
Total costs to date (exc. VAT & retention) at 04/06/26:	£9,973,277
Total costs to end of project (Exc. VAT & retention)	£ -2,415

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our Scottish Government (SG) funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

While it is not a prerequisite of the project, regular reports to the SG Capital team are also being provided to notify of progress against total budget.

A Rounded breakdown of actual spend to date (Exc. VAT) at 02 April 2026 is:

Securitas	£ 7.299m
Thomson Gray	£ 1.366m
Doig & Smith	£ 0.008m
HVM	£ 0.192m
Staff Costs	£ 1.231m
Miscellaneous	£ 0.002m
Income	-£ 0.125m
Total	**£ 9.973m**

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

4 RECOMMENDATION

The Board is invited to note the current status of the Project.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	Update paper on previously approved project.
Corporate Objectives Please note which objective is linked to this paper	**3. Better Value** i) Complete the security upgrade and move towards the development of the core security quality indicators.
Workforce Implications	N/A
Financial Implications	The projected overspend is regularly communicated to Scottish Government and is an ongoing action at Project Oversight Board.
Route to Board Which groups were involved in contributing to the paper and recommendations.	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	Previously reported, delays in completion incur additional capital cost.
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Contract agreement stipulates compliance with Fairer Scotland Duty in respect of the remuneration of staff and contractors.
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	1

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 9
Sponsoring Director:	Acting Director of Security, Estates and Resilience
Author(s):	Risk Management Team Leader
Title of Report:	Corporate Risk Register 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 the risk and a nominated manager who is responsible for ensuring appropriate control measures are in place.

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 provides an overview of directorate risks, monitors changes over time and sets out current risk management updates.

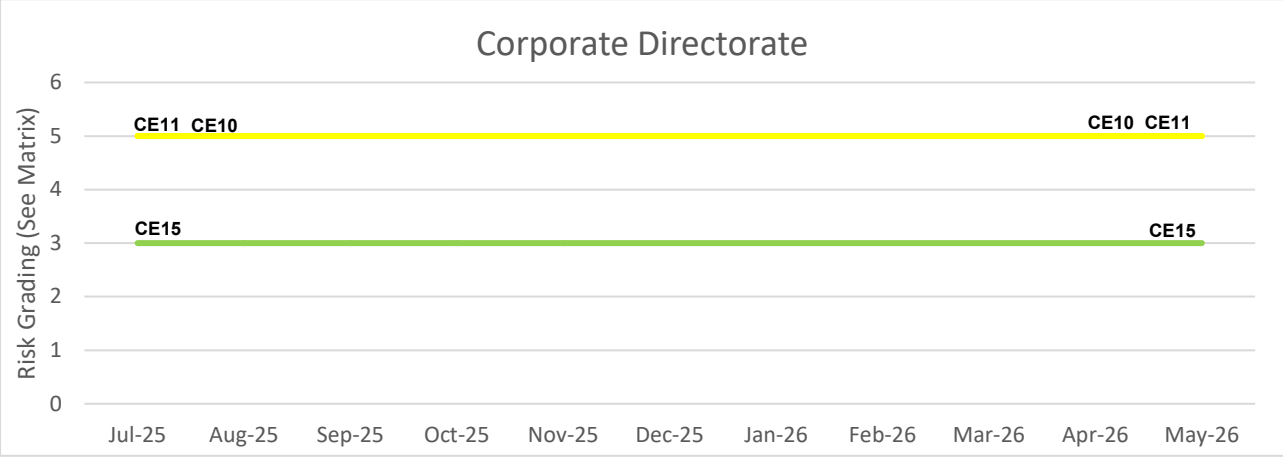
Risk Matrix

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

- Very High 17 -25
- High 10 - 16
- Medium 4 - 9
- Low 1 - 3

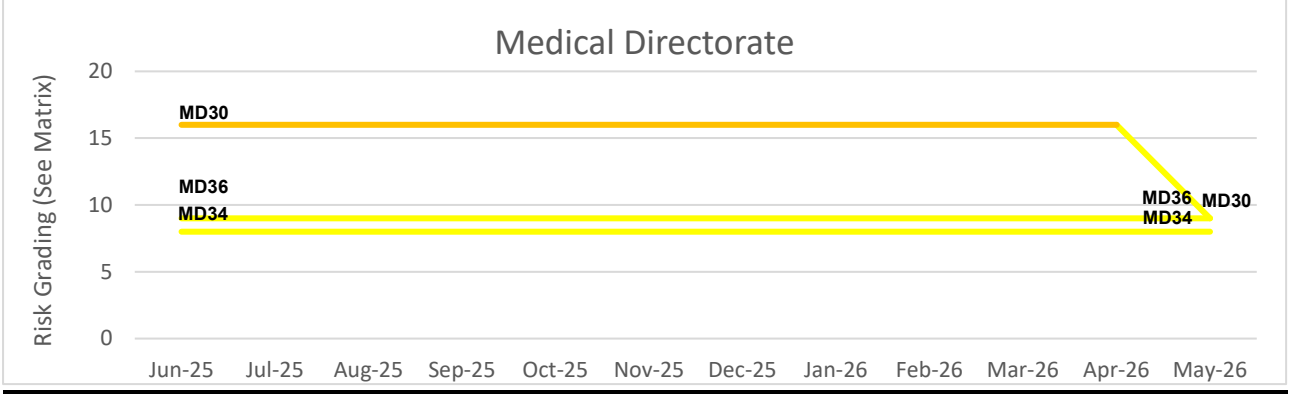
Corporate

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



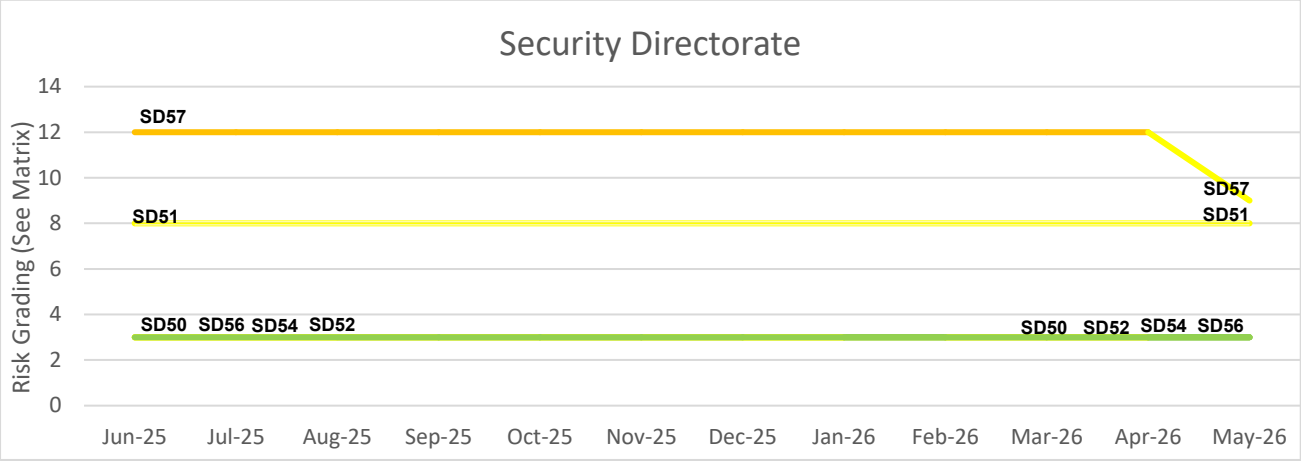
Medical

MD30 Failure to Prevent and Mitigate Obesity has been reviewed; the risk has been updated to reflect the new KPI for monitoring weight gain within the hospital and is now titled **MD30 Failure to Mitigate Excessive Weight Gain.** Following review of the data, the risk has decreased from Major x Likely (High) to Moderate x Possible (Medium). Full details of the updated risk assessment are available in Appendix 2.



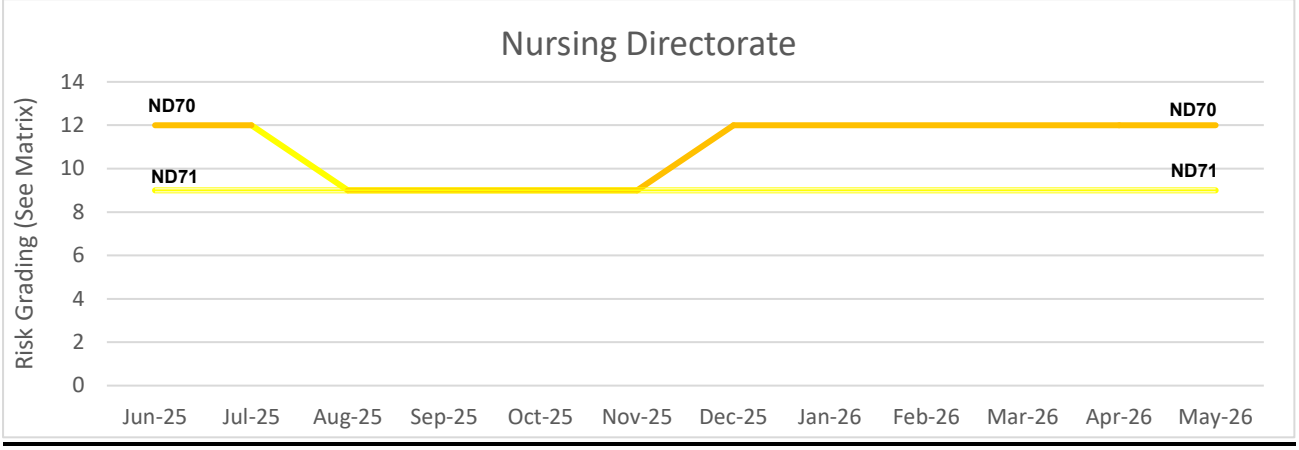
Security

SD57 Failure to complete actions from Cat 1/2 reviews within appropriate timescale has decreased from Moderate x Likely (High) to Moderate x Possible (Medium) following the completion of the latest SAER within the approved timescales.



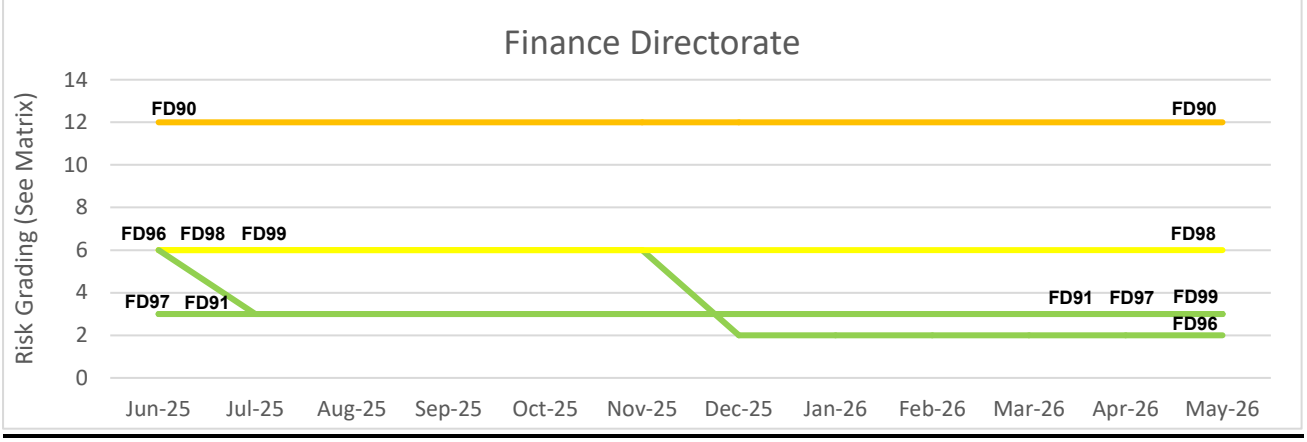
Nursing

There are no changes to the risk gradings within the Directorate

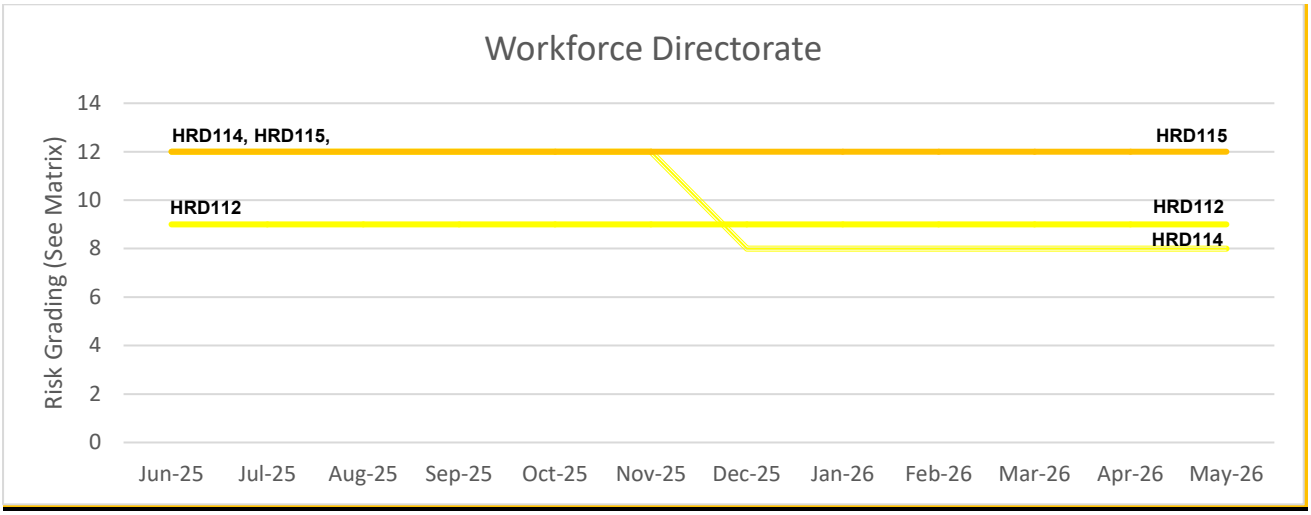


Finance

There are no changes to the risk gradings within the Directorate



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



3.4 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 Updates on High and Very High Risks and Related Consequential Risks

The State Hospital currently has no “Very High” rated risks but has 3 ‘High’ graded risks, reduced from 5 since the last report. Updates on the progress to reduce from High are outlined in this section.

Consequential risk describes the secondary or subsequent effects arising from an initial event. In contrast to direct risk, which relates to immediate harm or impact, consequential risk reflects the wider organisational implications that may follow, including financial loss, reduced patient care and broader service or system disruption.

Finance Director:

FD90 - Failure to implement a sustainable long-term model

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

Consequential Risk
A failure to achieve financial sustainability in the context of national funding pressures and ongoing uncertainty will increase cost pressures, reliance on non-recurring savings and constraints on service capacity, reducing the organisation’s ability to deliver safe, effective and sustainable care. Continued uncertainty over funding for the Women’s Service adds further pressure, constrains service delivery, particularly within the Male Service, increases reliance on short-term measures.

Workforce Director:

HRD115 - Sickness Absence

HRD115 remains at **'High'.** Whilst our sickness absence levels are beginning to show sustained improvement (6.69% for 25/26, a 1% reduction from 24/25), we remain above the 5% target on both a monthly and yearly target.

Focused work will continue to reduce the absence baseline and move closer to 5%, but it is important to recognise the scale of the challenge (TSH have only been under 5% once in the last 5 years (63 months).

Consequential Risk
Persistent sickness absence above target is weakening workforce resilience, increasing operational and financial pressures, and driving reliance on supplementary staffing and overtime. This is impacting on the organisation's ability to deliver safe and consistent care and presents a reputational risk, particularly from the current and future employee perspective where sustained workload pressure affects morale, wellbeing and staff experience.

Mitigating the risk would support safe staffing, improve patient outcomes and continuity of care, enhance staff wellbeing and morale, reduce operational and financial pressures, and promote a stable and reliable workforce. Improving patient outcomes and managing financial pressures are both important aspects of ND70 and FD90, two currently active 'High' risks affecting the organisation.

Nursing Director:

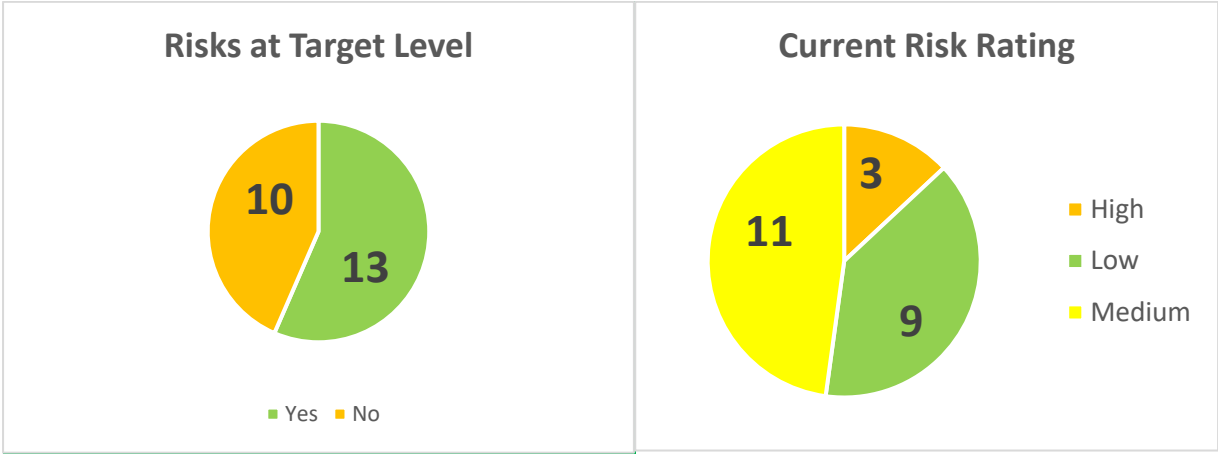
ND70 - Failure to utilise our resources to optimise excellent patient care and experience

Following analysis of recent data and staffing challenges this risk was elevated to **"High"** back in December 2025 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 and has remained over the funded establishment since Aug 25. Ongoing vacancies further exacerbate these challenges. Recruitment efforts are ongoing, with approval granted to over-recruit nursing staff by up to 5% of whole time equivalent. Additionally, initiatives are in progress to address broader issues related to gender and risk management. The issues raised are ongoing and further updates will continue to be provided.

Consequential Risk
Failure to effectively utilise hospital resources may result in reduced quality of patient experience and failure to achieve planned clinical outcomes. Additionally, there is an increased risk of adverse events, complaints, and restrictive practices, with associated impacts on patient safety and experience, service delivery, staff wellbeing, and organisational reputation. This risk, together with FD90 and HRD115, is interdependent and should be considered as part of a single system pressure. Clinical demand and staffing pressures increase absence levels and reliance on temporary staffing, which in turn adds financial pressure and slows progress towards delivering excellent patient care and experience. Although there are three distinct risks, in practice these are addressed together, to ensure they will reach their target levels or deliver the intended benefits.

3.6 Risk Distribution



Currently 13 Corporate Risks have achieved their target grading, with 10 currently not at target level. Note that only 3 out of the 10 risks not at target level exceed the tolerance levels stated in the TSH Risk Management Strategy.

Updates on risks not at target level below:

ND70 , HRD115 and FD90 are detailed in 3.5

MD30 Failure to Mitigate Excessive Weight Gain – Risk recently decreased from High to Medium following an update to the KPI and the overall monitoring of the risk. Positive progress has been made; grading will be updated regularly as the data becomes available with the plan to reduce further if possible.

SD57 Failure to complete actions from Cat 1/2 reviews within appropriate timescale – Risk recently decreased from High to Medium following positive progress relating to the management of SAER Timescales. This has been supported by the introduction of the SAER Group. If progress continues then this again then the risk can be reduced further.

MD36 Impact on patients within Female Service if long term model is not fully implemented – Risk currently graded as Moderate x Possible (Medium). Risk is not at target level due to several factors: uncertainty around funding for the service and the current impact the Interim Female Service is having on the wider hospital population. If funding is approved and a sustained model can be introduced, this in turn will reduce the risk further.

SD51 Major or Extreme Failure of Physical or Electronic Security System – Over the past five years, there have been nine physical or electronic security failures with a major impact. This indicates a likelihood rating of 'Unlikely' and an overall risk grading of 'Medium' when assessed against the risk matrix. Improvement work is continuing to strengthen systems and address identified concerns. SD51 is under review to ensure clarity around the types of failures experienced within TSH.

ND71 Serious Injury or Death as a Result of Violence and Aggression – Current impact of injuries meets the criteria of a moderate impact. The highest level of impact from violent and aggressive incidents recorded at TSH meet the criteria of a 'Moderate' impact within the risk matrix. A moderate impact is described as a RIDDOR reportable incident. The likelihood of this occurring within TSH is around 1 in 30 incidents that involve physical intervention which meets the criteria for 'Possible'. When comparing with the risk matrix this gives an overall grading of 'Medium'. There are several control measures in place to reduce the risk however there will always be an element of risk when performing any PMVA technique, due to the type of

environment at TSH, this risk cannot be eliminated. Consideration is being given to target grading of the risk.

HRD112 Compliance with Mandatory PMVA Level 2 Training – Currently graded as Moderate x Possible (Medium) with a target of Moderate x Rare (Low). Compliance has stayed steady around the 80% mark for several months, current resourcing challenges resulting in cancelled training impacting on sustained improvement of the current figure.

HRD114 Reduction in hours - remains at Major x Unlikely (Medium) with a target of Moderate x Unlikely (Medium). All areas within TSH have fully implemented the 36 hour working week, no significant concerns or issues have been raised since the implementation. Remaining risk due to ongoing attempts to backfill, particularly within Nursing which are currently ongoing.

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 Management Team Leader 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			ND70	HRD115	
Possible	FD91		ND71, HRD112, , MD36, MD30, SD57,	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 now complete, with system going live on 11 March 2026; incidents are now being recorded on the new system, with both Local and Corporate risks scheduled to be added to the system in June 2026.

3.8 Local Risk Register

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

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

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Monitoring of all Corporate Risks aligned to the organisation
Corporate Objectives Please note which objective is linked to this paper	**Better Care** • Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk. • Ensure organisational resilience and ability to respond to any increase in risk to care delivery within expected systems pressures and any unexpected events. • Learn locally and nationally from adverse events to make service improvements that enhance the safety of our care system. **Better workforce** • Sustain a safe working environment for staff with a focus on risk management across all aspects of the organisation.
Workforce Implications	There is no workforce implications related to the publication of this report.
Financial Implications	There are no financial implications related to the publication of this report.
Route to Board Which groups were involved in contributing to the paper and recommendations.	CMT
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	**1** There are no privacy implications.

Appendix 1

High Risks – Reviewed Monthly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Governance Group	Target Level Achieved
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Major x Almost Certain	Major x Possible	Moderate x Rare	Finance & eHealth Director	Finance & eHealth Director	Jun 26	Audit and Risk Committee	Finance, eHealth and Audit 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	Jun 26	Staff Governance Committee	Workforce Governance Group	Not at Target
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Major x Likely	Moderate x Likely	Minor x Unlikely	Director of Nursing, AHP and Operations	Director of Nursing & AHP	Jun 26	Clinical Governance Committee	Clinical Governance Group	Not at Target

Medium Risks – Review Quarterly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Governance Group	Target Level Achieved
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Major x Rare	Major Rare	Chief Executive	Board Secretary	Sep 26	The Board	CMT	At Target
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Moderate x unlikely	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	Sep 26	Clinical Governance Committee	Clinical Governance Group	At Target
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Likely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	Sep 26	Clinical Governance Committee	Clinical Governance Group	At Target
Corporate MD36	Medical	Impact on patients within Female Service if long term model is not fully implemented	Major x Likely	Moderate x Possible	Minor x Rare	Medical Director	Lead RMO – Female Service	Sep 26	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	Aug 26	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	Not at Target

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Governance Group	Target Level Achieved
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Finance & eHealth Director	Risk Management Team Leader	Aug 26	Audit and Risk Committee	Security, Risk, Health and Safety 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	Sep 26	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate MD 30	Medical	Failure to Mitigate Excessive Weight Gain.	Major x Likely	Moderate x Possible	Moderate x Unlikely	Medical Director	Lead Dietitian	Sep 26	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth/ Info Gov Officer	Sep 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Possible	Moderate x Rare	HR Director	Training & Professional Development Manager	Sep 26	Staff Governance Committee	Workforce Governance Group	Not at Target
Workforce HRD114	Workforce	Impact of reduced working week	Major X Possible	Major x Unlikely	Moderate x Unlikely	Director of Workforce	Head of HR	Sep 26	Staff Governance Committee	Workforce Governance Group	Not at Target

Low Risks – Reviewed 6 Monthly

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

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Governance Group	Target Level Achieved
Corporate SD 54	Service/Business Disruption	Implementing Sustainable Development in Response to the Global Climate Emergency	Major x Likely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Dec 26	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	At Target
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Aug 26	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	At Target
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Negligible x Possible	Negligible x Possible	Finance & Performanc e Director	Head of eHealth	Dec 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Negligible x Unlikely	Negligible x Unlikely	Finance and Performanc e Director	Head of eHealth	Jun 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performanc e Director	Head of eHealth	Aug 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performanc e Director	Head of eHealth	Dec 26	Audit and Risk Committee	Finance, eHealth and Audit Group Audit and Risk Committee	At Target

Appendix 2

MD30 Failure to mitigate excessive weight gain

Corporate Objective	**Better Health**	**Risk Owner**	Medical Director	**Action Officer**	Lead Dietitian

Risk	Complete the relevant details of the operation/ activity giving risk to the risk
The risk pertains to excessive weight and/or excessive weight gain with the associated risk of managing co-morbidities and high risk of premature mortality following admission to TSH. Target: 60% of patients will gain less than 15% of their admission body weight during their stay at The State Hospital, regardless of length of admission.	

Category		Tick the box to indicate the type of risk Descriptions of categories and level of impact are available in TSH Risk Matrix
Patient Experience	☒	
Objectives/ Project	☐	
Injury (physical or psychological)	☐	
Complaints/ Claims	☐	
Service/ Business Interruption	☐	
Staffing and Competence	☐	
Financial (inc damage, loss or fraud)	☐	
Inspection/ Audit	☐	
Adverse Publicity/ Reputation	☐	
Physical Security	☐	
Other (Specify)		

Hazards		Details the hazards associated with this risk, i.e. the effect. Impact of this risk if realised
The health risks of overweight and obesity both to physical health and to psychological wellbeing and mental health. The management of associated co-morbidities The associated mobility risks for patients and risk of injury to staff Risk of death		
Individuals or group exposed	Patients	Highlight those who would be affected by risk

Benefits	Detail any benefits associated with this risk being mitigated. (e.g. cost savings)
There is a well-established body of evidence that has examined the health implications of 5 and 10% weight gain or loss: a weight loss of ≥5% of initial body weight is associated with significant improvements in cardiometabolic risk factors, including better glycemic control, reduced risk of type 2 diabetes, and improved liver and muscle insulin sensitivity. Larger reductions, such as ≥10%, are linked to further benefits, including greater improvements in blood pressure, triglycerides, and potential remission of type 2 diabetes. Conversely, weight gain of similar	

magnitudes can increase risks for cardiovascular disease, diabetes, and other obesity-related complications.	

Existing Control Measures	List any existing measures in place to mitigate this risk.
1. Ongoing admission weight change monitoring and local KPI to support this. 2. Regular monitoring of all patients – BMI monthly, waist circumference (at least) 6 monthly, waist to height ratio 6 monthly. 3. Annual Health review including updates QRISK -3 monitoring for all those with dyslipidaemia. 4. Monthly nutritional screening and care planning from admission onwards. 5. Healthcare Retail Standard compliance for shop food and drink items. 6. Variety of psychological weight management interventions – including 1:1 and group based 7. Pharmacological Prevention and Management of Obesity Guidelines. 8. Target that 70% of patients will access 150 minutes of physical activity per week. 9. Whole-systems approach to managing 'overweight and obesity' guideline introduced and recommendations are being implemented. 10. Specific admission group targeted to improve levels of physical activity and healthy diet related behaviours: Test Admission Collaborative Kickstart (TACKS) 11. NICE Guidelines on managing overweight and obesity to review practice has been reviewed.	

Likelihood	**Impact/Consequence**				
	Negligible	**Minor**	**Moderate**	**Major**	**Extreme**
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Descriptor	**Rare** (1 in 1000)	**Unlikely** (1 in 100)	**Possible** (1 in 20/Month)	**Likely** (1 in 7 days)	**Almost Certain** (1 daily)
Probability Look at available data where possible to work out likelihood from information sources such as Datix.	Can't believe this event would happen – will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists – unlikely to occur.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	May occur occasionally, has happened before on occasions – reasonable chance of occurring.	This is expected to occur frequently / in most circumstances – more likely to occur than not.

For impact descriptors please refer to the NES Risk Matrix on the TSH Intranet:

http://adsp02/Departments/RiskandClinicalEffectiveness/RiskManagement/Documents/A4%20Incident%20Categories%20Matrix%20Sep%2021.doc

Review Periods:

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

Risk Rating Refer to the QIS Matrix and descriptors (appendix 1) to assess the likelihood of the risk occurring and the impact it would have and determine the overall level of the risk.	**Impact/Consequence** (use descriptor relevant to proposal and select level of impact)	**Likelihood** (use descriptor relevant to proposal and select level of impact)	**Rating** R=I/C x L
Initial Risk Rating Risk grading without controls	Major	Likely	High
Movement Movement since last review	-	-	-
Target Risk Rating	Minor	Rare	Low
Current Risk Rating	Moderate	Possible	Medium

Further Control Measures Required	Include any additional controls identified to reduce risk
- Support to action the ongoing work and changes regarding the Diabetes Framework (2018) supporting physical health and DM management. - Increased accessibility of physical activity opportunities for all patients daily using collaborative methods. - Need to agree a plan on ongoing supportive health education for patients from a variety of sources (inc 'My Health My Way' - weight management group). - Culture to promote active living and a healthier approach to eating – supported by the review of the patient's day in line with new clinical model – need support from SLTs. - Health Promotion Framework for Scotland and AHP's role in supporting this – needs to be identified. - Development of measures for pharmacological treatment - Development of measures for psychological treatment	

Assurances and KPIs	What assurances are there that current controls are effective? (Internal and external) Detail any existing
60% of patients will gain less than 15% of their admission body weight during their TSH stay no matter the length As of 30 April 26, 64.4% of eligible patients have remained within 15% of their body weight on admission. **70% of patients will undertake 150 minutes of physical activity per week**	

As of April 2026, achievement of the physical activity KPI has not been successfully reached during the month. The highest achievement was 63% during the week ending 25th April 2026. The median increased to 55% at this point. As can be seen in the chart below compliance in increasing however remains slightly lower that the same time periods over the past 3 years.	KPIs that would link to risk and show performance against risk

Date Added	14/01/2026
Completed by	Frances Waddell
Date Reviewed	20/05/2026
Next Review	20/08/2026

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 10

Sponsoring Director: Director of Security, Estates and Resilience

Author(s): Risk Management Team Leader

Title of Report: Risk and Resilience Annual Report 2025/26

Purpose of Report: For Noting

1 SITUATION

The Risk and Resilience Annual Report provides the Board with details of the activity undertaken within the Risk and Resilience department over period 1 April 2025 until 31 March 2026.

2 BACKGROUND

The Risk and Resilience Department, part of the Security Directorate, is involved in a range of functions including:

- The development and maintenance of Local and Corporate Risk Registers
- Risk assessments for identified risks
- Development and review of Resilience Plans,
- Incident Reporting and Enhanced Reviews (Cat 1 & 2)
- Health & Safety
- Duty of Candour
- Administration of Datix System
- Training

The Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures. Report is provided to The Board each year prior to publication.

3 ASSESSMENT

This report is presented to the Audit and Risk Board for approval.

4 RECOMMENDATION

The Board are asked to note the Risk and Resilience Annual Report for 2025/26.

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. 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

Risk and Resilience Annual Report 2025-26

Prepared by: Risk Management Team Leader and Acting Director of Security, Estates and Resilience

Approved by: Acting Director of Security, Estates and Resilience

CONTENTS

1. RISK MANAGEMENT DEPARTMENT

1.1 Introduction

The Risk and Resilience Department, situated within the Security Directorate, plays a pivotal role in safeguarding the organisation's operational integrity and ensuring preparedness across a range of critical domains. The department's core functions include:

- **Strategic Risk Management**: Development and ongoing maintenance of both Local and Corporate Risk Registers to ensure alignment with organisational objectives and regulatory requirements.
- **Risk Assessment**: Systematic evaluation of identified risks to inform mitigation strategies and support decision-making at all levels.
- **Resilience Planning**: Design, implementation, and periodic review of Resilience Plans to enhance the organisation's capability to respond to and recover from disruptive incidents.
- **Incident Management**: Oversight of incident reporting processes and facilitation of Enhanced Reviews for Category 1 and 2 incidents, ensuring lessons learned are captured and acted upon.
- **Health and Safety Governance**: Promotion and monitoring of health and safety standards across the organisation, in line with statutory obligations and best practice.
- **Duty of Candour Compliance**: Ensuring transparency and accountability through the effective application of Duty of Candour principles.
- **Datix System Administration**: Management of the Datix incident reporting system to support accurate data capture, analysis, and reporting.
- **Training and Capacity Building**: Delivery of targeted training programmes to embed a culture of risk awareness, resilience, and continuous improvement.

This department's work underpins the organisation's commitment to proactive risk management, regulatory compliance, and operational resilience.

1.2 Aims and Objectives

The Risk and Resilience Department continues to play a vital role in supporting the State Hospital's commitment to safety, quality, and operational continuity. Key areas of focus include:

- **Policy and Procedure Governance**: Development, implementation, and regular review of comprehensive Risk and Resilience policies and procedures to ensure alignment with best practice and regulatory standards.
- **Proactive Risk Identification and Management**: Early identification of emerging risks that may impact the State Hospital, followed by structured management using recognised risk management tools and methodologies.
- **Incident Review and Organisational Learning**: Implementation of robust incident review processes to ensure that significant adverse events are thoroughly investigated. Action plans are developed to address root causes and promote continuous learning across the organisation.
- **Fostering a Positive Risk Culture**: Supporting the development of a positive risk culture by enhancing staff competencies and embedding effective risk management practices throughout the State Hospital.
- **Crisis Preparedness and Resilience**: Ensuring the hospital remains resilient and capable of operating beyond normal parameters during times of crisis, through the development and maintenance of comprehensive response frameworks.
- **Partnership and Collaboration**: Building and sustaining strong relationships with partner agencies to foster shared understanding, coordinated responses, and mutual learning opportunities.

2. GOVERNANCE

2.1 Committees/Groups

The Audit Committee holds overarching responsibility for evaluating the effectiveness of the organisation's internal control systems and corporate governance framework. This includes oversight of the Risk Management Strategy and its associated policies and procedures.

Risk management is embedded throughout the State Hospital's governance structure. The Risk and Resilience team is actively involved in most hospital committees and groups, helping to ensure risk is considered in decision-making at every level.

Regular reporting is provided to these groups, covering key areas such as:

- Risk activity and emerging threats.
- Incident trends and analysis.
- Updates to local and corporate risk registers.
- Operational stability and resilience.
- Progress on adverse event investigations and subsequent action plans.

Key Committees and Groups Receiving Risk and Resilience Reports:

- Clinical Governance Group/Committee
- Audit and Risk Committee
- Corporate Management Team
- Organisational Management Team
- Health and Safety Committee.
- Security, Risk & Resilience, Health & Safety Oversight Group.
- Security and Resilience Group.
- Climate Change and Sustainability Group.
- Patient Safety Group.
- SAER Group
- Service Leadership Teams

In addition to these core groups, the Risk and Resilience team maintains a presence across a range of other hospital forums, including:

- Infection Control.
- Information Governance.
- Corporate Governance.
- And other operational and strategic groups as required.

This integrated approach ensures that risk awareness, resilience planning, and safety culture are consistently reinforced across the organisation.

3. KEY WORK ACTIVITIES (2025-2026)

3.1 Risk and Resilience

3.1.1 Changes within Department

In 2024/25, the team underwent structural changes due to retirements within the overall Directorate, which created opportunities for staff to take on temporary 'acting up' roles. In 2025/26 these roles continue to remain in place. The structure of the team was not reviewed in 2025/26 as planned and the team remains in a temporary structure.

- The Head of Risk and Resilience position is currently inactive, with the postholder acting as Director of Security, Risk and Resilience.
- The Risk Manager role is also inactive. The postholder is acting as Risk Management Team Leader, overseeing the team and reporting directly to the Director of Security, Estates and Facilities.
- The Risk and Resilience Support Officer 0.8 WTE from 2024/25 was changed to a 1.0 WTE. Due to the temporary structure a member of staff is currently on secondment within this role until November 2026.

Current Model (Temporary) as of May 2026:

3.1.2 Corporate Risk Register (Appendix 1)

A corporate risk is defined as a potential or actual event that:

- Interferes with the achievement of a corporate objective or target.
- Would have an extreme impact if effective controls were not in place; or
- Is operational in nature but cannot be mitigated to an acceptable level of risk.

Risks are reviewed regularly throughout the year, with updates provided to the Corporate Management Team (CMT), the Board and all governance groups, where they are embedded within workplans.
Four risks are currently rated as high, while the remaining risks are rated medium or low.

As part of a planned project, all corporate risks were fully reviewed last year. Each Directorate was assessed separately, which led to some risks being revised, updated, merged, or moved to the Local Risk Register. New risks were also added to reflect emerging issues and changing priorities.

3.1.3 Department/Local Risk Registers

Departmental or Local Risk Registers capture risks specific to individual departments. These are risks that fall within the scope and capability of local managers to manage and are monitored and reviewed by the Head of Service. All departments are expected to maintain a Local Risk Register, supported by relevant risk assessments and action plans where necessary.

The Head of Service is responsible for informing the relevant Executive Director of any departmental risks. They must also identify risks that warrant escalation, particularly those graded as Very High or High, for potential inclusion in the Corporate Risk Register. Additionally,

the Head of Service is accountable for the ongoing development, review, and updating of the Local Risk Register.

The Risk Management Team Leader continues to oversee the Local Risk Register process. Each department within the hospital maintains an active register, which is reviewed regularly and evolves in response to changes in the hospital environment. This process is supported by members of the Organisational Management Team.

The Corporate Management Team (CMT) and Board are kept informed of progress through updates provided by the Director of Security, Estates and Resilience.

3.2 Resilience

The Director of Security, Estates and Resilience has overall responsibility for resilience at the State Hospital and currently chairs both the Security, Risk and Resilience, Health and Safety Oversight Group and the Security and Resilience Group.

The Risk and Resilience Department supports these functions by producing an Annual Report for the Board's Audit and Risk Committee, as well as providing regular Resilience Reports to the relevant oversight groups.

The Resilience Department was audited by our internal auditors, RSM, in December 2025 and received a reasonable assurance rating.

3.2.1 Resilience Plans

3.2.1.1 Level 2 Plans

Level 2 Plans primarily address Loss of Service scenarios and are managed internally by operational teams. In most cases, services are restored quickly, and recovery is handled within standard operational procedures.

Currently, all Level 2 Plans are up to date. Each plan is subject to a three-year review cycle, during which it will be tested to ensure it remains fit for purpose. This process is coordinated by the Resilience Officer.

All Level 2 Plans are formally approved by the Security and Resilience Group which meets quarterly.

3.2.1.2 Level 3 Plans

Our Level 3 plans, including Roles and Responsibilities, Action Plans, the Multi-Agency Incident Response Guide (MAIRG) and MAIRG Contingency Plans, were all updated during 2025. This was a substantial piece of work carried out in coordination with our external multi-agency partners and was subject to external audit in December 2025.These plans are based on a multi-agency joint working model (JESIP), involving collaboration with Police Scotland, Scottish Fire and Rescue Service, Scottish Ambulance Service, South Lanarkshire Council, and the West of Scotland Regional Resilience Partnership.

3.2.2 Resilience Related Incidents

In line with the approved Resilience Framework, all resilience related incidents are reported via our Incident Reporting Platform, with Level 2 and 3 incidents being reviewed directly by the Security, Risk and Resilience, Health and Safety Oversight Group.

The Incident levels are defined within the Resilience Framework as follows:

- **Level 1**: Incidents which cause minor service disruption with one area/department affected which can be contained and managed within the local resources.
- **Level 2**: Incidents which cause significant service disruption, interruption to hospital routine, special deployment of resources and affect multiple areas/departments.
- **Level 3**: A major/emergency situation which seriously disrupts the service and causes immediate threat to life or safety. These incidents will require the involvement of the Emergency Services.

Over the year April 25 – March 26, there have been two incidents managed at Level 3 and one Level 2 incidents out with the staffing issues recorded.

	2021/22	2022/23	2023/24	2024/25	2025/26
Level 2	19	8 (+ 3106 staffing resource)	0 (278, All staffing resource, only full closure)	1 (23 full closure incidents were recorded)	1 (81 full closure incidents were recorded)
Level 3	0	0	1	2	2

*Staff resource reporting changed in 22/23 with further refinement in 23/24. This highlights why reporting is different.

One Level 2 incident was recorded this year. The incident occurred in response to a Red Category Storm Warning, which subsequently led to internal and external power supply issues within the State Hospital.

The remaining incidents related to full ward closures caused by staffing pressures. Although the number remains high, it has reduced significantly from previous years. No other incidents at the State Hospital met the threshold for Level 2 classification, and all other events were managed within normal service arrangements.

Two Level 3 incidents were recorded during the year, and both involved the standing up of Incident Command following violent behaviour by patients in their rooms, requiring coordinated multi-agency support for their safe removal. This figure is the same as last year.

3.2.3 Training and Exercising

3.2.3.1 Risk Management Training

Datix training was delivered to all new staff during induction. Advanced training was also delivered to additional personnel supporting the Risk and Resilience Team. The advanced training is designed to:

- Teach staff how to navigate and use the Datix system effectively.
- Ensure quality assurance of all Datix entries.
- Support thorough investigation of incidents recorded in the Datix system.
- Enable staff to extract and analyse data from the system.

Following the introduction of a new Incident Recording Platform (InPhase), in March 2026, guidance documents were created to assist colleagues with using the new system. The training has also been updated to reflect the technical changes within InPhase, the theory part of the training remains the same.

3.2.3.2 Resilience Training

Resilience training remains a key part of our approach to maintaining strong organisational resilience. Over the past year, we have continued to build capability through a range of targeted training activities, including:

- Completion of Level 3 PPE refresher and accreditation training. This is completed on a yearly basis to ensure competency and consistency.
- Delivery of Critical Incident Communicator (CIC) CPD events for the State Hospital CICs.
- One CIC attended the full Negotiator Course at Tulliallan Police College.
- Four CICs attended a bespoke Negotiator Coordinator (Neg Co) course designed and supported by Police Scotland. External delivery of Mental Health Awareness training sessions to Police Scotland Negotiator Unit and, more recently to the Scottish Prison Service continues.
- Golden Hour training for Operational Managers.
- Tactical Decision games for Security Managers
- Induction training for new nurses (First on the Scene).

3.2.4 Partner Agency Working

Maintaining strong relationships with partner agencies remains a key part of our resilience strategy, particularly during periods of crisis. Our main partners include:

3.2.4.1 **Police Scotland**

Our relationship with Police Scotland remains strong. Over the past twelve months, the following milestones have been achieved:

- Continued support from a dedicated Police Scotland response team for the hospital, with close liaison with the Security, Resilience and Estates Department.
- Operational site visits for all new response Chief Inspectors, Local Inspectors and Sergeants for familiarisation and situational awareness.
- Joint development of our Level 3 and Multi-Agency Incident Response Plans.

3.2.4.2 **Scottish Fire and Rescue Service**

- The State Hospital has continued to work closely with the Scottish Fire and Rescue Service through the Local Resilience Partnership over the past year. Operational site visits for relevant crews have continued, alongside ongoing work on operational intelligence and annual fire safety visits and audits.

3.3.4.3 **Scottish Ambulance Service**

Key milestones achieved in collaboration with the Scottish Ambulance Service include:

- Operational familiarisation visits to the hospital with key departments, including Resilience and SORT teams from the West and East of Scotland

3.3.4.4 **South Lanarkshire Council**

As an active member of the Local Resilience Partnership (LRP), we maintain a close working relationship with South Lanarkshire Council and other partners agencies within this remit. We have facilitated visits of Council staff from both North and South Lanarkshire Councils again for familiarisation and resilience.

3.3.4.5 **Scottish Government**

As part of NHS National Resilience arrangements, we work closely with all other boards and with Health Emergency Preparedness, Resilience, and Response (EPRR), a statutory framework in the UK designed to ensure the health and care sector can anticipate, prepare for, respond to, and recover from emergencies. Governed by legislation like the Civil Contingencies Act 2004, it requires NHS organisations to maintain critical patient services during incidents.
As part of this work, one of the priorities this year was to work with EPRR on the following:

Critical National Infrastructure

Critical National Infrastructure (CNI) refers to the essential assets, systems, and networks, such as energy, water, telecommunications, and healthcare, that are fundamentally necessary for a country to function.

Over the last year we have reported on our Critical Infrastructure as part of the national database and more recently on Critical supplies, Fuel, Food and Medication.

3.2.5 Business Continuity Arrangements

Business Continuity (BC) is the organisation's ability to maintain essential services at an acceptable level during and after a disruptive event.
The organisation clearly sets out its Business Continuity Arrangements in a defined policy. This policy was reviewed in January 2025 in line with the organisations policy review process.

3.3 Health & Safety

3.3.1 Control Book Audits

Health & Safety electronic Control Books (eCBs) provide the framework for managing Health & Safety arrangements across the State Hospital, ensuring compliance with both organisational and local policies and procedures. To support a consistent and informed approach, these Control Books are audited regularly. During 2025/26, 11 Control Books were audited against agreed compliance standards.

In addition to the eCB audits, Clinical Ligature Point Audits are also undertaken. Their purpose is to identify, assess and manage ligature risks to reduce harm to in-patients, minimise opportunities for self-harm, and maintain the safest possible care environment.

During 2025/26, the Health and Safety Advisor visited all wards and worked with staff to review and update previous audits.

The result is that all wards now have a 6 monthly audit schedule to follow with audits being saved within the eCBs. Further work this year will include an updated review of other areas in the hospital identified as having potential ligature risks.

3.3.2 2025/26 Training Plan

Staff Training remains a key priority for the Risk and Resilience team. The Health and Safety advisor not only engaged with the Ward management teams on the eCB but also spent significant time on the female service, updating risk assessment and associated paperwork and providing Fire Awareness and Evacuation Training prior to opening in 2025.

3.3.3 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

RIDDOR requires employers to report incidents that arise out of or in connection with work, including:

- The death of any person.
- Specified injuries to employees or hospital treatment for non-employees.
- Employee injuries resulting in more than seven consecutive days of absence.
- Dangerous occurrences.
- Certain occupational diseases.

In 2025/26, 20 RIDDOR incidents were recorded, representing a 50% reduction from 40 in the previous year. This positive improvement suggests that relevant training, including Health and Safety and PMVA, together with current Health and Safety processes, is helping to reduce the frequency of RIDDOR incidents.

	Q1	Q2	Q3	Q4	2023/24	2024/25	2025/26
'Specified' Injuries	1	0	0	0	**2**	**8**	**1**
Over 7day lost time Injury	1	4	4	10	**12**	**32**	**19**
Total	2	4	4	10	**14**	**40**	**20**

All RIDDOR incidents were reported to the Health and Safety Executive (HSE). Although a small number were submitted out with the agreed timescales, reporting performance continued to improve during the year, with fewer late submissions than in the previous year.

All individual RIDDOR incidents continue to be monitored and reviewed by the Health and Safety Committee, ensuring ongoing oversight and organisational learning. Following each report, relevant risk assessments are updated to reflect any new findings or additional controls required.

3.3.4 DSE Assessments

Display Screen Equipment is an essential part of the workplace and following the annual survey a detailed DSE Assessments was carried out for 8 members of staff during 2025/26.

3.3.5 Face Fit Testing

The safety of our staff while carrying out their duties remains a high priority. Face Fit testing continues to be managed by the Risk and Resilience Department. New equipment was purchased in 2025/26 to allow the team to test more efficiently.

3.4 Fire

During the year, 2 fire alarm activations occurred at the State Hospital, all of which received a response from the Scottish Fire & Rescue Service. Importantly, no actual fires were identified.

Of the 2 incidents both were due to faults within the fire alarm system. The Fire System is currently being upgraded.

These events highlight the importance of ongoing maintenance and staff awareness to minimise false alarms and ensure effective emergency response.

On the 18 March 2025, Fire Alarm Evacuations were carried out within every department across the site. These were also carried out in all patient areas with full patient and staff involvement. This reinforces our commitment to ensure staff and patients are fully familiar with on-site Fire Evacuation procedures.

3.5 Incident Reporting

3.5.1 InPhase

In March of 2026, Datix was replaced with a new risk, compliance and performance management platform called InPhase. The platform, supported by a suite of applications, is currently used to record incidents, complaints, claims and whistleblowing concerns with further functionality due for development in 2026/27.

Initial discussions for the implementation of the system began in April 2025. Following sign off on the project, the development of the applications began in August 2025, with planned completion anticipated end of March 2026.

The project was managed by the InPhase Project Board, chaired by the Director of Finance and eHealth. It was supported by the Risk and Resilience Team, the Corporate Team and the E-Health Project Team, with technical input from InPhase.

The project was delivered successfully both within budget and within the agreed timescales with the system going live on 11 March 2026. There were some challenges throughout the project relating to resourcing, development and communication but all issues were managed appropriately through the Project Board resulting in a successful delivery.

Benefits identified with the InPhase include:

- Live support for the system, Datix no longer received technical support. This reduces the risk should there be any technical issues with the system.
- Building the system from the ground up gave opportunity to implement new features and resolve known issues with the outgoing Datix system.
- Financial security through National Procurement with agreed costs and better value for money with the number of apps included in the price.
- Opportunity to have additional modules that were not available on the old Datix system.
- Opportunity to reinvigorate incident reporting through training and communications.
- Additional features available to investigators and those responsible for management of areas within TSH.
- Cloud based system that reduces the impact on TSH IT systems and is accessible anywhere.

The project is due to conclude in June 2026 following completion of the End Project Report.

3.5.2 Incidents and Reporting

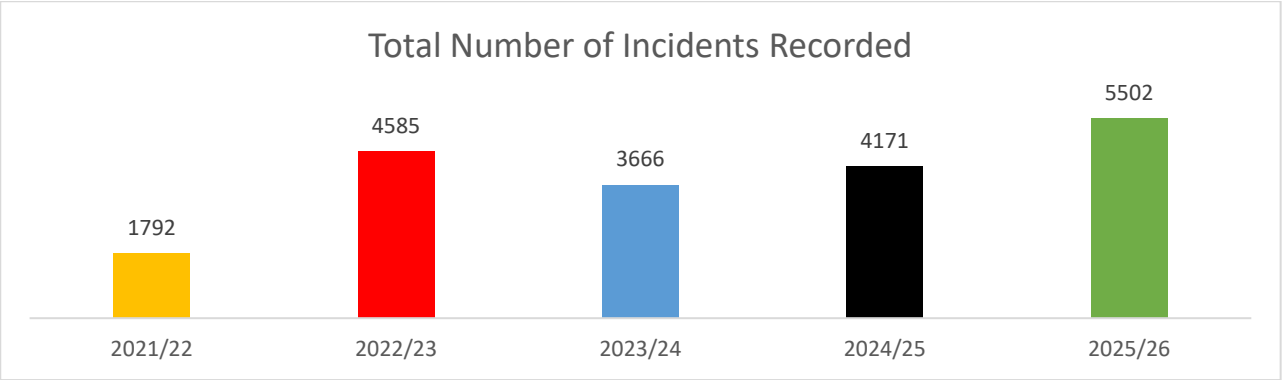
Datix was used to record incidents up until 10 March 2026, with InPhase going live on 11 March 2026. All historic data was transferred from Datix to InPhase.

Each reported incident is investigated locally to ensure that appropriate remedial and preventative actions are taken. The Incident Management system also supports the identification of incident trends and significant individual events through well-defined analytical processes.
Our Incident Management reporting system, both old and new classifies incidents into seven overarching types:

1. Health and Safety
2. Security
3. Direct Patient Care
4. Equipment, Facilities & Property
5. Communication / Information Governance
6. Infection Control
7. Other

This classification helps ensure that incidents are appropriately categorised and addressed, supporting continuous improvement in safety and service delivery.

5502 incident reports were finally approved during 2025/26; a significant increase in the number of incidents finally approved in 2024/25 (4171). The chart below shows the changes in the number of incidents reported within Datix over the last five years.



3.5.3 Incident 'Type' Trends over last 5 years

Incident Type	2021/22	2022/23	2023/24	2024/25	2025/26
Staffing Resource	X**	3192	2296	2264	3403
Health & Safety	461	660	554	886	1332
Security	139	277	297	348	279
Direct Patient Care	146	206	232	386	330
Equipment/Facilities/Property	75	105	135	171	171
Infection Control	60	77	53	18	0
Communication/Information Governance	65	51	94	88	71
Other	846	11	5	10	20
Totals	1792	4585	3666	4171	5502
*Average Patient Population	115	110	102	101	98

* based on bed compliment at end of each quarter/4
** Staffing resource not recorded

Incidents are monitored by relevant groups who are responsible for taking forward any additional actions.

3.5.4 Risk Assessment

The process of risk assessment at the State Hospital involves evaluating two key factors:

- Likelihood of an event occurring (e.g. rare, unlikely, possible).
- Impact or consequence of the event on the organisation (e.g. financial, reputational, operational, regulatory).

The table and chart below illustrate the number of incidents graded as **High** and **Very High** risk from 2021/22 to 2025/26. These figures have substantially increased from last year, primarily due to the increase in reports of Staff Resource Incidents.

Likelihood	Consequences/Impact				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

Year	No. of "High" or "Very High"Graded Risk Incidents
2021/22	628
2022/23	684
2023/24	2026
2024/25	305
2025/26	1581

3.5.5 Duty of Candour

The Organisational Duty of Candour is a legal obligation that outlines how healthcare organisations must respond when an unintended or unexpected incident results in harm or death.

Under this duty, organisations are required to:

- Inform those affected that such an incident has occurred.
- Offer a sincere apology.
- Involve the individual or their family meaningfully in a review of what happened.

This process ensures transparency, accountability, and a commitment to learning and improvement in the delivery of care.

Duty of Candour Incidents	2022/23	2023/24	2024/25	2025/26
Considered	115	54	170	61
Investigated	0	2	4	0

- There was a decrease in the number of incidents considered by the group.
- This trend reflects improved identification, recording and reporting processes of incidents, while maintaining a high threshold for formal investigation.

Further details and analysis can be found in the Duty of Candour Annual Report 2025/26.

3.6 Serious Adverse Event Reviews (SAER)

A Significant Adverse Event Review (SAER) in NHS Scotland is a formal investigation into incidents that cause, or could have caused, serious harm or death to patients, staff, or visitors.

SAERs are conducted to identify the contributing factors of an incident, with the aim of reducing the likelihood and/or impact of similar events in the future. The level of review is proportionate to the severity of the incident:

- Category 1 Reviews are the most rigorous and involve a full Root Cause Analysis. These are used for the most serious incidents to ensure comprehensive organisational learning.
- Category 2 Reviews are used for less serious incidents that still require an in-depth investigation to identify learning points and reduce the risk of recurrence.

SAERs were previously managed by the Corporate Management Team (CMT), which commissioned, reviewed and closed all adverse event reviews. Following a review of this process, a dedicated SAER Group was established in October 2025 to take full responsibility for commissioning, monitoring and reviewing all SAERs after notification from the Risk and Resilience Department.

SAERs Commissioned in 2025/26 were as follows:

Category 1 Review:
- Cat 1 25-01 Room Damage (originally commissioned as a Category 2 Review, upgraded following the level of investigation required to complete)

Category 2 Reviews:

- No Category 2 Reviews were commissioned.

3.7 Freedom of Information (FOI) Responses

During 2025/26 the Risk Management Team received 4 FOI requests totalling 22 questions. The team provided data for all of them where it was held by our department.

4. SUMMARY

4.1 Areas of Good Practice

In addition to the positive outcomes highlighted throughout this report, several areas of good practice have been identified across the hospital in relation to risk management:

4.1.1 Hospital-Wide Practices

- More succinct and consistent incident reporting and investigation
- Effective monitoring and ownership of risk information by relevant groups and committees.
- Regular and focused review of patient-specific risks by clinical teams.
- Strong evidence of learning from incidents, with local actions being implemented to minimise recurrence.
- Successful transition from Datix to InPhase, a new incident management system that was built from the ground up.

4.1.2 Risk Management Department Developments

- Continued delivery of resilience training programmes across the hospital, including Incident Command, Golden Hour Training and Negotiator training
- Continued updating of all resilience and business continuity plans across the organisation
- Completion of work to enhance the SAER process, ensuring a more robust system for commissioning, monitoring, and approvals.
- Development of training and guidance documents for incident reporting, Health and Safety, and Resilience to reflect ongoing changes and improvements.
- Continued development of ongoing Audit for Health and Safety oversight
- The Risk and Resilience Support Officer 0.8 WTE from 2024/25 was changed to a 1.0 WTE. This member of staff is currently on secondment within this role until November 2026.

4.2 Identified Issues and Potential Service Developments

4.2.1 Identified Issues

- Risk and Resilience Team remains in a temporary structure which has resulted in a prolonged period of uncertainty and resourcing issues. This has had an impact on the team in terms of wellbeing with additional pressure throughout the year to deliver on the varied remit the team is responsible for delivering.
- Exacerbated by the temporary structure, the development of the InPhase project resulted in further pressures on the Risk and Resilience Team due to the increased workload from the project.

4.2.2 Service Developments

- In 2026/27, the Risk and Resilience Team will continue to develop InPhase and embed the use of the system within the organisation. The next focus will be to manage the Corporate and Local Risk Registers through InPhase, develop dashboards that support managers in

reviewing the recorded data and develop an electronic system for recording Health and Safety related Alert Notices.

- There is a need to review the Local Risk Register Process within the organisation, this will take place alongside the implementation of the risks on InPhase. Risks should be reviewed to ensure they are up to date and relevant within each department with a clear structure for reviewing, reporting and escalating any identified concerns.
- The structure of the team will aim to be finalised in 2026/27 to allow for permanent posts to be advertised and duties allocated to the relevant role.

5. NEXT REVIEW DATE

The next annual report will be submitted to the Audit Committee in June 2027.

Appendix 1

High Risks – Reviewed Monthly

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

Medium Risks – Review Quarterly

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Governance Committee	Governance Group	Target Level Achieved
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Major x Rare	Major Rare	Chief Executive	Board Secretary	The Board	CMT	At Target
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Moderate x unlikely	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	Clinical Governance Committee	Clinical Governance Group	At Target
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Likely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	Clinical Governance Committee	Clinical Governance Group	At Target

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Governance Committee	Governance Group	Target Level Achieved
Corporate MD36	Medical	Impact on patients within Female Service if long term model is not fully implemented	Major x Likely	Moderate x Possible	Minor x Rare	Medical Director	Lead RMO – Female Service	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	Not at Target
Corporate ND 71	Health & Safety	Serious Injury or Death as a Result of Violence and Aggression	Extreme x Almost Certain	Moderate x Possible	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements	Moderate x Likely	Moderate x Unlikely	Moderate x Unlikely	Finance and Performance Director	Head of eHealth/ Info Gov Officer	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Possible	Moderate x Possible	Moderate x Rare	HR Director	Training & Professional Development Manager	Staff Governance Committee	Workforce Governance Group	Not at Target
Workforce HRD114	Workforce	Impact of reduced working week	Major X Possible	Major x Unlikely	Moderate x Unlikely	Director of Workforce	Head of HR	Staff Governance Committee	Workforce Governance Group	Not at Target

Low Risks – Reviewed 6 Monthly

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

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Governance Committee	Governance Group	Target Level Achieved
									Oversight Group	
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	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	At Target
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	At Target
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Negligible x Possible	Negligible x Possible	Finance & Performance Director	Head of eHealth	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Negligible x Unlikely	Negligible x Unlikely	Finance and Performance Director	Head of eHealth	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	Audit and Risk Committee	Finance, eHealth and Audit Group Audit and Risk Committee	At Target

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 11

Sponsoring Director: Director of Finance and E-Health

Author(s): Deputy Director of Finance

Title of Report: Finance Report to 30 April 2026

Purpose of Report: For Noting

1 SITUATION

This report provides an update on financial performance for Month 1 (M1), 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 2026/27 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 6 May 2026.

3 ASSESSMENT

3.1 Budget

A baseline recurring allocation of £49,099k has been agreed with the Scottish Government.

The following additional allocations have also been included within the current budget position:

- Recurring allocations awarded in 2025/26, including the agreed pay uplift: £4,711k
- Anticipated capital depreciation uplift: £2,146k

This results in a total annual revenue budget of £55,956k reflected in the annual position.

At this stage, assurance has only recently been received verbally regarding the level of funding for Women's Services for 2026/27, for which written confirmation is now awaited. In addition, certain non-recurring budget allocations remain outstanding and will be incorporated into the budget once confirmed.

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

- Month 1 financial position shows a £188k overspend against plan.

Directorate Summaries:

Directorate	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance £'k	Budget WTE	Actual WTE
Cap Charges	4,484	374	380	(6)	0.00	0.00
Central Reserves	421	0	(0)	0	0.00	0.00
Chief Exec	2,857	238	236	2	25.07	24.38
Finance	3,098	219	215	3	34.31	32.05
Human Resources Directorate	1,299	108	102	6	16.50	15.64
Medical	6,252	592	538	54	44.98	38.38
Nursing And Ahp's	27,516	2,115	2,366	(251)	394.77	445.81
Security And Facilities	10,028	844	839	5	129.42	123.05
	55,956	**4,490**	**4,678**	**(188)**	**645.05**	**679.31**

Capital Charges -variance – (£6k)
Capital charges are expected to increase again during the year as a result of new assets being brought into operational use. Any costs above the £2,868k included within the baseline budget will be funded by the Scottish Government and has been assumed in the current budget. The small variance at Month 1 will be managed and funded within future months.

Central Reserves – variance -Breakeven
Central reserve funding is held to support anticipated unfunded pressures that may arise during the financial year. Costs will be met from reserves as they are incurred during 2026/27.

Chief Executive – variance - £2k underspend
The underspend reflects a vacancy within Corporate Planning, alongside minor underspends against non-pay budgets.

Finance – variance – £3k underspend
An emerging cost pressure of £12k relating to IT contracts has been offset by underspends within Finance (£12k) and Procurement (£4k), primarily arising from vacancies that are expected to be filled. Once these posts are appointed, the IT pressure will emerge as a net pressure within the Finance Directorate.

In addition, M365 continues to represent a cost pressure within e-Health; this is currently being managed through the appropriate use of non-recurring reserves.

Human Resources - £6k underspend
Vacancies remain across Occupational Health, Human Resources, and Learning & Development. There is also a current underspend against the corporate training budget.

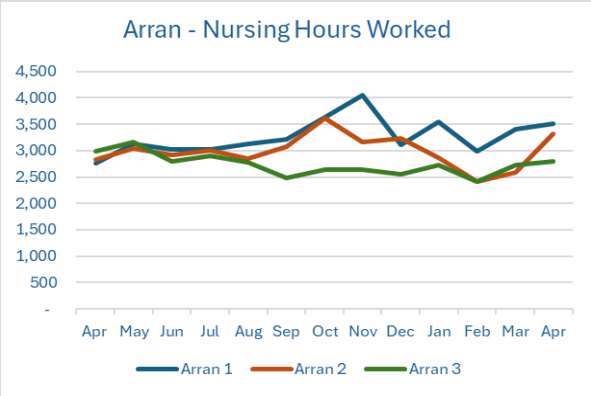
Medical - £54k underspend
Clinical Psychology was previously reported within the Nursing Directorate and was transferred to Medical from Month 1. There is a £21k underspend within Clinical Psychology and a £25k underspend within Medical, both largely attributable to vacancies.

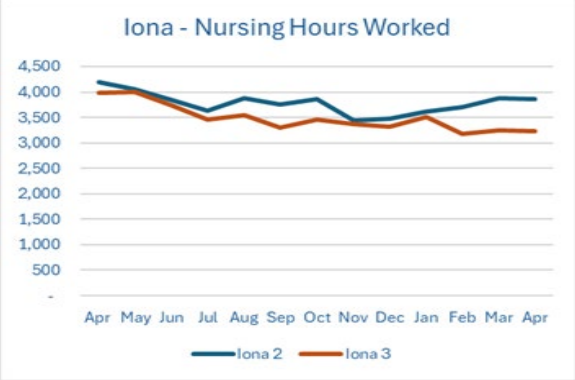
Drug expenditure has increased in recent months and is currently presenting a small emerging pressure.

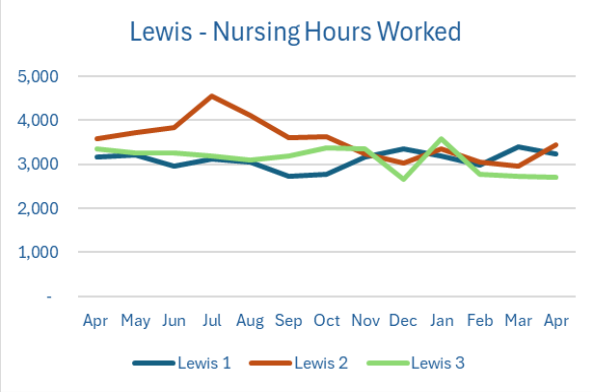
Nursing & AHP - £250k overspend
A £267k overspend has occurred within the Women's Ward. As noted above, funding for Women's Services for 2026/27 remains to be confirmed in writing, following verbal assurances, with the final level of allocation therefore yet to be formally agreed. Costs reported relate solely to staff specifically recruited to the Women's Service; staffing borrowed from other wards being not currently included in overspend reported for women's services.

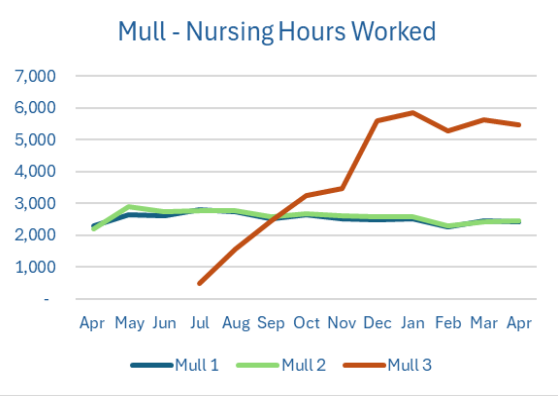
This pressure is partially offset by underspends within Skye Centre and Allied Health Professionals, arising from vacancies. Other wards show an overspend of £51k. The cost of borrowed staff utilised to support the Women's Service totals £110k; these costs are included under the other wards overspend.

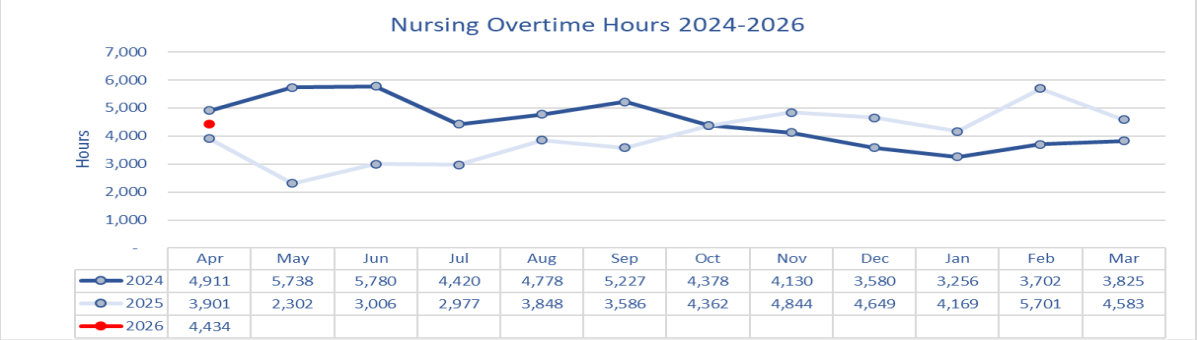
The accompanying graphs provide an overview of nursing hours utilised by ward.











	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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	5,701	4,583
2026	4,434											

Nursing Update from Associate Nurse Director:
Nursing overtime pressures at The State Hospital continue to be driven by increased clinical acuity across both female and male services, alongside ongoing vacancies and sickness absence. Recruitment activity remains a key focus, with continued Band 5 and Band 3 campaigns showing some success, including the plan to over-recruit to 105%.

The opening of the additional female ward in July 2025, while successfully staffed, has displaced some capacity from male services and, combined with higher acuity within the female ward, has contributed to increased overtime usage. Funding requirements to safely manage the female service going forward have now been identified and shared with SG. Robust attendance management, regular finance and roster reviews with Senior Charge Nurses, and ongoing oversight through monthly Nursing and Finance leadership meetings remain in place and are beginning to demonstrate positive impact on staffing and financial control.

Security - £5k underspend
Pressures have been identified in relation to perimeter fencing (£30k) and utilities (£21k). Following full capitalisation of the Enhanced Security Project, remaining staffing and project management costs no longer met the criteria for capital treatment and have therefore been charged to revenue, creating a £30k pressure at Month 1.

Utility costs for 2026/27 are still indicative but are expected to increase further, with ongoing underlying pressure from inflationary impacts in prior years.

These pressures are currently offset by underspends arising from vacancies across Security, Hotel Services, Housekeeping and Risk.

3.3 Assessment - Savings

The recurring savings target for 2026/27 is 3% of baseline funding, equating to £1,620k.

Due to cost pressures relating to the Enhanced Security Project, utilities, and Women's Services, savings targets are currently not being fully achieved within the Nursing & AHPs and Security & Facilities Directorates. These shortfalls are offset by over-achievement of savings within other Directorates, resulting in a balanced overall position.

Directorate	Annual Target £k	YTD Target £k	Savings Achieved £k	Suplus/ (Shortfall) £k
Chief Exec	44	4	4	0
Finance	48	4	8	4
Human Resources Directorate	38	3	3	0
Medical	127	11	19	8
Nursing And Ahp's	799	67	62	(5)
Security And Facilities	564	47	40	(7)
	1,620	**136**	**136**	**0**

3.4 Capital Resource Limit

Capital resource will remain at £282k. Spend will be agreed by the capital planning group and shared in due course.

4 RECOMMENDATION

The Board is invited to note the content of the report - highlighting the following position and forecast:

Revenue
The forecast outturn remains breakeven, on the assumption that funding is now confirmed for Women's Services. The principal risks to this position relate to:

- Funding assurance for Women's Services
- Nursing overtime expenditure
- Utilities costs
- The Enhanced Security Project

Capital
Capital plans and projects will continue to be progressed through the Capital Planning Group and are currently under discussion.

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 Audit & Risk Committee
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. There are no privacy implications

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 12
Sponsoring Director:	Chair of Clinical Governance Committee
Author(s):	Chair of Clinical Governance Committee Head of Clinical Quality
Title of Report:	Clinical Governance Committee Annual Report 2025/26
Purpose of Report:	For Decision

1 SITUATION

The attached Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2025/26. The stock take also includes the Committee's Terms of Reference.

2 BACKGROUND

Each year the committee undertakes a review of clinical governance arrangements, consisting of:

- A review of the committee's terms of reference.
- An annual report summarising the work of the groups and departments that report to the Clinical Governance Committee.

3 ASSESSMENT

Terms of Reference
The Committee's Terms of Reference are subject to annual review.

Clinical Governance Committee Annual Report
The report summarises the work of the Clinical Governance Committee and highlights particular areas of good practice along with matters of concern that have been discussed throughout the year.

4 RECOMMENDATION

The Board is asked to approve the Clinical Governance Committee Annual Report 2025/26

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	To give assurance to the Board that clinical governance processes are fit for purpose. It also supports the Quality Strategy within the hospital.
Corporate Objectives Please note which objective is linked to this paper	Better Care: a; d; e; f; j; k; l; n; s Better Health: a; b; c; f Better Value: f; h; k
Workforce Implications	The various reports throughout the year would include any issues
Financial Implications	Clinical Governance Group for noting Clinical Governance Committee for noting Risk and Audit Committee for decision
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	The various reports throughout the year would include any issues
Risk Assessment (Outline any significant risks and associated mitigation)	The various reports throughout the year would include any issues
Assessment of Impact on Stakeholder Experience	All the reports are assessed as appropriate
Equality Impact Assessment	All the reports are assessed as appropriate
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).	All the reports are assessed as appropriate
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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2025 – 31 March 2026

1. Introduction

The State Hospital, like all NHS organisations, has a statutory responsibility to establish clinical governance arrangements to ensure continuous improvement in the quality of care and treatment provided to patients. The national requirements for clinical quality have been the subject of substantial guidance, from the *Clinical Governance and Risk Management Standards* published by NHS Quality Improvement Scotland (NHS QIS) in 2005, to *Better Health, Better Care*, published by NHS Scotland in 2007, the Scottish Government's publication of the *Healthcare Improvement Strategy for NHS Scotland* in 2010 and subsequently through the NHS Healthcare Improvement Scotland *Making Care Better – Better Quality Health and Social Care for Everyone in Scotland 2017-2022.* The 5 main strategic priorities are:

1) Enable people to make informed decisions about their own care and treatment.
2) Help health and social care organisations to redesign and continuously improve services.
3) Provide evidence and share knowledge that enables people to get the best out of the services they use and helps services to improve.
4) Provide and embed quality assurance that gives people confidence in the quality and sustainability of services and supports providers to improve.
5) Make best use of all resources.

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2025-2026 and examples of good practice and matters of concern. CGC reports follow a standard format to ensure consistency and ease of reference between reports. The headings are:

- Core Purpose of Service/Committee
- Current Resource Commitment
- Summary of Core Activity for the last 12 months
- Comparison with Last Year's Planned QA/QI Activity
- Performance against Key Performance Indicators
- Quality Assurance Activity
- Quality Improvement Activity
- Stakeholder Experience
- Planned Quality Assurance/Quality Improvement for the next year

2. Committee Chair, Committee Members and Attendees

Committee Chair
Cathy Fallon, Non-Executive Director

Committee Members
Stuart Currie
David McConnell
Shalinay Raghavan

Attendees
Brian Moore, Chair of The State Hospitals Board for Scotland
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director (Lead Director for Clinical Governance)
Dr Elizabeth Flynn, Head of Psychological Services
Monica Merson, Head of Corporate Planning and Business Support
Karen McCaffrey, Director of Nursing and Operations
Robin McNaught, Director of Finance & eHealth

Allan Hardy, Acting Director of Security, Risk & Resilience

Dr Gordon Skilling, Chair, Medical Advisory Committee
Sheila Smith, Head of Clinical Quality
Margaret Smith, Board Secretary

The Committee can decide to invite the Board Chair to sit as a member of the Committee for a meeting, should this be required for quorate decision-making.

3. Meetings during 2025-2026

During 2025/26 the Clinical Governance Committee met on four occasions, in line with its terms of reference. Meetings were held on:

- 8 May 2025
- 14 August 2025
- 13 November 2025
- 19 February 2026

Attendance of members at the meetings can be found in appendix 1

4. Reports Considered by the Committee During the Year

4.1 12 Monthly Internal Governance Reports

May
Medicines Committee
This report covered the period 1 April 2024 - 31 March 2025.
The Committee received and approved the key activities and commended the service for being able to work within budget.

August
Research Committee/Research Governance and Funding
This report covered the period 1 April 2024 - 31 March 2025. The main areas of focus was the range of research activity and its dissemination undertaken by the State Hospital staff, and the mechanisms and roles in place to support research across the organisation. In total, there were 15 study proposal reviews with 19 study progress reports and 9 final reports

Patient Learning Annual Report
This report covered the period 1 January 2024 - 31 December 2024.
The Committee noted the progress that had been made and acknowledged the planned future developments that were detailed within the report. The report noted that a key focus for 2024 had been to maintain current learning provision and achieve greater stability in service delivery within the patient learning centre.

Duty of Candour
This report covered the period 1 April 2024 - 31 March 2025. The report covered information on the policy, training that had been implemented across the site as well as the governance and monitoring arrangements. Of the 170 incidents considered by the Duty of Candour Group four of the incidents fulfilled the criteria for Duty of Candour..

Patient Safety
This report covered the period 1 July 2024 - 30 June 2025. The four principles remained: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. All these work streams had been considered within the report with key priorities for 2025/26 being discussed and agreed at the meeting.

Rehabilitation Therapies Service
This report covered the period 1 July 2024 – 30 June 2025 and provided a summary of the key areas of work and the committee endorsed the future areas of work and service developments contained within it.

Mental Health Practice Steering Group
This report covered the period 1st April 2024 – 31 March 2025. The Committee approved the activities carried out and the areas of work the Mental Health Practice Steering Group intend to focus on over the next 12 months.

November
Pre-Transfer CPA/MAPPA
This report covered the period 1 October 2024 - 30 September 2025. The report identified a number of key areas and areas of good practice.

Child and Adult Protection
This report covered the period 1 October 2024 - 30 September 2025. The report highlighted key areas of work and the Committee commended the planned activity for the next 12 months.

Physical Health Steering Group
This report covered the period 1 September 2024 – 31 August 2025. The report noted the developments and progress made in the five key strands for which the Physical Health Steering Group had responsibility. 2026 will see the PHSG working towards the target of patients gaining no more that 5% of their admission weight within the first 12 months and continuing to progress the Supporting Health Choices Improvement Programme.

Supporting Healthy Choices
The report evidenced the strong foundations that had been established in previous years through clear governance and reporting structures. Alongside this, details of improvement activity that had been initiated and implemented were commended by the Committee.

Person Centred Improvement Service
This report covered the period 1 October 2024 – 30 September 2025 and key areas of work were presented. Future areas of work were also endorsed by the Committee.

February
Clinical Governance Group
This report covered the period 1 January 2025 - 31 December 2025. The report provided a summary of the work of the Clinical Governance Group over the past 12 months and outlined the areas of future work.

Psychological Therapies
This report covered the period 1 January 2025 - 31 December 2025 and highlighted a number of positive areas as well as outlining key pieces of work for 2026/27.

Activity Oversight Group
This report covered the period 1st January – 31st December 2025 and highlighted some key achievements and areas of future work over the next 12 months.

4.2 Standing Items Considered by the Clinical Governance Committee during the Year

August
Learning from Adverse Events (SAERS) Action Tracker
These reports were submitted from August 2025 and provided the Committee with a summary of outstanding recommendations from various sources across the hospital including adverse event reviews (CAT 1 and CAT 2), conduct investigations and medication incident reviews and timescales for completion of actions.

Reports at All Meetings

Bed Capacity
The reports highlighted continued problems with capacity across the Forensic Network; bed occupancy within the State Hospital (across the 4 main Services – 5 from November meeting) and details on surge bed contingency planning that has been implemented through the Clinical Model Oversight Group.

Daytime Confinement
Data and updates on daytime confinement within the hospital were presented at every meeting to give assurance that robust systems and processes are in place to keep daytime confinement to a minimum.

Learning from Complaints
The quarterly Learning from Complaints & Feedback report was considered and noted and actions arising from all complaints are included within the report to share the learning which enables the organisation to develop services which take cognisance of complaint outcomes.

Incident Reporting and Patient Restrictions Report
The reports showed the type and number of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. This was the second full year of the Committee only getting the clinical data that was relevant to them.

Infection Control
Updates on the 9 Standards within the HIS Infection Control Standards (2022) were given at each meeting during the reporting period with actions being agreed.

Nurse Resource Report
These reports included updates on staffing; clinical resourcing; use of daytime confinement; resource incidents as well as updates on our compliance with the Health Care Staffing Act (HCSA).

Corporate Risk Register – Clinical Update
The most recent paper at the February 2026 meeting showed that all clinical risk assessments were within their review date; Two high/very high risks remain within the hospital, MD30 – Failure to prevent/mitigate obesity and ND70 – Failure to utilise our resources to optimise excellent care and experience. There are a number of areas being worked on to reduce these risks.

4.3 Other Items discussed During the Year

Clinical Model Implementation Evaluation
This report presented interim findings from the 3-year evaluation of the clinical model, noting positive patient outcomes, challenges in staff experience due to systemic pressures, and recommendations for further development.

Committee members proposed that the evaluation is brought to a future development session for in-depth discussion.

5. Presentation Items During the Year

Unscheduled Care
The May 2025 meeting saw a presentation that provided an overview of the work being carried out in relation to unscheduled care. The workstreams included:

- Unscheduled outings
- Outboarding processes
- Physical healthcare
- Daytime confinement and
- Recommendations from unscheduled care report

Clinical Care in TSH Interim Women's Service
The Clinical Lead led a presentation discussion at the August 2025 meeting about the Women's Service within the hospital. The presentation covered various aspects of setting up this service including the many challenges faced and the significant progress that had been made in an extremely short period of time.

Intellectual Disabilities Service
The Clinical Lead led the Committee through a comprehensive overview of the Intellectual Disabilities (ID) Service at the Meeting in November 2025.

Triangle of Care
At the February 2026 meeting, the Person Centre Improvement Team Lead gave a presentation on the Triangle of Care, its alignment with the Carers Strategy and our progress with the 6 key standards.

6. Special Topics/Items for Approval

Clinical Governance Annual Stock Take
At its May 2025 meeting, the Committee received and noted:

- Programme of Work for 2025/26 subsequent to any changes that may arise at future meetings;
- Clinical Governance Committee Terms of Reference;
- Clinical Governance Annual Report 2024/25.

7. Areas of Good Practice Identified by the Committee

- Unscheduled care report
- Review of Guidelines through the Medicines Committee
- The work being undertaken by the Supporting Healthy Choices Group
- Involvement of patients in the development of the Participant Information Sheet Template outlined within the Research Committee annual report
- Physical health annual screening
- High rates of ground access
- The transfer CPA completion rate of 100%
- Streamlining of the patient timetable
- Reduction in clinical waste incidents

8. Matters of Concern to the Committee

There were no areas of concern noted throughout the reporting year.

9. Conclusion

From the review of the performance of the Clinical Governance Committee, it can be confirmed that the Committee has met in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Clinical Governance arrangements were in place throughout the year.

Attendance at meetings (members)

	8 May 2025	14 August 2025	13 November 2025	19 February 2026
Brian Moore	X	X	X	
Cathy Fallon		X	X	X
Stuart Currie		X	X	X
David McConnell	X	X	X	X
Shalinay Raghavan	X			

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 13
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Director of Nursing and Operations
Title of Report:	Daytime Confinement (DTC) Report
Purpose of Report:	For Noting

1. SITUATION

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

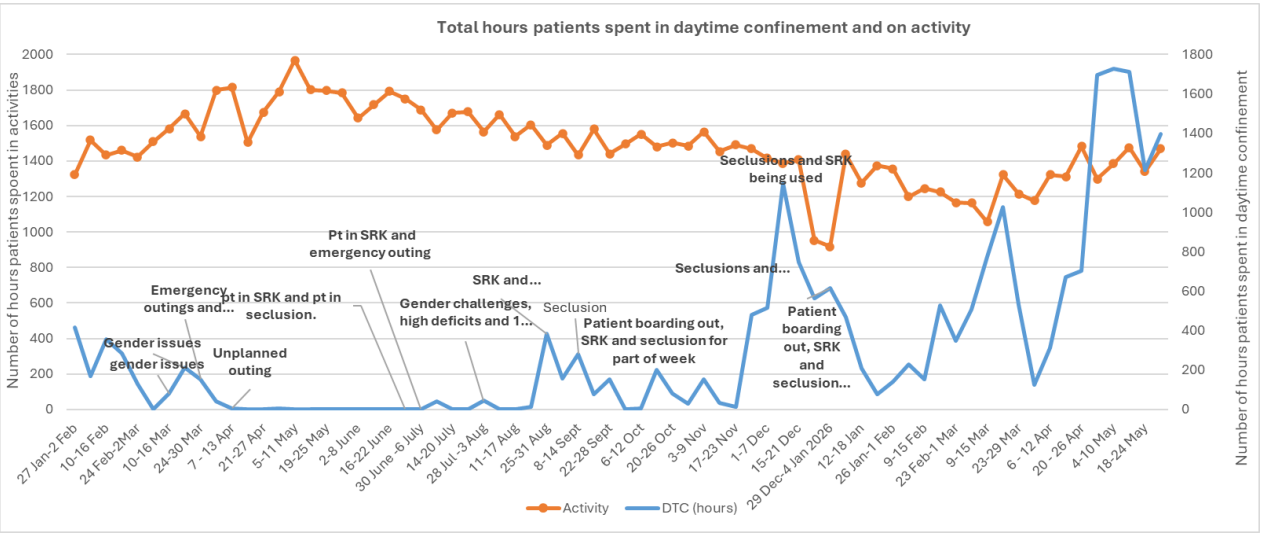
The data presented in the report covers the period up to and including the 31 May 2026.

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)

April – saw an increase in DTC from 2844 hours to 3512.75 hours. The number of activities being provided to our patients increased across the reporting month with these ranging from 1176.3 hours week beginning 30 March and 1482.2 hours week beginning 20 April. This is less in May and June last year which average 1750 hours (this is all planned and drop-in activity) but could be linked to the amount of time patients experienced DTC throughout April. The weekly DTC median remained at 530 hour, although continue to note an upward trend in the data:

May - has seen an increase in DTC from 3512.75 hours to 6049 hours. The number of activities being provided to our patients increased across the reporting month with these ranging from 1385.4 hours week beginning 4 May and 1475.6 hours week beginning 11 May. This is less than in May and June last year which averaged 1750 hours (this is all planned and drop-in activity) but could be linked to the amount of time patients experienced DTC throughout May. The weekly DTC median increased from 530 hours to 1455 hours due to a continued negative shift in the data.

Operational Management

Meeting Structure and Progress
Oversight meetings continue. Work still ongoing following the process mapping exercise on the 18th March to look at the various resource meetings.

Recruitment
Nursing recruitment and onboarding continues to be of firm focus within the Directorate. An onsite recruitment fayre has been scheduled for 10th June with twenty-five Band 5 interviews planned for the day.

In addition to ongoing recruitment campaigns a series of onboarding dates have been scheduled, with the next onboarding planned for 17th June whereby 7 individuals are due to commence employment (six of these as Band 5 registrants and one Band 3 – until NMC PIN is received in September/October).

As at 31st May 2026 there were approximately 10WTE unfilled Band 5 posts however this will increase due to confirmation of additional funding for the female service. Work to review requirements for this is underway.

DTC Incident command

Incident command process in place, some feedback from SCNs regarding impact of approval process on delaying action. Agreed to look at this and refine to ensure safety but maintain robust governance and assurance regarding decision making.

Patient Impact
We have received 14 complaints regarding DTC during this reporting period. Of these 12 have been upheld. Two have escalated to Stage 2 and are still being considered. The Director of Nursing has arranged to attend PPG to speak to the patients regarding this on the 18 June.

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:	18 June 2026
Agenda Reference No:	Item No: 14
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

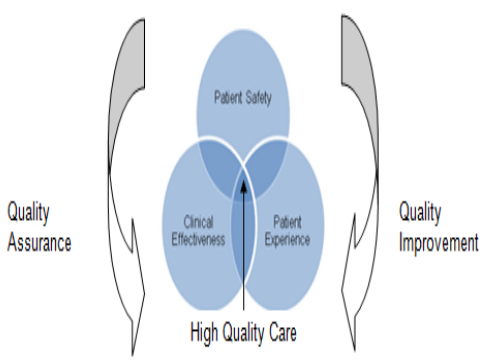
2 BACKGROUND

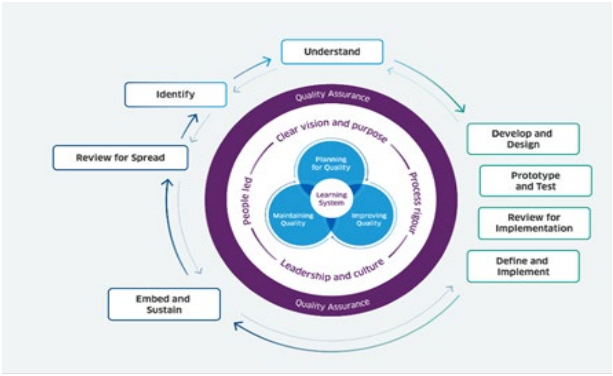
Quality assurance and improvement at the State Hospital align with the Clinical Quality Strategy 2024–2029, approved by the Board in August 2024. This strategy outlines the direction and goals for enhancing clinical care, aiming to improve patient experiences through person-centred, safe, high-quality 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 governance oversight monitoring report.
- 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 2026/27. **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 – APRIL/MAY 2026

1. ASSURANCE OF QUALITY

1.1 Clinical Audit

The Clinical Quality Department carries out a range of planned audits. Over the course of a year there are usually 21-25 audits carried out. The audits provide feedback and assurance that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure quality improvement and action plans are discussed at the commissioning group.

Within this reporting period, there have been four local audits completed by the Clinical Quality Department and actioned through the Commissioning Groups. The Diabetes audit, Observations of Care audit and RMO Record Keeping audit gave significant assurance to the organisation and the Clozapine Audit gave moderate assurance with an improvement plan agreed through the Medicines Committee.

- Diabetes Audit
- Clozapine Audit
- Observations of Care Audit
- RMO Record Keeping

A number of other audits have been completed but await approval from the Commissioning Groups.

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

Table 1: Master Audits

	Arran 1	Lewis 1	Arran 2	Arran 3	Lewis 2	Lewis 3	Mull 1	Mull 2	Mull 3	Iona 2	Iona 3
Medication Trolley Audit									n/a		
Medicine Fridge Audit									n/a		
HEPMA Audit									n/a		
PMVA Post Physical audit			n/a				n/a	n/a	n/a		
Unvalidated progress notes									n/a		
Nurse progress note on each shift									n/a		
Controlled Drugs Audit											
RMO contact with patients									n/a		
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		n/a		
Clinical Care Policy Audit							n/a	n/a	n/a		
PRN Audit						n/a	n/a		n/a		
Nutritional Screening Tool Audit											
Mechanical Restraint Audit				n/a		n/a	n/a	n/a		n/a	
Diabetes Audit		n/a					n/a		n/a	n/a	
Clozapine Audit	n/a	n/a							n/a		

Service Leadership Teams are advised of the master audit adherence to enable overview of audit adherence within their wards. A report on the master audit adherence was provided to the Clinical Governance Group in February 2026.

1.2 CPA oversight monitoring report

Following implementation of the new electronic CPA process, Clinical Quality have now resumed providing governance level flash reports to all relevant groups with the hospital:

HOSPITAL WIDE CPA OVERSIGHT MONITORING FLASH REPORT

Date: April 26

Overview and areas of good practice

This report refers to all annual and intermediate reviews held across the hospital in April 26. Data is pulled direct from RiO from individual profession CPA reports and the CPA attendance and minute form.

The monthly VAT report is split as follows:

April 26	Annual	Intermediate	Total	MDT attendance
Admission	0	0	0	-
Arran T & R	2	1	3	70% - increased from 64% in March 26
Lewis T & R	3	1	4	71% - increased from 55% in March 26
ID	0	1	1	43% - decreased from 48% in March 26
Transition	1	3	4	76% - increased from 68% in March 26

In addition, a seperate Admission report will be provided to relevant clinical teams – there were no Discharge CPA meetings held in April 26.

All interventions continued to show random variation over the period. Report provision continues to be good.

RMO, Psychologist and Social Work met or exceeded their KPI attendance target.

After a decrease last month Social Work completed all interventions.

There was improvement in all Psychology interventions.

Areas of concern

Nursing Key Worker, Occupational Therapy, Pharmacy, Security and Dietetics did not meet their KPI attendance target.

Provision of the Medical Report on Lewis T & R service decreased to 25% - all other services recorded 100%.

Nursing: Post-CPA discussion of the review with patients remains low at **33%**. This represents a significant decline since the introduction of the new process and suggests ongoing issues with adherence to the revised requirements. Senior Charge Nurses are asked to contact Clinical Quality if they require clarification around this issue.

Any challenges with the systems that are being addressed

The legacy VAT process was replaced by the CPA Oversight Monitoring process in January 2026. This change means that data on key steps in the patient pathway, both leading up to,during and after CPA meetings, will be collected directly from RiO. Staff should note that separate VAT forms no longer need to be completed.

For the first three months of the new reporting approach, the Clinical Quality Team provided Heads of Service with detailed information highlighting where the process has not been followed, to support improvement – April will be the first month when this information is not provided.

Heads of Service will now be responsible for running their own profession-specific reports from RiO and identifying areas of good practice as well as opportunities for improvement. Particular attention should be paid to ensure that profession reports are being provided at least 7 days in advance of the CPA. Clinical Quality has met with all Heads of Service to explain the new Profession Specific Oversight Monitoring Reports – all professions now have access to these reports on RiO. These reports should be run to ensure that interventions are being completed on time and that the new CPA process is being followed.

Testing of the CPA Oversight Monitoring Tableau Dashboard is complete, and the data is now confirmed as accurate. However, noting that further changes are still required prior to go-live due to the proposed changes to the operationalisation of the clinical model, design enhancements to the dashboard have been paused pending confirmation of the revised reporting requirements.

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

QI Projects: Eleven 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.

TSH3030: Seventeen teams registered for TSH3030, with thirteen completing the QI sprint which ran from 1 -30st May. Teams committed to spending 30 minutes each day on a QI project for 30 days. Participating teams produced midway posters summing up their project work for the first 2 weeks. Project themes include improving processes and enhancing patient care and experience. Nine teams developed midway posters, which were judged with

three posters receiving high commended awards. Midway posters are displayed on the QI noticeboard in reception. Teams have also submitted their 'word of the week' summarising how their QI projects are developing. Submission of final posters is due by the 8 June 2026, and an Oscars Events is planned for the 25 June 2026 to celebrate achievements, recognise improvement work and share learning.

2.3 QI Capacity Building

2.3.1 – Scottish Improvement Leaders Programme (ScIL)

Cohort 53 – Three staff members commenced in November 2025 and are currently working through the course.

Cohort 56 – Recruitment is open for staff to consider applying. The State Hospital has been allocated two places (1 EiC and 1 H&SC)

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 Six is being advertised in the coming week and will commence in September 2026.

2.4 Realistic Medicine

Four members of staff will be attending the Realistic Medicine Conference on the 19 June 2026. Three posters were submitted for consideration for the event, with one of these being accepted.

3. EVIDENCE FOR QUALITY

3.1 National and local evidence-based guidelines and standards

The State Hospital has a robust process for reviewing all incoming guidance to determine its relevance to the State Hospital. Pertinent documents are evaluated by multidisciplinary teams using a gap analysis to ensure compliance. During the period 1 April to 31 May 2026, 29 guidance documents have been reviewed: 19 documents were considered either not relevant or were overridden by Scottish guidance, 7 were shared for information and a 5 required either a gap analysis or further work to be carried out. Of these 5, a gap analysis is required in relation to anaphylaxis, another is being completed for a review of migraine (SIGN) whilst a 3rd is being updated regarding the Food, Fluid and Nutritional Care Standards. The final 2 documents from the MWC in relation to announced visits will require further action via the Clinical Governance Group.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Gap analysis /action required
SIGN	1	0	1
MWC	4	4	2
HIS	2	1	1
National Institute for Health & Care Excellence (NICE)	22	2	1

There are currently no gap analyses which have been outstanding for a prolonged period.

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE **CGC(M)26/01**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 19 February 2026.

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
In Attendance:	
Corporate Business Manager	Anne Donnelly [Minutes]
Head of Psychology	Dr Liz Flynn
Skye Centre Manager	Jacqueline Garrity [Item 5]
Acting Director of Security, Estates and Resilience	Allan Hardy
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey [to Item 9]
Board Chair	Brian Moore
Research Fellow	Cheryl Rees [Item15]
Head of Corporate Governance	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Professor Lindsay Thomson

1 APOLOGIES AND INTRODUCTORY REMARKS

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

2 CONFLICTS OF INTEREST

Professor Thomson declared a potential conflict of interest in relation to Item 15, Clinical Research Model Findings. She confirmed that the research was undertaken in her role at the University of Edinburgh and not in her capacity as Medical Director at the State Hospital and noted the importance of making this distinction clear to the Committee.

3 TO APPROVE THE MINUTES OF PREVIOUS MEETING

The Committee approved the minute of the previous meeting held on 13 November 2025.

The Committee:

1. Approved the minute of the meeting held on 13 November 2025.

4 MATTERS ARISING / ROLLING ACTIONS LIST

The Committee noted that there were no matters arising from the previous meeting.

In relation to the rolling actions list the Committee received the following updates:

- Action 8 - Mr Moore sought clarification regarding the reference in the update to the NHS 10-year health plan related to NHS England. Mr Jenkins confirmed it should read Public Health Scotland's Population Health Framework 2025-2035 and would be updated.
- Action 7 – Professor Thomson noted that patients within the intellectual disability service could apply for grounds access the same as any other patient, but an amended route had also been created. It was agreed the action could be closed.

In response to a query from Ms Fallon, Mr Hardy confirmed that Social Work and Security had reviewed the child searching processes and that a standard operating procedure had been developed with further work underway to ensure it was child-friendly.

The Committee:

1. Noted the updates from the Rolling Action List.

5 DISCUSSION ITEM: TRIANGLE OF CARE

Ms Garrity joined the meeting and presented an overview of the Triangle of Care, a best-practice framework introduced in 2010 to strengthen partnerships between carers, patients, and professionals. While primarily developed for acute settings, it was noted to have clear benefits in forensic mental health by supporting complex patient needs, improving safety and risk management, and enabling carers to share valuable insights that enhance communication and therapeutic relationships. She advised the framework had six key standards and provided an overview of each.

Ms Garrity advised that the 2022 reassessment review identified outdated evidence, inconsistent documentation and gaps in required actions. Eighteen criteria previously marked as complete required refreshed evidence, primarily relating to carer involvement, information sharing, staff awareness and supporting documentation. An action plan had been developed to strengthen compliance, improve carer involvement, and enhance governance and monitoring, including quarterly and annual reviews, audited carer questionnaires following each Care Programme Approach (CPA) meeting and routine reporting to the Clinical Governance Committee.

She noted that the carer feedback process had been simplified into two questionnaires (admission and CPA) which would feed directly to the CPA audit. The carer information pack was being updated for approval through the Clinical Model Oversight Group (CMOG) and local confidentiality guidance for carers was being developed, with staff training identified as a priority. She added that national training materials and Health Improvement Scotland (HIS) resources from carer engagement work would require local adaptation.

The audit identified a gap in support for carers attending first visits for new admissions, as these often took place on wards. Although previously marked as complete, this gap highlighted the need for improved arrangements. Options were being explored to ensure carers were supported on arrival and escorted to wards, with responsibility shared across the Clinical Team. Ms Garrity concluded the Triangle of Care was recognised as central to strengthening collaboration, safety, and communication by recognising carers as key partners in forensic mental health care.

Ms Fallon thanked Ms Garity for the presentation and opened for questions.

Professor Thomson suggested prompts from the Clinical Teams and Advocacy at meetings may improve response rates. She added the 'Getting On and Getting Out' booklet, which was the patient's perspective on what they need to do, may be useful for carers. Finally, in relation to advanced statements, she sought confirmation that they were up to date, and how compliance was being audited.

Ms Garrity advised that work was underway to improve the timely sharing of carer feedback with service leadership and Clinical Teams and confirmed that advance statements were up to date. She noted that a standard letter to carers or named persons, if CPA attendance was declined at the patient's request, had not been used consistently and this would be reinforced to improve clarity and communication.

In response to questions from Mr Moore and Ms Fallon, Ms Garrity confirmed that a summary of the main points discussed today would be included within the Carers Strategy Update being reported to the Board on 26 February and would be included in the Person-Centred Improvement Service 12 Month Report which was scheduled to come to this Committee in November.

Mr Jenkins sought clarification on where oversight of the Triangle of Care improvement work was prior to the annual assurance report to the Clinical Governance Committee. Ms Garrity confirmed that oversight was provided through the Person-Centered Improvement Group, with escalation to the Clinical Governance Group.

Ms Fallon thanked Ms Garrity for today's presentation and asked if the Carers Trust: Triangle of Care information leaflet was available to carers visiting the hospital. Ms Garrity advised that it was not at present, but this would be arranged.

Action: J Garrity

The Committee:

1. Discussed and noted the content of the presentation.
2. Requested confirmation on availability of the Carers Trust: Triangle of Care Information Leaflet.

6 DAYTIME CONFINEMENT (DTC)

The Committee received the DTC report, which covered the period from the end of September and most of December 2025. Ms McCaffrey highlighted that this was a predicted peak period, with increased DTC driven by higher patient acuity, the requirement for increased staffing and admissions, and that staff were less able to take on additional shifts in the lead up to the festive period. She referred to Page 2 of the report where analysis of DTC during normal working hours, with a full complement of staff and all departments open showed higher-than-expected levels, however targeted actions resulted in a reduction by December.

An update was provided on the work of OMT to strengthen the escalation process for DTC. Director and staff training supported the introduction of a bespoke DTC incident command process, removing the need for full Gold Command while maintaining robust governance. A standardised decision-making template was in place, with discussions recorded via MS Teams and securely stored to ensure a clear and auditable decision trail.

Finally, Ms McCaffrey advised that work continued to rebalance staffing following over-recruitment ahead of the Women's Service opening. Recruitment remained proactive, with attendance at recruitment fairs and a local event planned, and onboarding expected through to March. As part of DTC contingency arrangements, non-nursing staff had at times supported ward activity, with the impact on Skye Centre, Psychology and AHP services being carefully monitored. While some work was deferred during peak pressures, support was used only when necessary, with efforts ongoing to minimise this as much as possible.

Ms Fallon thanked Ms McCaffrey for the update and opened up for comments or questions.

Mr McConnell thanked Ms McCaffrey for the update and asked for clarification on DTC within normal working hours. Ms McCaffrey explained that this related to maximising support from other available disciplines during office hours, adding that gender balance, not just staffing numbers,

was a key factor. She confirmed the approach would result in an overall reduction in DTC. Mr Jenkins provided assurance that recent DTC pressures were attributable to under-resourcing of the Women's Service, which was operating above its funded baseline. He advised that discussions with the Scottish Government were underway in this respect, noting that without this resource diversion, the predicted reduction in DTC would likely have been achieved. He also referenced current recruitment efforts aimed at achieving recruitment to 1055 within nursing. In response to a question from Ms Fallon, Mr Jenkins advised that reporting would be brought to the Board meeting scheduled for 16 April 2026 in this respect.

Mr Moore thanked Ms McCaffrey for the detailed report, particularly the context provided on the December pressures. He noted emerging frustration among some staff regarding redeployment and asked whether there were ways to mitigate this or provide assurance that such pressures were recognised and would not become a recurring feature. Ms McCaffrey acknowledged staff frustration regarding redeployment and reiterated the context of the pressures faced. She recognised the significant contribution made by staff, emphasised that redeployment decisions were not taken lightly, and highlighted the value of colleagues' substantive roles. She advised that ongoing engagement sessions have supported understanding and would continue to provide opportunities for staff to raise questions.

Mr Currie emphasised the importance of securing a re-based budget for the Women's Service that reflected operational reality, noting that without this certainty the hospital recurring DTC pressures would continue. He highlighted that a stable and realistic baseline would strengthen accountability, reduce reliance on resource diversion, and support effective scrutiny of future performance.

Mr Jenkins highlighted the significant detrimental impact of ongoing pressures on staff morale and the wider culture. He emphasised that without a sustainable funding solution, DTC risked becoming a recurring issue that undermined service delivery and the benefits of the clinical model. He stressed the need for a definitive, long-term solution to remove this distraction and enable effective leadership, governance, and accountability.

Ms Fallon thanked Ms McCaffrey for the report and acknowledged the significant organisational and workforce impact of DTC pressures. She noted the importance of the ongoing work to address these issues and emphasised the impact on patients as the primary concern and welcomed future updates on progress.

The Committee:

1. Noted the Daytime Confinement Report.
2. Noted that further reporting would be received by the Board in April 2026.

7 ACTIVITY OVERSIGHT GROUP (AOG) 12 MONTH REPORT

The Committee received the AOG 12 Month Report from Ms McCaffrey who advised that this would be the final report to come to the Committee following a review of governance arrangements and the work of the AOG would be discharged to other groups. She acknowledged the significant contribution of all involved in establishing a strong foundation for ongoing activity oversight. Key highlights included the development of clinical quality dashboards to support service-level decision-making, progress in stabilising and delivering Skye Centre activity, and continued focus on key performance indicators, including patient activity and exercise. She provided assurance that the work programme would continue following the formal closure of the AOG, with a final handover report to be submitted to the Clinical Governance Group.

Ms Fallon thanked Ms McCaffrey for the update and opened for questions.

Mr Moore welcomed the progress on digitalisation and reduction of manual processes, and noted the positive performance of the Skye Centre, including delivery of nearly 80% of planned sessions and improved weekend activity. He highlighted the report's many positives in the context of DTC

pressures. He also reflected on the amount of data being collected and suggested that a broader review of organisational data requirements, use and interpretation would be helpful. Ms Fallon echoed this and added that it may be useful for discussion at a Board Development session, and this was agreed.

Action: Secretariat

Professor Thomson highlighted that since the establishment of the AOG, average weekly activity hours at the Skye Centre had increased from just over four hours to 7.3 hours which showed clear evidence of improvement in patient activity, in part attributable to the work of the Group and the actions outlined in the report.

Ms Fallon acknowledged the positive progress highlighted, noting that activity was now seen as a collective responsibility across the hospital. She requested an update on the Room4U quality improvement project. Ms McCaffrey advised that the Room4U quality improvement project reported into the Person-Centred Improvement Group with onward reporting to the Clinical Governance Group and then to Committee.

The Committee:

1. Noted the final AOG 12 Month Report.
2. Requested addition of review of data collection/use/analysis was added to board development session programme.

8 PSYCHOLOGICAL THERAPIES 12 MONTH REPORT

The Committee received the Psychological Therapies 12 Month Report presented by Dr Flynn who noted that the report had been revised to place greater emphasis on patient impact. Key areas highlighted included ongoing work on skill mix within the service, noting that psychologists retained clinical oversight of cases, while other staff groups, including unqualified staff and nurse therapists, made significant contributions to care. Dr Flynn advised that work was underway to better align capacity with demand, recognising the limitations of existing workforce modelling approaches.

Despite wider pressures, Dr Flynn reported that services were largely maintained, with KPIs broadly achieved and improvements in risk assessment completion. She highlighted increased ward-based talking groups and contributions to service development, including Women's Service outreach work. Progress was noted in risk assessment processes, with information-sharing arrangements with Police Scotland nearing completion. Further progress included improved supervision arrangements, transitions work through the Mind the Gap project under TSH3030, the well-received Made Purple initiative, and ongoing development of the SilverCloud digital programme.

Ms Fallon thanked Dr Flynn for the report and opened for questions.

Mr McConnell thanked Dr Flynn and noted the staffing challenges highlighted in the report, including recruitment difficulties and the impact of DTC related redeployments. While acknowledging that most KPIs had been achieved, he asked where pressures were most evident in terms of service delivery, and whether this was primarily reflected in reduced clinical session activity and individual contacts, or if challenges were emerging in other areas.

Dr Flynn replied that pressures had been felt across the service rather than in any single area. She explained that priority had been given to maintaining direct therapeutic work and risk assessments, with efforts made to avoid cancelling treatment appointments. As a result, some non-clinical areas, including service development work, CPD and training, had been more affected, although essential activities such as note-keeping and report writing continued. She noted that reduced training activity had been the most significant impact over the past year.

Mr Jenkins reflected on the skill-mix discussion and suggested that further work on psychologist job planning and expected outputs would be valuable. He noted that clearer articulation of planned versus delivered activity would support understanding of performance, help explain variation, and provide a clearer trajectory of what was achieved and what was missed over time.

Mr Moore noted the strong sense of progress within the report, particularly in relation to partnership working and initiatives such as Mind the Gap and digital interventions, including the development of SilverCloud. He also welcomed the update provided on improvements to risk assessment processes. Dr Flynn advised that risk assessment remained a priority and outlined plans to create a new post to strengthen risk assessment and therapeutic input within the Intellectual Disability service which would be funded through a combination of reduced working week funding and existing resources and expressed confidence that this would enable further progress over the coming year.

Ms Fallon thanked Dr Flynn for the report and acknowledged the challenges faced and the team's achievement in delivering key priorities. She welcomed the range of ongoing and planned developments, including partnership working and digital initiatives, and asked that further work on job planning and outputs be progressed with Ms McCaffrey and brought back to the Committee in due course as part of regular reporting.

The Committee:

1. Noted the Psychological Therapies 12 Month Report.

9 MENTAL HEALTH PRACTICE STEERING GROUP (MHPSG) 6 MONTH UPDATE

The Committee received the MHPSG 6 Month Update presented by Professor Thomson who noted that the group had met monthly and oversaw all areas of mental health practice, with responsibility for review, development, and implementation of improvements. She highlighted the Group's ambitious work programme and progress across a number of key areas.

Professor Thomson advised that significant progress had been made in relation to CPAs with new documentation and associated processes now fully rolled out across the hospital, completion of the training programme, and the commencement of a peer review panel in January to assess the quality of CPA documentation. This represented an important shift towards quality-focused assurance, with clear reporting routes into the Clinical Governance Group and onward to the Committee.

Updates were also provided on work to develop outcome measures, with completion anticipated later in the year, and on Structured Clinical Care, which was a whole-system framework for relational and psychologically informed care. A needs and gap analysis would be undertaken, supported by project management input, and Professor Thomson acknowledged the scale of this work.

In relation to carers, family intervention and engagement, Professor Thomson noted alignment with the wider Carer Strategy and Triangle of Care work, with recognition that individualised approaches may be more appropriate than formalised programmes given the hospital context. She highlighted trauma-informed care as a key priority, noted ongoing training and plans to establish a steering group using the Scottish Government's trauma-informed roadmap to accelerate progress. She also commended the Relational Approach to Care LearnPro module, which was an effective means of integrating core psychological concepts into practice.

Finally, Professor Thomson noted that routine quality assurance work continued, including a review of mental health documentation and guidance, and highlighted improvements in decision-making on grounds access times, with the median timeframe reduced from 20 to 14 days.

Ms Fallon thanked Professor Thomson for the update and opened up for questions.

Mr Currie commended the strong emphasis on quality and outcomes rather than task completion alone, noting the importance of understanding the impact of work delivered. He welcomed the focused and phased approach to delivery, highlighting the value of completing priority areas to a high standard before progressing further, and recognised this as good practice from a governance and assurance perspective.

Dr Flynn provided an update on trauma-informed care work and advised that the initial focus would be on the Women's Service, with a trauma walkthrough planned alongside staff focus groups to identify areas where additional support would be most beneficial. She also reported that recurring funding had recently been confirmed from NES to support educational infrastructure, including a Transforming Psychological Trauma role. This would enable a resource to be ring-fenced to progress trauma-informed work.

Ms S Smith noted agreement with Mr Currie's comments and added that the CPA peer review panel had met this week and reviewed three CPA reports and had demonstrated the value of collective scrutiny in improving quality. She noted the importance of managing perceptions as the new process embedded, as similar quality issues were evident under the paper-based system. However, the process was helping staff to better understand SMART objectives and how reports linked into care and treatment plans, and that it was positive to focus on quality.

Ms Fallon thanked everyone for their comments and asked that Professor Thomson provide feedback to the group. She also welcomed the reduction in grounds access decision-making timescales, noting this as a positive and significant improvement.

The Committee:

1. Noted the MHPSG 6 Month Update.

10 LEARNING POINTS FROM SERIOUS ADVERSE EVENTS REPORT (SAERs)

The Committee received the Learning Points from SAERs Report presented by Mr Hardy who advised that the SAERs group was fully established and meeting regularly, with one active investigation currently underway and progressing within agreed timescales. He noted that one investigation had recently concluded, with associated actions expected to be completed and reported in the next quarter. He noted there was one Duty of Candour (DoC) incident which would be managed through the DoC Group, chaired by the Associate Medical Director. He confirmed that only one outstanding action remained on the Learning from Events tracker, with completion imminent, and provided assurance that overall progress was satisfactory.

Ms Fallon thanked Mr Hardy for the update and opened for questions.

Mr Currie asked whether an annual report on learning from events was produced, noting that such a summary could be helpful from a governance perspective to demonstrate key themes, learning identified, and actions taken as a result. Mr Hardy advised that there was not at present, but it would be explored to see if an annual report may be more appropriate than on a quarterly basis. Ms Fallon commented that timescales may be missed if reporting was reduced to annually. Mr Jenkins noted that the establishment of the SAERs Group, aligned with the Duty of Candour Group, had strengthened oversight of adverse events. He suggested that a six-monthly summary may provide appropriate assurance to Executive and Non-Executive members, alongside existing reporting to Healthcare Improvement Scotland, and proposed further discussion on the most effective reporting route to support governance, assurance, and scrutiny. It was agreed that this should be included in discussion on risk reporting within the Board Development Session.

Action – Mr Hardy

Ms Fallon asked that consideration was given to the title of the report and its content some of which did not fall under the scope of Committee. Clarity within reports would support appropriate

correct governance and ensure the Committee received only relevant information.

Action: A Hardy

The Committee:

1. Noted the Learning Points from SAERs Report.
2. Requested review of reporting within Board Development Session.
3. Requested review of scope of reporting to the Committee so framed within clinical governance route.

11 INCIDENTS AND PATIENT RESTRICTIONS

a) Male Service

The Committee received the Incidents and Patient Restrictions Report for Q3 presented by Mr Hardy who advised that the data would be presented separately for the male and female services, with tailored security measures applying to both contained within the Male Service report.

Firstly, Mr Hardy provided a summary of the data contained within reporting, focused on the Male Service, before Ms Fallon opened discussion. There was discussion around how to report data for each service in a meaningful way whilst ensuring all aspects of patient confidentiality were considered and protected. It was noted that guidance was sought in this respect from the information governance lead within the organisation, and that this would continue to be kept under close review. Reporting should enable a clear understanding of underlying factors rather than a reliance on headline figures alone. There was a recognised need for clear, robust evidence to support effective scrutiny and inform budget and resource discussions, particularly in demonstrating the wider organisational impact of the Women's Service. Ms Fallon requested clarity on this point to be brought back to the next meeting.

Action – Mr Hardy

She also noted it was good to see no waste incidents reported. She also noted the need to further disaggregate data for each of service, as this was not evident in reporting.

b) Women's Service

Mr Hardy then provided a summary overview of reporting in relation to the Women's Service.

Mr McConnell thanked Mr Hardy for the report and provided context following a recent walkround of the service. He noted the positive engagement and achievements of staff despite the challenges. He highlighted the importance of consistency of staffing, which he noted helped to explain the activity reflected in the data.

Mr Currie noted that a consistent impact had been evident across papers in respect of the Women's Service and questioned if the current increase in incidents represented an expected early peak and whether this might stabilise over time. He suggested that a fuller assessment may be possible after Quarter 4, with continued monitoring to determine whether activity levels reduced. Ms S Smith said that 12 data points were normally required before activity levels were assessed, and so this would be considered further. She added that patients tended to be more settled when supported by core staff and the redeployment of staff from other areas appeared to have had a destabilising effect, reflective of the current lack of substantive staffing for the service.

Mr Jenkins highlighted the differences in presentation and long-term recovery trajectories between female and male forensic patients. He referred to work progressed clinically in this area, saying that this could be considered as an addition to the Board Development Session programme.

Action: Secretariat

Ms Fallon thanked Mr Hardy for the report and added that discussions today should inform future reporting. She noted that the Staff Governance Committee should have awareness of reporting, in terms of how this may affect staff.

The Committee:

1. Noted the Incidents and Patient Restrictions Report.
2. Requested further review of how data was reported across services.
3. Reporting to be amended as noted.
4. Presentation at Board Development Session on clinical aspects of female forensic mental health patients.

12 LEARNING FROM COMPLAINTS & FEEDBACK

Members received the Learning from Complaints and Feedback Report Q3 presented by Ms M Smith who provided a summary of the key points.

She noted a reduction in formal complaints during the quarter, which may reflect concerns being raised through alternative routes, including the Patient Participation Group. (PPG). Key learning included upheld complaints relating to delays in the administration of DWP benefits. This prompted a review by the Finance Team and engagement with the PPG to agree improved arrangements. Resourcing pressures continued to feature, though concerns were largely raised informally. One complaint regarding a request to review CCTV footage had identified a process gap

Mr Currie noted the complexities associated with benefits administration, including where awards were made retrospectively, resulting in significant lump-sum payments and added that Social Security Scotland offer useful outreach/advisory support. He expressed disappointment around the number of complaints relating to staff attitude/conduct which was an area within organisational control and therefore important for learning, even if not upheld. He noted the importance of robust CCTV processes to ensure confidence in complaint handling as central to maintaining trust. Finally, he added that the volume and nature of complaints suggested patients had confidence in the process, supported by effective advocacy and constructive engagement through the PPG.

Mr Jenkins noted that patients often raised concerns openly at community meetings, particularly in relation to staffing and DTC, which may influence formal complaint themes and increased Executive presence at these forums was potentially beneficial. He also noted strong patient engagement, supported by advocacy, which may contribute to changing complaint trends.
Mr Hardy added that in respect of CCTV, processes had been strengthened to ensure clearer mandates and earlier escalation, and a similar issue was not expected to recur.

Ms Fallon thanked Ms M Smith and her team for the detailed nature of the report, which was helpful.

The Committee:

1. Noted the Learning from Complaints and Feedback Report.

13 BED CAPACITY REPORT

The Committee received the Bed Capacity Report presented by Professor Thomson who provided an overview of activity in this respect, including transfers across TSH services and capacity in the wider network for the three months to 31 December. Overall, while pressures remained high and capacity was tight, the hospital continued to manage admissions and successfully move patients to lower levels of security.

Ms Fallon thanked Professor Thomson for the helpful report.

The Committee:

1. Noted the Bed Capacity Report.

14 CLINICAL GOVERNANCE GROUP 12 MONTH REPORT

The Committee received the Clinical Governance Group 12 Month Report presented by Ms S Smith who assured members that robust and effective clinical governance arrangements remained in place, with oversight focused on safe, effective, patient-centred care and continuous quality improvement. She provided a summary overview of the main aspects of reporting across the wide remit of oversight taken by the group, as detailed within the report.

Ms Fallon thanked Ms S Smith for the update and acknowledged the level of assurance the report provided and opened for questions.

Mr Moore sought clarification regarding whether a quality-of-care review was scheduled for March 2025, as referenced in section 2.9 and asked if this was separate from the ongoing HIS adult mental health reviews, noting recent inspection findings on standards and consistency of practice. Ms S Smith replied that it was not a formal HIS inspection, but a review carried out by Nursing Practice Development colleagues and that the paragraph would be amended to clarify that.

Action: S Smith

She further highlighted that the forthcoming national Clinical Governance Standards, expected shortly, would introduce a more extensive peer-review and self-assessment process.

Professor Thomson noted her thanks to the Clinical Quality Team who were integral to every area of the groups work. Ms Fallon concurred and added that the Committee looked forward to receiving an update on the standards when published and would look to shape the Committee agenda around these.

The Committee:

1. Noted the Clinical Governance Group 12 Month Report.
2. Noted the amendment required to reporting.

15 CLINICAL MODEL RESEARCH FINDINGS

The Committee received a report from the University of Edinburgh, in relation to evaluation of the implementation of the clinical model within the State Hospital. Ms Rees joined the meeting and provided an overview of the key points of the report, and the findings. She provided a reminder of the key challenges experienced during implementation, as well as a summary of the research findings which covered feedback from patients, carers and from clinical staff groups. Overall, the core principles of the model were evident and valued by patients, but further work was required to support staff experience, and to improve progression pathways to fully realise its benefits.

Ms Fallon thanked Ms Rees for the update and opened up for discussion, and the route of reporting to the Committee was discussed initially. In response to a query from Mr Jenkins, Professor Thomson noted the ask of this Committee had been for further reporting on the impact of the clinical model following its implementation. She added that the governance route was through the Research Committee. She advised the evaluation was being used as research in action, with interim findings fed back to clinical teams to support improvement rather than awaiting final conclusions. She added that the report was noted to be a research report, presenting findings based on agreed methodology.

Mr Moore acknowledged that the Committee had previously received updates on the implementation of the clinical model as well as this having been reported directly to the Board. He said that understanding progress against intended outcomes remained important. However, he emphasised that decisions on research recommendations were not best routed through a standing Committee. He underlined the need for careful contextualisation alongside wider organisational improvement activity.

Ms Fallon summarised for the Committee, and it was agreed that reporting would be added to the Board Development Session programme.

Action: Secretariat

The Committee:

1. Noted the Clinical Model Research Findings.
2. Requested further discussion at a Board Development Session.

16 CORPORATE RISK REGISTER - CLINICAL RISKS

The Committee received the Corporate Risk Register - Clinical Risks report presented by Mr Hardy who advised that, of the seven corporate risks within the remit of the Committee, two remained rated as high. In respect of MD30 (Failure to prevent/mitigate obesity), the related Key Performance Indicator (KPI) had been updated and the risk assessment revised following input from the relevant working group. Further data was awaited to confirm the current risk position. ND70 (Failure to utilise our resources to optimise excellent care and experience), which remained rated as high due to ongoing staffing pressures.

Ms Fallon thanked Mr Hardy for the report and opened for questions or comments.

Mr Currie highlighted the importance of considering consequential risk in the sense that this could create a ripple effect across the whole organisation. He noted this in terms of resource pressures, including the wider organisational and patient care impacts beyond the Women's Service. He noted the potential effects across services and the need to clearly articulate these risks, particularly in the context of future assessment of resource needs. He also referenced previous mitigation through over-recruitment to provide additional flexibility.

Mr Jenkins supported the points raised in the wider context of risk and thought that this would be a positive addition to risk reporting generally and confirmed that this would be taken forward to consider a broader assessment of consequential risk.

Action – Mr Hardy

The Committee:

1. Endorsed the Corporate Risk Register - Clinical Risks as an accurate statement of risk.
2. Noted work to progress on broader assessment of risk as discussed.

17 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted the streamlined timetable for patient activity, as well as the reduction in clinical waste incidents as areas of good practice.

18 COMMITTEE WORKPLAN 2026

The Committee noted the Workplan for the remainder of 2026 and the Chair advised that actions

from the meeting today would be added.

19 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Ms Fallon noted that impacts of incidents would be shared with the Staff Governance Committee.

20 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

Ms Fallon noted the topic for discussion at the next meeting was Structured Clinical Care and the discussion items for the remainder of the year were set out in the Workplan.

21 ANY OTHER BUSINESS

There was no other business raised at the meeting.

22 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 14 May 2026** at 09:30 hours via Microsoft Teams.

The meeting concluded at 1237 hours

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 15ii

Author(s): Corporate Business Manager

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 14 May 26.

	Item	Summary
1	Structured Clinical Care	The Committee received a presentation on Structured Clinical Care, a phased whole-system approach intended to improve consistency of care, support a more psychologically informed environment and strengthen risk management.
2	Women's Service Update	The Committee received an update on the Women's Service and the funding pressures, but also recognised progress in patient care, service integration and staff development, and requested further updates.
3	Clinical Governance Committee Annual Report 2025/26 and Terms or Reference	The Committee approved the Annual Report and Terms of Reference, which outlined the Committee's remit, structure and work over the year, demonstrating its broad focus on patient-centred governance and highlighting areas of good practice.
4	Daytime Confinement (end December 2025 – end March 2026)	Reporting provided an overview and noted that daytime confinement remained at a significant level which reflected ongoing clinical and operational pressures. The Committee acknowledged the operational pressures experienced.
2	6 / 12 Month Reports: • Medicines Committee • Supporting Healthy Choices • Patient Learning • Infection, Prevention and Control	The Committee received assurance reporting from a range of areas, including the Medicines Committee, Supporting Healthy Choices, Patient Learning and Infection, Prevention and Control. The Committee welcomed and acknowledged the scope and breadth of work across these areas.
	Learning from Complaints and Feedback Report Quarter 4 2025/26	Reporting highlighted an increase in complaint volumes, reflecting wider staffing and clinical pressures, but received assurance that complaints' performance remained strong, with most complaints resolved at stage 1 and only limited escalation during the quarter.
	Bed Capacity Report	Reporting highlighted continuing pressure on bed capacity,

	Item	Summary
		particularly within the women's and intellectual disability services, and that the contingency plan was in use. Assurance was provided that all admissions during the period took place within six weeks of referral.
	Corporate Risk Register / Risk Reporting	The Committee reviewed the clinical risks and agreed that reporting represented an accurate statement of risk. The Committee noted the need to reflect consequential impacts in future reporting.
	Incident Reporting and Patient Restrictions Q4 2025/26 • Male Service • Women's Service	Reporting provided the position on the types and numbers of incidents, including RIDDOR reporting and restrictions across both services. The range of metrics reported was covered in detail and it was considered how to ensure data reported was meaningful in terms of providing assurance.
	Learning points from SAERs	The Committee received assurance that SAER actions were being progressed appropriately, with most actions completed within timescales with only limited outstanding matters remaining.
10	Areas of good practice/concerns	The Committee noted improvement in the patient shop and the good practice of sharing literacy and numeracy deficits with the clinical teams.

RECOMMENDATION

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM **CF(M)26/01**

Minutes of the meeting of the Clinical Forum held on 10 March 25, 2026.This meeting took place by way of MS Teams and commenced at 10am.

Chair:

Consultant Clinical Psychologist	Dr Joe Judge

Present:

Consultant Psychiatrist	Dr Stuart Doig
Consultant Nurse	Dr Hamish Fulford
Senior Charge Nurse	Kim McClelland
Dietitian	Diane Mullen
Pharmacist	Ashleigh Wallace

In Attendance:

Head of Corporate Governance	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Dr Judge opened the meeting and welcomed everyone, noting that there were no apologies.

2 MINUTES OF THE PREVIOUS MEETING

The Forum approved the minutes of the previous meeting.

3 MATTERS ARISING AND ROLLING ACTION LIST

The Forum noted that the majority of actions were closed, and that one remained outstanding in relation to the Nursing Professional Advisory Forum, and that this was on today's agenda.

4 REFLECTIONS ON MINISTERIAL ANNUAL REVIEW

The Clinical Forum received and noted the content of the letter dated 16 December 2025, from the Minister for Social Care and mental Wellbeing, which had been received following the Ministerial Review which took place at the State Hospital on 23 November 2025.

The Forum discussed their experience on the day, focusing on their meeting with the Minister, and the way in which this had facilitated discussion of some key issues including daytime confinement and staff resourcing. The Forum had highlighted to the Minister the impacts across clinical professions and care delivery. Further, there had been discussion on the importance of digital connectivity for patients, and the progress made with the Made Purple pilot, and the importance of this continuing. It was also noted that the Minister had visited the Women's Service on the day to see the facilities in place.

Clinical Forum Members underlined that they would be keen to follow the progress of the Board's continued engagement with the Minister on these key areas.

5 ORGANISATIONAL STRUCTURE: PROFSSIONAL IMPACTS

Dr Joe Judge introduced this item, outlining the progress of work to date, led through the Chief Executive. There had been a number of development sessions with senior leaders looking both at strategic planning, as well as organisational structures and wider governance. The focus had been on how to support leaders to have greater autonomy at a local level, especially the Service Leadership Teams. Further, to look at management reporting structures through governance groups with a view to streamlining these. This was a work in progress at the moment. Ms Smith added that the work on governance structures would align with the new organisational structure, with the aim of those leading it have a greater voice in determining what was functioning well.

There was discussion on the Service Leadership Teams, with agreement that these were not all functioning optimally presently, indicating the need for change, particularly around the speed and effectiveness of local decision- making. The Clinical Forum noted the need to be involved in the development of this, and the need to clarify how the new structure would work in practice across service delivery including roles and responsibilities. This was noted as an action to stay on the agenda, as this progressed, to support the Forum's involvement.

Action – Ms Smith

6 NURSE RESOURCING: DAYTIME CONFINMENT / IMPACT ON CPAs

Clinical Forum Members received and noted the paper which had been submitted to the Board at its meeting on 26 February, relating to daytime confinement.

Members noted in particular the current aim to over recruit by 5% within nursing, and the context of the increased pressures including the Women's Service and the Reduced Working Week. Further, that lengthy period of time that the hospital had been experiencing resourcing pressures and daytime confinement, and the impacts of this across the organisation with staff from other clinical professions being redeployed to support service delivery. Although the paper noted some improvement, this had not been meaningful or sustained over time.

There was discussion about the difficulties being experienced within the Women's Service, since it had been implemented, and the impacts of this. It was understood that the anticipated level of staffing required had in practice not proven to be sufficient due to the demands of the service in reality.

Clinical Forum Members also highlighted the challenges being experienced in relation to patient attendance at their Care Programme Approach (CPA) meetings due to the need for three level 2 PMVA qualified staff being required to be in attendance. This had not always been possible meaning that there had been instances of patients not being able to attend. The importance of the patient being in the room for their CPA was underlined, with it being noted that it would be very frustrating for those patients who were keen to do so, should they be unable to attend. Further that staff also felt that this was not adequate for patients.

Members considered the existing policy in this respect, and the requirement for three level 2 trained staff to be in the room, and whether this was always necessary. In particular, as an example patients in the Transitions Service may not need to have that in place. It was noted that there had been discussion on this point at the Medical Advisory Committee, and that the issue would be raised further with the Medical Director.

There was agreement around the table that as the hospital had a key aim of ensuring that daytime confinement was eliminated, then there should be equal importance given to ensuring that patients could attend their CPA. It was noted that the Responsible Medical Officer (RMO) had a duty to complete an incident report should the patient not be able to attend the CPA due to resourcing

issues. The difficulty of changing the date of the scheduled CPA was also highlighted, given lack of flexibility in the system.

The Clinical Forum also discussed daytime confinement more widely, with consideration of the evidence base, and whether this did point to detriment to patients. This included how the patients viewed this experience, and how this fitted with therapeutic care and whether some patients may benefit from more time spent within their bedrooms, if they chose to do so. The Forum considered the need for more local ownership of practice within services, emphasising the need to follow the evidence base in decision-making in practice.

There was also discussion around how staffing was being managed to support services. This included retention of staff. Dr Joe Judge noted that the Board had been advised at its meeting that this was not a key concern within the State Hospital presently, which was performing well compared to NHS Scotland as a whole.

Clinical Forum Members discussed current practice within the hospital with multiple resourcing meetings occurring daily and whether this was effective. The need of clinical service delivery was reviewed including whether clinical acuity had increased within the male service overall, or whether this was subject to periods of peaks and troughs in activity. The staffing base of the Women's Service was noted, and that the need to re-base the budget requirement had been underlined within budgetary discussions with Scottish Government. The Clinical Forum also considered the impact of the Health and Care Staffing legislation and related reporting requirements, with assurance that staffing deficits were reported as appropriate.

Dr Judge summarised the key points, emphasising the broad nature of the discussion and the helpfulness of contributions. It was agreed that he would draft a letter to the Board Chair on behalf of the Clinical Forum to outline the level of concern, and this would be circulated for input and approval.

Action – Joe Judge

7 REVIEW /UPDATES FROM EACH GROUP/PROFESSION

(a) Medical Advisory Committee

Forum members received and noted the Medical Advisory Committee Meeting minutes from 10 November 2025 and 9 February 2026.

Dr Stuart Doig advised that the latest meeting had taken place on the previous day, and that there had been discussion on workforce issues and the impact on levels of daytime confinement, and on clinical care. Further on the new organisational structure and roles of Clinical Leads, as well as on physical health care especially medical management of obesity.

(b) Psychology Professional Practice Group

Members received and noted the Psychology Professional Practice Group Meeting minutes from 9 October 2025 and from 5 February 2026.

Dr Joe Judge also highlighted the focus on operational and professional issues related to daytime confinement, as well as the work being developed in terms of service structures. There had been discussion of non-medical staff taking on statutory roles, in comparison to the position in NHS England through "Responsible Clinician" roles which could be psychologist or nurses.

(c) Allied Health Professionals Advisory Group

Members received and noted the minutes of the meeting of the AHP Advisory Group which had met on the previous day.

Diane Mullen advised that the main area of focus in the meeting had been the impacts of staff resourcing and daytime confinement, as discussed elsewhere in today's meeting. She spoke to the increased pressure being experienced in order to provide support to the Women's Service in particular, although acknowledging the pressures being experienced across the organisation. She noted that there had been a concern about the quality and consistency in handovers, when AHP colleagues provided support on wards. Kim McLelland noted that she would check on this point.

The issue of cancellation of rehabilitation outings had been raised within the group. She also spoke of concern within the department about recent experience of colleagues choosing to leave the State Hospital to work elsewhere. Ther was increased concern amongst this staff group about their ability to deliver their professional expertise to patients, due to system pressures presently.

Clinical Forum Members discussed the risk of damage to staff morale, as well as the risk of burnout and attrition od staff in this context. This linked to the previous discussion on the application of safe staffing reporting, with assurance and reflection that this did include reporting on the skills mix within a clinical are in terms of the numbers being reported, and that this was completed on a daily basis to Healthcare Improvement Scotland (HIS) as required.

(d) Pharmacy

Members received and noted the Pharmacy Group Updates from November 2025, and from March 2026 as well as the most recent Medicines Incidents Flash Report for information. Ashleigh Wallace outlined the key issues which included challenge in recruitment of technical staff, as well as Metaformin workstream which was underway during January to March, and the slower Clozapine titration via HEPMA.

(c) Nursing

The Clinical Forum acknowledged that Kim McLelland was in attendance to support representation of the nursing cohort, however, there was no nursing professional advisory group in situ separate from the existing management reporting structure.

Kim McLelland was able to provide updates from the Senior Nurse Meeting, noting progress on recruitment with Band 3 colleagues being onboarded during March. There was an initiative in place for job offers to be made on the day, where possible, at an upcoming Recruitment Fair on 31 March. The group also received a presentation on TSH3030.

Clinical Forum Members noted concern about the lack of progress in setting up a discrete nursing advisory forum, whilst acknowledging the organisational pressure being experienced which had contributed to this. This was noted as a key action that should be progressed, in conjunction with the Associate Director of Nursing. Hamish Fulford voiced his concerns about this issue, and willingness to support this where this was possible.

Action – Joe Judge/ M Smith

8 ANY OTHER BUSINESS

There was no other business raised at this meeting.

9 NEXT MEETING DATE

The next meeting will be held on 10 June 2026 at 10:00am via Microsoft Teams.

The meeting ended at 11.45am

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 17
Sponsoring Director:	Chair of Staff Governance Committee
Author(s):	Director of Workforce
Title of Report:	Staff Governance Committee Annual Report
Purpose of Report:	For Decision

1 SITUATION

The attached Staff Governance Committee Annual report outlines the key achievements and key developments overseen by the Committee during 2025/26. This also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

3 ASSESSMENT

In the performance year 2025/26, The State Hospitals Board for Scotland's Staff Governance Committee has continued to refine our approach in the monitoring of activities in relation to SG standards, both in terms of assurance but also improvement and best practice.

The Committee members support the delivery of our Workforce Plan, and its key priorities around 'Prioritising Organisational Health' and 'creating a sustainable workforce'. The Workforce Plan is a clear commitment to a culture within The State Hospitals Board for Scotland in which the delivery of the staff governance standards is at the forefront of our approach, in

terms of people management, staff engagement, learning and development and partnership working.

4 RECOMMENDATION

The Board is asked to approve the Staff Governance Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Reporting to demonstrate that committee has met its remit
Corporate Objectives Please note which objective is linked to this paper	Better Workforce
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route to Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for 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).	No impact 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. There are no privacy implications**

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2025 – 31 March 2026

CONTENTS

1 INTRODUCTION

Staff Governance is defined as '**a system of corporate accountability for the fair and effective management of all staff**.'

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented.

In addition to this, the Standard specifies that staff are entitled to be:

- Well informed.
- Appropriately trained and developed.
- Involved in decisions.
- Treated fairly and consistently; with dignity and respect, in an environment where diversity is valued.
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2025/26, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of these standards.

The Committee members recognised their obligations to support a culture where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon by the principles of partnership.

Members of the Staff Governance Committee are appointed annually by the NHS Board.

Membership details of the Committee during 2025/26 are detailed below.

2 COMMITTEE CHAIR, COMMITTEE MEMBERS AND ATTENDEES

Committee Chair:

- Pam Radage (Chair of Committee, Non-Executive Director).

Committee Members:

- Allan Connor (Employee Director).
- Stuart Currie (Non-Executive Director).
- Cathy Fallon (Non-Executive Director).
- Shalinay Raghavan (Non-Executive Director).

In attendance:

- Graeme Anderson (Head of Organisational Development and Learning).
- Alan Blackwood (lay member, Prison Office Association).
- Josephine Clark (Associate Director of Nursing).
- Graeme Fergusson (POA Representative).
- Sandra Dunlop (Head of Organisational Development and Learning).
- Gary Jenkins (Chief Executive).
- Leanne Keenan (Clinical Services Manager, NHS D&G).
- Monica Merson (Head of Corporate Planning and Business Support).

- Brian Moore (Board Chair).
- Anthony McFarlane (Unison Representative).
- Richard Nelson (RCN Representative).
- Laura Nisbet (Head of HR).
- Margaret Smith (Head of Corporate Governance/Board Secretary).
- Stephen Wallace (Director of Workforce).

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purpose of verbal updates, information sharing and presentations.

3 MEETINGS 1 APRIL 2025 – 31 MARCH 2026

During 2025/26 the Staff Governance Committee met on four occasions, in line with its terms of reference (Appendix 1).

Meetings were held on:

- 15 May 2025.
- 21 August 2025.
- 20 November 2025.
- 12 February 2026.

Attendance from Committee members is shown below.

Committee Member	Number of Meetings Present
Pam Radage	4
Allan Connor	4
Stuart Currie	3
Cathy Fallon	2
Shalinay Raghavan	3

4 SUMMARY OF REPORTING

The Committee received reports and monitored areas as follows:

- Workforce (HR, Learning & Wellbeing & OD) Report:
    - Maximising Attendance.
    - Recruitment.
    - Employee Relations.
    - Staffing Turnover.
    - Exit Interview Findings
    - Job Evaluation.
    - PDPR Compliance.

- iMatter.
- Workforce Planning.
- Whistleblowing.
- Statutory and Mandatory Training Compliance.
- Fitness to Practice.
- NHSScotland Staff Governance Standard Monitoring Framework.

- OD and Wellbeing Strategy.
- Occupational Health.
- Health and Care Safe Staffing.
- eRostering.
- Corporate Risk Register – Staff Governance Risks.
- Workforce Equalities.
- RWW – Reduced Working Week
- Once for Scotland.
- Nursing Practice Development.
- Non-Executive Director Walk rounds.
- Working Environment.
- Internal Audit Reporting.

4.1 Annual Reports

4.1.1 Staff Governance Monitoring (SGM) – Assurance of Compliance:

The Committee received the Staff Governance Monitoring Return. The return took the form of a streamlined core assurance mechanism and enabled members to review compliance with the Staff Governance Standard and assess progress across the organisation. Its inclusion reflected the Committee's responsibility to evaluate how effectively the organisation supports staff to be well-informed, engaged, fairly treated, appropriately trained, and provided with a safe working environment.

The Committee noted the return's role in identifying strengths, highlighting areas requiring improvement, and strengthening assurance frameworks in advance of year-end governance reviews.

4.1.2 iMatter

Members of the Committee received the iMatter Annual Report which provided a summary of organisational staff-experience performance. The report highlighted a 6% reduction in response rates, though levels remained above national averages, and confirmed that overall Employee Engagement Index (EEI) scores remained broadly stable. A key achievement reported was the marked increase in action-plan coverage, rising from 56% to 75%, demonstrating strengthened follow-through on staff feedback. Members noted the positive trajectory and emphasised continued focus on linking team-level data to targeted improvement activity.

4.1.3 Occupational Health Service Annual Report 2024/25

The annual report and presentation provided to the Committee on 21 August 2025 summarised the key achievements. Members of the Committee were advised the quality of referrals from line managers had improved through targeted questions which had supported timely occupational health advice and outcomes. It was also highlighted that there had been a reduction in non-attendance at appointments. The Committee noted the report's contribution to ongoing oversight of staff wellbeing and organisational support mechanisms, reaffirming the importance of Occupational Health in maintaining a safe and healthy workforce.

4.2 Progress Updates

The Committee received regular updated reports and monitored issues relating to the following:

4.2.1 Personal Development Planning & Review (PDPR)

Across the 2025–26 reporting year, the Committee received regular updates on PDPR compliance, noting consistently strong organisational performance. It was reported that PDPR completion was at 92%, with ongoing work to address areas falling below internal thresholds. By February 2026, this position was maintained, with PDPR review compliance plateauing at 91.1%, accompanied by targeted efforts to minimise overdue reviews and strengthen local accountability. These updates provided assurance to the Committee that appraisal activity remained a clear organisational priority, closely monitored through performance structures and supported by directorate-level scrutiny.

4.2.2 Maximising Attendance

Members of the Committee have received assurance throughout the year that maximising attendance remained an organisational priority, supported by strengthened reporting and targeted managerial actions.

Members reviewed detailed analysis of sickness absence patterns and noted the scale, operational impact, and widespread nature of absence across the workforce, with over three-quarters of staff recording at least one episode. The Committee welcomed the refined reporting format and emphasised the need for consistent, confident attendance management by line managers.

Across the year, updates provided to SGC-linked governance forums reinforced that absence reduction was being driven through improved data insight, clearer management pathways, proactive escalation processes, and enhanced occupational health and well-being support. The Committee took assurance from the sustained focus at operational and leadership levels, recognising the collective effort to stabilise absence trends and embed a long-term, culture-led approach to improving attendance.

4.2.3 HR Performance – Employee Relations Activity

Members of the Committee received assurance that Employee Relations (ER) activity remained stable and well-managed, with early resolution increasingly preventing escalation into formal processes. Members were advised that the number of active ER cases remained low, reflecting constructive dialogue between managers, HR, and staff and the positive impact of early intervention approaches. Discussion highlighted that longer or more complex cases—particularly those extending beyond the 3–6-month window—can place significant psychological and operational strain on staff, underscoring the continued importance of timely progression and strong case management. The Committee welcomed HR's commitment to reviewing timelines and learning from complex cases to strengthen future practice, alongside the emphasis on prevention through high-quality conversations, coaching for managers, and a supportive organisational culture.

4.2.4 OD, Wellbeing and Learning

Across 2025–26, the Committee received regular updates on Organisational Development (OD), Learning and Wellbeing, noting continued progress in embedding a supportive, skilled and engaged workforce culture. Members welcomed strong performance in key indicators, including sustained high PDPR completion, robust mandatory training compliance, and growing utilisation of wellbeing supports such as the staff care specialist, Time for Talking service, and peer support network. These reports also highlighted the significant effort invested in improving leadership capability, strengthening team development, and advancing culture-change workstreams aligned to organisational values.

The Committee further endorsed the new OD Strategy, recognising its clear priorities—direction, leadership and working environment—and the extensive staff engagement that shaped it, providing confidence in its relevance and credibility. Taken together, the OD and wellbeing updates provided assurance that the organisation is investing meaningfully in staff support, capability, and culture, with increasingly coherent and well-governed activity evident across the Workforce Directorate.

4.3 Standard Items considered by the Committee during the year

4.3.1 Fitness to Practice

Committee members received the Fitness to Practice Annual Report. The report provided assurance on the Board's processes for monitoring and maintaining professional registration for all eligible employees, outlining the relevant professions covered and the systems in place to ensure timely checks. The Committee noted positively that there had been no lapses, concerns, or failures in professional registration during the reporting year, reflecting strong compliance and effective governance across the organisation.

4.3.2 Whistleblowing Quarterly updates

No formal whistleblowing concerns were presented to the Staff Governance Committee during 2025–26, providing assurance that no issues required escalation through the national whistleblowing standards pathway

4.3.3 Corporate Risk Register – Staff Governance Risks

The Committee received assurance that staff governance-related risks within the Corporate Risk Register were actively monitored and updated throughout 2025–26, with key risks being refined, reclassified or retained as appropriate to ensure accurate oversight of emerging workforce pressures and organisational controls.

4.3.4 Health and Care Staffing and eRostering

Members of the Committee were advised on key developments relating to health and care staffing and the implementation of eRostering. The Committee also received an update on the national audit of rostering practices, noting that although the organisation had successfully implemented the eRostering system, further work was required to strengthen local compliance, eliminate manual processes, and improve the timely application of protocols for shift swaps, annual leave and time-off-in-lieu. Assurance was provided that a structured improvement programme was underway, including monthly audits by lead nurses, enhanced governance checks, and a bimonthly oversight process involving senior leadership to ensure that remedial actions were progressing and risks were being addressed. These updates affirmed that staffing challenges were being actively managed and that the eRostering programme continued to mature, with clearer controls and stronger accountability embedded across operational areas.

4.3.5 Workforce Equalities Group

Throughout 2025–26, the Committee received assurance on the ongoing work of the Workforce Equalities Group (WEG), which continued to progress the organisation's equalities priorities and shape a more inclusive culture. Updates provided through governance routes highlighted WEG's development of an Equalities Action Plan, informed by findings from the Lived Experience Survey and focused on three priority themes: senior visibility and leadership commitment, education and awareness, and zero-tolerance of discriminatory behaviours. Meeting outputs confirmed active work on leadership-endorsed communications, training programmes—including unconscious bias, bystander intervention and behavioural standards—and exploration of enhanced staff engagement methods such as video messaging and improved internal visibility

of equality work. Assurance was also provided that equality considerations were increasingly embedded across governance structures, with equalities featuring routinely in board-level agendas and reporting frameworks. Taken together, the updates demonstrated meaningful progress in strengthening organisational culture, broadening staff awareness, and laying the foundations for a robust Equalities Action Plan.

4.3.6 Once for Scotland Policies

During 2025–26, the Committee received assurance on the ongoing implementation of the Once for Scotland (OFS) workforce policies, with a formal updates presented to the SGC advising of the OFS policy programme and confirmed steady progress across the national policy phases, including the launch of Phase 2.2 in August 2025 and preparatory work for Phase 3, which introduced new policies relating to adverse weather, substance use, and other key employment matters. Most national policies will be adopted in full, with only limited local guidance retained where required for the unique operational context of the State Hospital. Together, these updates provided the Committee with assurance that national policy changes were being systematically implemented, supported by local governance, and that staff were being prepared for consistent, modernised practice aligned to NHS Scotland standards.

4.3.7 Internal Audit Report: Absence, Disciplinary and Suspension Management

Members of the Committee received the Internal Audit Report and noted the high level of compliance with policies and the reasonable assurance provided by the report.

4.3.8 Notes of Minutes and updates from other meetings

The Committee received and noted minutes/reports from the following:

- Partnership Forum.
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue).
- Workforce Governance Group.

5 AREAS OF GOOD PRACTICE

Across 2025–26, the Committee noted several areas of strong practice that demonstrated positive cultural and operational progress. Members highlighted the Committee's increasingly discursive, constructive approach, recognising that meetings had become more focused, transparent, and effective in supporting continuous improvement.

The following examples were provided throughout the year:

- The development and implementation of the OD Strategy
- The work undertaken by the HR Team in supporting PVG activity
- Non-Executive Walkaround
- The open and transparent communication, which was evidenced through Committee meeting and also Partnership Forum minutes.
- Improvements across the Occupational Health Service
- The positive approach to Maximising Attendance, in reporting and outcomes
- The response to eRostering
- Focus on Employability initiatives

6 CONCLUSION

Across the 2025–26 reporting year, the Staff Governance Committee demonstrated sustained and effective oversight of the key workforce priorities required under the Staff Governance Standards.

Throughout the year, the Committee engaged in detailed consideration of progress on maximising attendance, employee relations, OD and wellbeing, equality, workforce planning, training compliance, health and care staffing, and wider governance matters, drawing assurance from strengthened data reporting, improved managerial practice, and maturing systems of workforce oversight.

Members emphasised and recognised areas of good practice, including improved paper quality, clearer alignment to governance standards, constructive dialogue, and proactive cross-team collaboration, all of which contributed to a positive governance culture.

The Committee also acknowledged areas of challenge, responded to proactive approach to organizational learning whilst ensuring scrutiny of emerging risks relating to staffing, attendance, training and organisational sustainability and was assured that appropriate controls, escalation routes and improvement plans were in place.

From the review of performance of the activity of the Staff Governance Committee, it is clear that the Committee has met its obligations in line with the Terms of Reference and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Staff Governance arrangements were in place throughout the year.

I offer my thanks for the continuing support and encouragement of Committee members and to those members of staff who have worked on the Committee's behalf during 2025/26.

Pam Radage
STAFF GOVERNANCE COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Staff Governance Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Staff Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that staff governance mechanisms are in place and effective within the State Hospital.

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and at least three other Non-Executive Board Members one of whom shall act as Chair.

The Committee can invite the Board Chair to be a member of the Committee for the purposes of a meeting, should it be the case that the Committee would otherwise be inquorate.

There will be three lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members will have the right to attend meetings and have access to all papers, except where the Committee resolves otherwise.

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Director of Workforce shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least three clear working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Director of Workforce in conjunction with the Chair of the Staff Governance Committee.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and once approved, submitted at the next Board meeting. The Corporate Services Team are responsible for minute taking arrangements.

The minutes and action list of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

3.5 Other

In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 REMIT

4.1 Objectives

The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within the State Hospital; and that the principles of the national Staff Governance Standards are applied equitably and fairly to all staff.

Existence and effective operation of this Committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 Systems and accountability

To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.
To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 People management

To provide assurance to the Board in respect of people management arrangements, that:

- Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.
- Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.
- Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.
- Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.
- Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.
- There is timely submission of all staff governance data required by the Scottish Government Health Department and in respect of the Local Delivery Plan.
- Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.
- Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.
- Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

- The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.
- The planning and delivery of services has fully involved partnership working.
- Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.
- Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that Committee. The Remuneration Committee must include, as a minimum, three Non-Executive Directors of the Board. The Remuneration Committee will be a closed Committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the Remuneration Committee: these can only be considered by Non-Executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Staff Governance Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

Reviewed June 2024

DRAFT PENDING COMMITTEE APPROVAL

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 18

Sponsoring Director: Chair of Remuneration Committee

Author(s): Director of Workforce

Title of Report: Remuneration Committee Annual Report – 2025/26

Purpose of Report: For Decision

1 SITUATION

The attached Remuneration Committee Annual Report outlines the workplan overseen by the committee during 2025/26.

2 BACKGROUND

Staff Governance is defined as 'a system of corporate accountability for the fair and effective management of all staff. The State Hospitals Board for Scotland's Remuneration Committee fulfils this remit with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

3 ASSESSMENT

In the performance year 2025/26, the Remuneration Committee continued to focus its monitoring activities in respect of the above responsibilities and provided reporting to the National Performance Monitoring Committee in this regard. The committee also considered the award of Consultant Discretionary Points.

The Committee approved this report in email in advance of this meeting.

4 RECOMMENDATION

The Board is asked to approve the Remuneration Committee Annual Report 2025/26.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Reporting to demonstrate that committee has met its remit
Corporate Objectives Please note which objective is linked to this paper	Better Workforce
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route to Board Which groups were involved in contributing to the paper and recommendations.	Audit Committee Remuneration Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for 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).	No impact 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. There are no privacy implications**

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2025 – 31 March 2026

1. Introduction

Staff Governance is defined as '**a system of corporate accountability for the fair and effective management of all staff**.'

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented.
In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2025/26, The State Hospitals Board for Scotland's Remuneration Committee continued to ensure monitoring and challenge in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

The NHS Board Vice-Chair remains Chair of the Committee which aligns with practice throughout NHS Scotland. This ensures that the committee chair does not play a role in the Executive and Senior Manager Appraisals process, avoiding potential conflict of interest

2. Committee Chair, Committee Members and Attendees

Committee Chair:
David McConnell (Chair of Committee, Non-Executive Director)

Committee Members:
Allan Connor (Employee Director)
Cathy Fallon (Non-Executive Director)
Brian Moore (Board Chair)
Pam Radage (Non-Executive Director)

In attendance:
Gary Jenkins (Chief Executive)
Stephen Wallace (Director of Workforce)
Margaret Smith (Head of Corporate Governance)

3. Meetings 1 April 2025 – 31 March 2026

During 2025/26 the Remuneration Committee met on three occasions, in line with its terms of reference (Appendix 1).

Meetings were held on:

- 26 June 2025
- 1 September 2025
- 6 November 2025

Attendance of Committee members were as follows:

	Number of Meetings Present
David McConnell	3
Allan Connor	3
Cathy Fallon	2
Brian Moore	3
Pam Radage	2

4. Summary of Reporting

The Committee received reports and monitored areas as follows:

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2025-26.
- Agreement of the Appraisal outcomes 2024-25 for Executive Directors.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2025/26.
- Agreement of the Executive Directors Mid-Year Reviews for 2025/26
- Consultants discretionary points were reported on and reviewed in line with Constitution.
- Updates on the vacant post of Director of Security, Estates & Resilience
- Transition of staff from Senior & Exec Grade to AFC
- Guidance on Settlement Agreements
- Agreement of the change in responsibility to the payment of non-executive expenses.

The Remuneration Committee also reviewed other issues related to its remit. They received an update of national and regional group involvement.

During this year the committee considered and supported interim arrangements to Executive and Senior Management positions in the organisation to ensure resilience in the Executive Team.

5. Areas of Best Practice

Usage of National TURAS Appraisal was seamlessly adopted.

Evidence and return, including excerpt from minutes, for ‘Superior’ outcome was satisfactory from NPMC.

Continued openness and transparency in all processes

6. Conclusion

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers’ performance management and remuneration.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee’s behalf during 2025/26**.**

David McConnell
REMUNERATION COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit and Risk Governance Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND
REMUNERATION COMMITTEE

TERMS OF REFERENCE

1 The Committee shall be known as the Remuneration Committee of The State Hospitals Board for Scotland. It will be a standing Committee of The State Hospitals Board for Scotland and will make decisions on behalf of The State Hospitals Board for Scotland.

COMPOSITION

2 The Remuneration Committee members will be appointed by The State Hospitals Board for Scotland and will consist of:

- The Vice-Chair of The State Hospitals Board for Scotland, who will be the Committee Chair
- Four Non-Executive Directors of the Board, including the Employee Director and the Board Chair.

In addition, there will be in attendance (in full or part):

- Chief Executive
- Director of Workforce
- Head of Corporate Governance/Board Secretary

No employee of the Board shall be present when any issue relating to their employment is being discussed.

3 The Director of Workforce will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor.

Executive Director Lead

Generally, the designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference.

Specifically, they will:

- support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;

- liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;

- oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;

- agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Workplan;

- oversee the production of an Annual Report, informed by self-assessment of performance against the Remuneration Committee Self-Assessment Handbook, on the delivery of the Committee's Remit and Workplan for endorsement by the Committee and submission to the Board.

4 Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance and Performance Management Director may be invited to attend meetings of the Remuneration Committee.

5 The quorum for the Remuneration Committee will be attendance by 3 Non-Executive Directors, inclusive of the Chair.

FUNCTIONS

6 To oversee and agree the remuneration arrangements and terms and conditions of employment of Executive Directors and Senior Managers of The State Hospitals Board for Scotland, to include:

- content and format of job descriptions
- terms of employment including tenure
- remuneration
- benefits including pension or superannuation arrangements
- annual salary review

7 To ensure arrangements are in place for the assessment of the performance of The State Hospitals Board for Scotland and to monitor the performance of The State Hospitals Board for Scotland against pre-determined performance criteria to inform oversight of objective setting and support for decisions on individual performance appraisal.

8 To agree The State Hospitals Board for Scotland's arrangements for performance management and to ensure that the performance of the Executive Directors is rigorously assessed against agreed objectives within the terms of the performance management arrangements referred to above.

9 To ensure that clear objectives are established for Executive Directors of The State Hospitals Board for Scotland before the start of the year in which performance is assessed by

- receiving a report from the Chair on the agreed Objectives for the Chief Executive
- receiving a report from the Chief Executive on the agreed Objectives for the other Executive Directors of the Board.

10 To monitor arrangements for the pay and conditions of service of other Senior Managers on Executive Pay arrangements and on Professional/Management Transitional pay arrangements in accordance with appropriate guidance and to implement annual pay uplifts and pay progression in accordance with national guidance.

11 To approve The State Hospitals Board for Scotland's arrangements for the grading of Senior Manager and Executive Director posts and to oversee these arrangements by receiving regular reports from the Director of Workforce.

12 To ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for staff employed under the Executive and Senior Management Pay arrangements. To receive formal reports (at least annually) providing evidence of the effective operation of these arrangements.

13 To consider any redundancy, early retiral or termination arrangement in respect of all State Hospital staff, excluding early retirals on grounds of ill health, and approve these or refer to the Board as the Committee sees fit. In addition, the Committee will oversee the award of discretionary points to medical staff.

14 To fulfil its functions, the Remuneration Committee will take into account a range of factors which will include

- regular reports from the Director of Workforce
- the Remuneration Committee Self-Assessment Handbook
- guidance issued by the Scottish Government Health Department
- an annual report on the application of pay awards and pay movements
- the need to recruit and retain appropriately qualified and skilled Directors and Senior Managers
- equitable pay and benefits for the level of work performed

CONDUCT OF BUSINESS

15 Meetings of the Committee will be called by the Chair of the Committee with items of business circulated to members one week before the date of the meeting.

16 The Committee will seek specialist guidance and advice as appropriate.

17 All business of the Committee will be conducted in strict confidence.

REGULARITY OF MEETINGS

18 Meetings of the Remuneration Committee will be held as necessary to conduct its business. At a minimum, the Committee should meet twice per annum, once to approve the performance assessments and annual Objectives of the Executive Directors and once to approve the annual application of pay awards and pay progression.

REPORTING ARRANGEMENTS

19 The Remuneration Committee will report to the Board.

Membership of the Remuneration Committee will be reported to and agreed by the Board. Appropriate details of Executive Members remuneration will be published in The State Hospitals Board for Scotland's Annual Report.

Annual Report

In accordance with Board and Committee Working, the Committee will submit to the Board each year an Annual Report, encompassing : the name of the Committee; the Committee Chair; members; the Executive Lead and officer supports / attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee.

Where the review by the Committee of its Terms of Reference results in amendment the revised Terms of Reference must be submitted to the Board for approval. The Committee Annual Report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Statement of Internal Control.

20 Details of the business conducted by the Committee will be made available to the Scottish Government Health Department, the form and content being determined by the latter.

21 Reporting, marked as 'official sensitive', on each meeting of the Remuneration Committee will be issued to the Non-Executive Directors of the Board.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 19
Sponsoring Director:	Director of Workforce
Author(s):	Head of HR
Title of Report:	Staff Governance Report
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

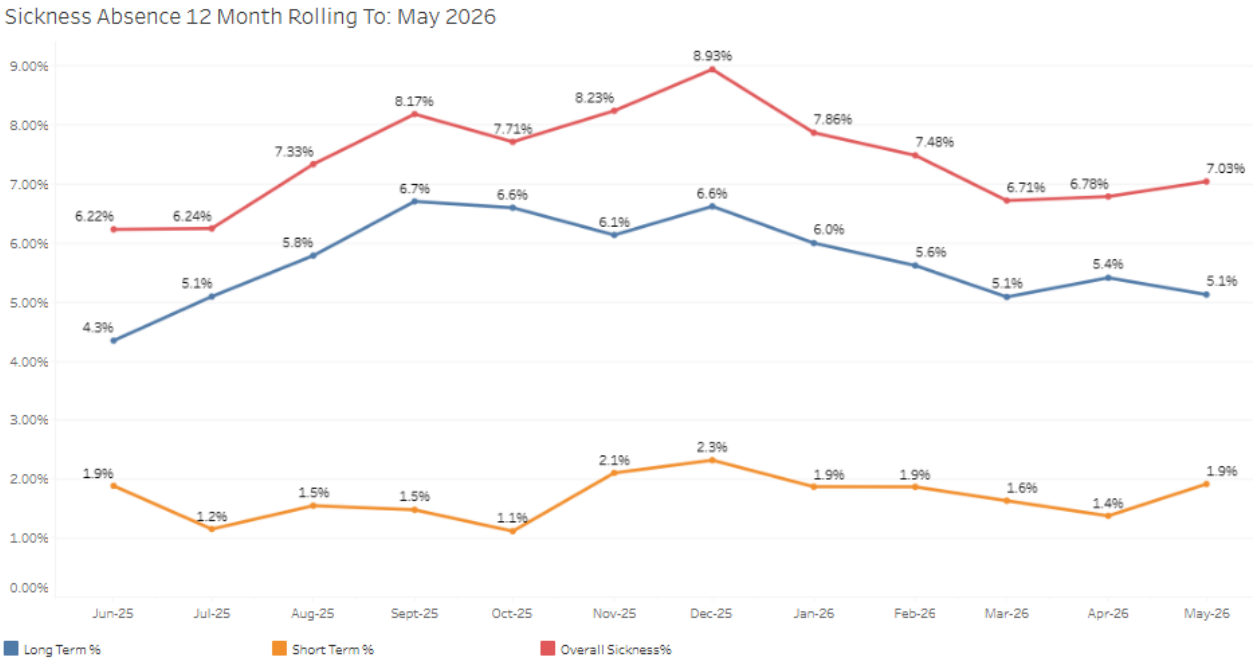
3 ASSESSMENT

(a) ATTENDANCE MANAGEMENT

TSH Sickness Absence current position

The downward trend of Sickness Absence throughout 2026 has plateaued in the month of May where absence rate was 7.03%. The slight increase is 0.25% from the month of April which was 6.78%. This is illustrated in graph 1 below.

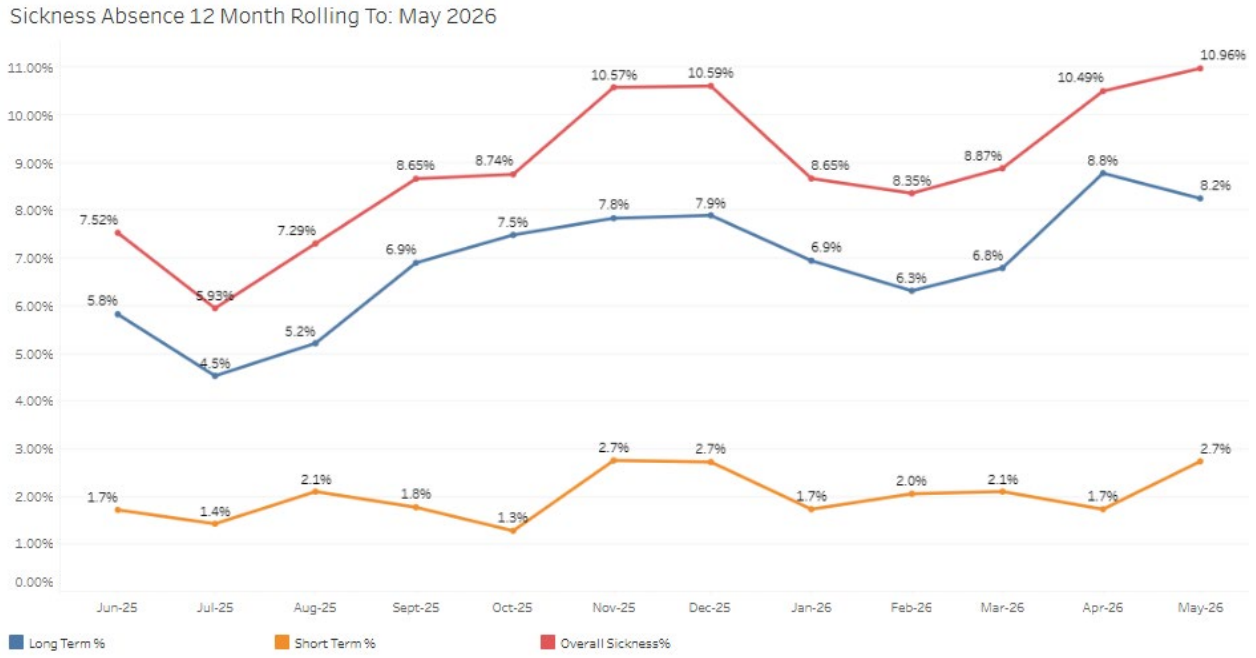
GRAPH 1 – All Staff



Nursing Sickness Absence

There has been an increase in absence within Nursing as outlined below (from 10.49% to 10.96%) This is now slightly higher than the peak in November / December 2025. For comparison, the absence rate in Nursing in May 2025 was 8.56% (an increase of 2.11%). This increase is partly due to the jump in long term absence between March and April and the increase in short term absence in May.

GRAPH 2 – nursing hubs



ATTENDANCE MANAGEMENT OBSERVATIONS

Patterns/Trends for TSH:	Short-term absence: 1.91% (April was 1.4%) an increase of 0.51% Long-term absence: 5.12% (April was 5.4%) a decrease of 0.8%	
Identified Departments of Concern:	Mull 1 Lewis 2 Mull 3	16.19% 14.27% 13.79%
	Escalated meetings are scheduled for the areas of concern as well as utilisation of wellbeing support for challenging areas.	
Identified Departments of Improvement:	Arran 2 Arran 3 Iona 2 Psychology Housekeeping Security	**3.72%** from 5.77% in Apr (-2.05%) **4.03%** from 8.46% in Feb 26 (-4.43%) **4.54%** from 8.77% in Apr 26 (-4.23%) **2.31%** from 7.35% in Feb 26 (-5.04%) **3.73%** from 12.31% in Feb 26 (-8.58%) **5.97%** from 18.47% in Feb 26 (-12.5%)
Reasons:	**Key reasons for long-term absence:** Anxiety, stress, depression, and other psychiatric illnesses (2,432 hours lost) Injury, fracture (1,129 hours lost) Gastro-intestinal problems (308 hours lost) **Key reasons for short-term absence:** Anxiety, stress, depression, and other psychiatric illnesses (262 hours lost) Other known causes – not otherwise classified (248 hours lost) Gastro-intestinal problems (243 hours lost)	
Activity:	In May 2026, 15 people have been invited to a formal stage meeting (14 x Stage 1, 1 x Stage 2 and no Stage 3s). There is a total of 95 staff on current monitoring 44% of staff are monitored for 3 months up to 6 months, 33% are monitored for 6 months, 17% are monitored for 7 to 9 months, with 9 months being the most common period in this group, and 6% are monitored for 12 months	

National Position

The challenge of reducing absence in a sustained manner remains a key theme across NHS Scotland. The National figures below are produced centrally and retrospectively by SWISS and tend to have a slight variance to the figures reported in boards through SSTS and earlier in this paper. The table below reflects the March 2026 position.

Sickness Absence Statistics by NHS Board 1st March 2026 - 31st March 2026	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**6.43**	**4.06**	**2.37**	**37,846**	**10,802**	**27,044**	**34,750**	**3,096**
NHS Ayrshire & Arran	6.67	4.47	2.20	2,179	666	1,513	2,030	149
NHS Borders	5.48	3.46	2.02	611	160	451	551	60
NHS National Services Scotland	7.23	4.96	2.26	809	219	590	658	151
NHS 24	11.04	7.41	3.63	742	220	522	726	16
NHS Education For Scotland	1.28	1.16	0.12	55	30	25	40	15
Healthcare Improvement Scotland	3.22	2.11	1.11	51	19	32	48	3
Public Health Scotland	3.72	2.42	1.30	162	43	119	153	9
Scottish Ambulance Service	8.13	5.31	2.82	1,322	440	882	1,278	44
The State Hospital	6.48	3.90	2.58	111	46	65	103	8
National Waiting Times Centre	6.30	3.65	2.65	581	163	418	538	43
NHS Fife	6.97	4.70	2.27	1,928	647	1,281	1,836	92
NHS Greater Glasgow & Clyde	6.64	4.32	2.32	8,967	2,924	6,043	8,337	630
NHS Highland	6.17	3.79	2.39	2,294	608	1,686	1,872	422
NHS Lanarkshire	7.50	5.28	2.22	2,936	1,058	1,878	2,673	263
NHS Grampian	5.16	2.74	2.42	3,355	691	2,664	3,012	343
NHS Orkney	5.96	3.68	2.28	116	28	88	112	4
NHS Lothian	5.90	3.34	2.56	5,731	1,266	4,465	5,187	544
NHS Tayside	6.76	4.27	2.49	3,120	825	2,295	2,912	208
NHS Forth Valley	7.56	4.97	2.59	1,529	472	1,057	1,488	41
NHS Western Isles	5.63	3.06	2.57	224	45	179	211	13
NHS Dumfries & Galloway	5.77	3.35	2.42	888	207	681	858	30
NHS Shetland	4.72	2.45	2.27	135	25	110	127	8

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

Our Maximising Attendance approach continues with:-

- Regular RAG Reviews (3 of 11 Nursing wards below 5%) and significant improvement across Arran and Iona Hubs
- Audit and monitoring of consistent Pathways usage
- Manager development
- Accountability and performance management for areas which require additional support

(b) RECRUITMENT /ESTABLISHMENT/ SUPERNUMARY STAFFING

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

TIME TO HIRE	72 days	KPI is 75 days
	The average Time to Hire in May was 72 days, (the KPI being 75 days). Areas where we are successfully below the national KPI are, • Job Approval to Live by 1 day, Closing date to shortlisting complete by 4 days and from Conditional Offer to Contract issued by 5 days. • This has been achieved by hiring managers beginning to shortlist whilst the advert is still live and setting time for when the advert closes to complete shortlisting timeously. • The advert period continues to run longer than the KPI at 13 days compared to 10. This can be due to hard-to-fill posts that require an extension in advertisement. The areas which are above the KPI is from inviting to interview to updating interview outcomes for conditional contract, in total this is 20 days compared to the KPI of 11. This can be reduced by only giving one week notice of interviews and also hiring managers ensuring they are planning time promptly after conducting interviews to update the system.	

VACANCIES ADVERTISED	12 posts were advertised in May, totalling 24 vacancies.
NURSING RECRUITMENT	**Ward-Based Nursing** The following nursing staff are due to commence employment: • June induction: 7 (5 female 2 male, 1 starting as band 3) • August induction: 6 (4 male 2 female, 5 starting as band 3) • October induction: 1 (starting as band 3 if no PIN) An in-person recruitment event is taking place on 10 June 2026. So far 34 individuals have registered to attend. There will also be 25 interviews held on the day for successful attendees who will be advised of this prior to attending.

(c) EMPLOYEE RELATIONS - LIVE CASES

- No new formal cases in May
- 1 formal bullying and harassment case, which was raised in February
- 2 formal conduct cases which are ongoing
- 1 formal Grievance which is at Stage 1 which was raised in Feb 2026

(d) LEAVERS

- There were 5 leavers in May 2026.
- One retired and returned to the SSR.
- 3 from Nursing & AHP Directorate and 2 from the Medical Directorate.
- Analysis of exit interview findings will be presented to WGG in July for Staff Governance Committee in August.

(e) JOB EVALUATION – JANUARY 2026

Progress & Status

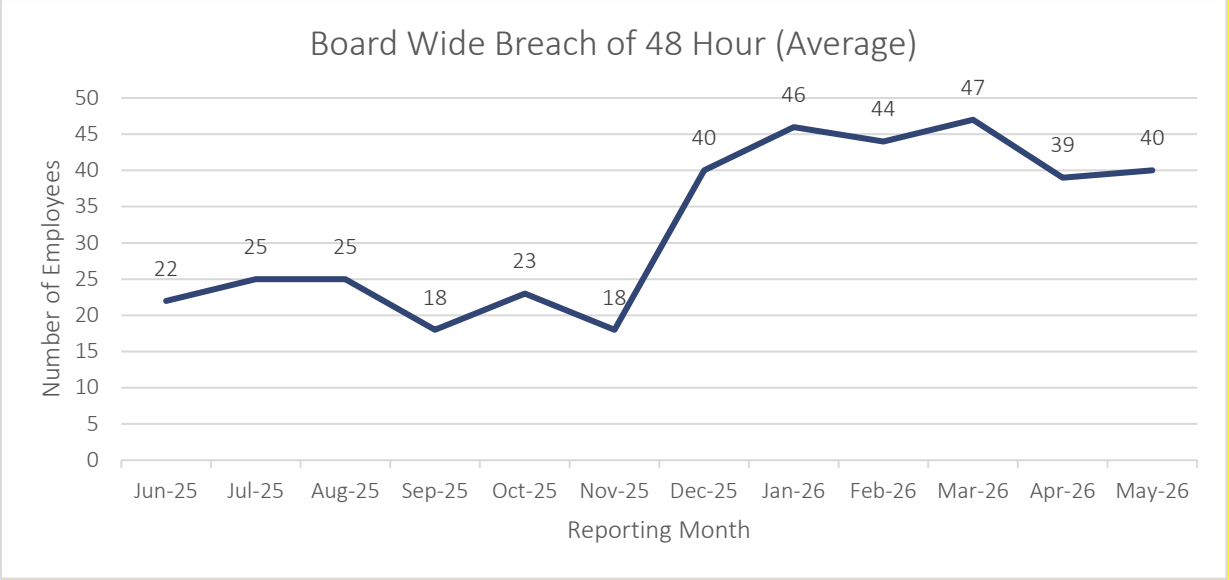
- Three new job descriptions were submitted in May
- One progressed to Quality Checking as per JD Share Protocol
- Two outcomes were given in May within 14 weeks of receipt
- Two posts remain active with June panel dates scheduled

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

Board wide, there were 40 staff who breached the average 48 hour working week as defined by WTD as highlighted above. This number has increased by 1 from the 39 staff last month, this had been decreasing since March 2026.

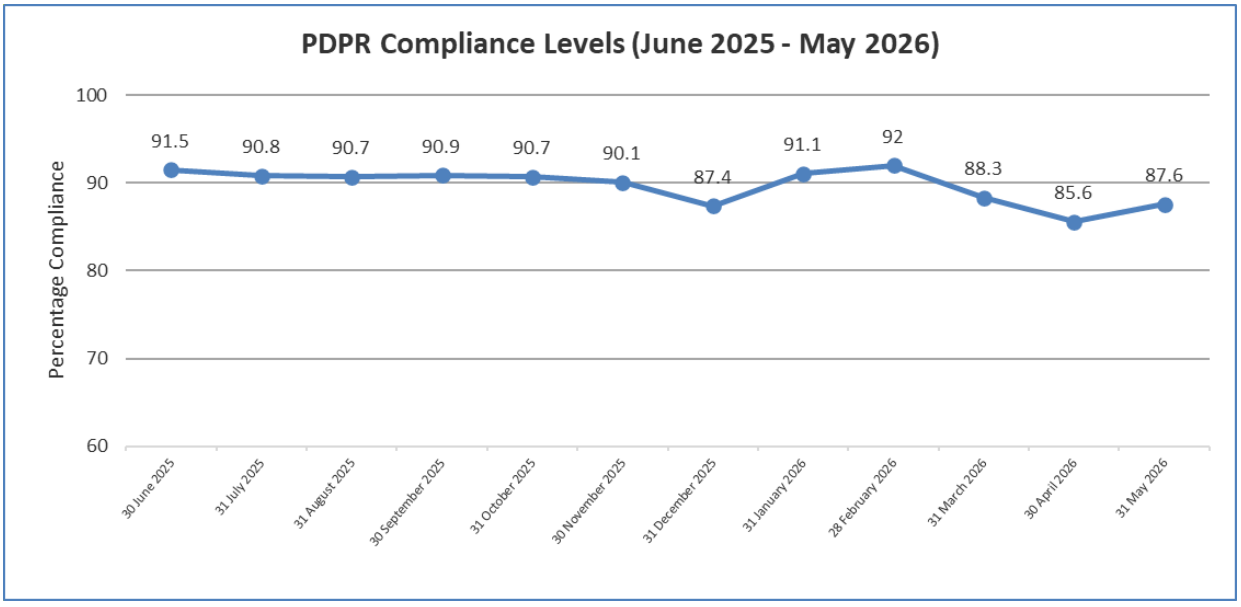
Monthly reports are issued to Heads of Service to highlight those who are breaching, along with whether a waiver has been completed.

Graph 3 – WTD breaches



(g) PPR COMPLIANCE

Graph 4 – PDP compliance



4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Support delivery of Staff Governance Standards and Workforce Plan
Corporate Objectives Please note which objective is linked to this paper	Better Workplace
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	WGG
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE **SGC(M)26/01**

Minutes of the meeting of the Staff Governance Committee held on Thursday 12 February 2026.

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

Chair:	
Non-Executive Director	Pam Radage
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Shalinay Raghavan
In attendance:	
Joint Head of Organisational Development and Learning	Graeme Anderson [to Item 7]
POA Representative	Alan Blackwood
Associate Director of Nursing	Josie Clark
Personal Assistant	Jen Davies **[Minutes]**
POA Representative	Graeme Fergusson
Chief Executive	Gary Jenkins
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore
Head of Corporate Governance	Margaret Smith
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage opened the first meeting of 2026 and welcomed attendees, including Mr Fergusson, who was attending in an observational capacity. Apologies were noted from Ms Cathy Fallon, Non-Executive Director and Ms Laura Nisbet, Head of Human Resources.

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 20 November 2025.

The Committee:

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

4 MATTERS ARISING AND ROLLING ACTIONS LIST

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

Ms Radage requested an update on succession planning and Mr Wallace provided a brief update, noting that this was being progressed through existing leadership development, talent management and workforce planning acuity rather than as a standalone programme. He advised a future update would be brought back in May.

The Committee:

1. Noted the updates from the Rolling Actions List.

5 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.

Mr Wallace highlighted a related nursing workforce risk (ND70) for context, which reflected acuity and staffing pressures, with mitigation through planned over-recruitment to 105%.

Mr Blackwood asked about gender balance initiatives, especially for night shifts, and their timeline. Mr Wallace said a gender-specific paper would be shared with staff, and analysis continues on achieving a 60% male, 40% female split. He mentioned a possible male-only recruitment drive and efforts to review risk management. Data was expected in about two months. Mr Jenkins noted that the organisation had experienced a shift in gender balance resulting in an increase in female staff within the nursing cohort. He said that the 60:40 ratio was previously agreed, and this should remain unless evidence suggested otherwise. In this respect, the Head of Psychology was currently reviewing and assessing risks related to this issue, and that the results of this would be debated in partnership.

Mr Currie welcomed progress in managing the Protecting Vulnerable Group (PVG) process related risk. He also highlighted the importance of presenting a balanced narrative in workforce risk reporting, noting that the reduced working week should be recognised not only for short-term implementation challenges but also for its longer-term wellbeing benefits for staff. This may assist in recruiting new staff as well as retaining staff.

Ms Radage agreed with these points and thanked Mr Wallace for the timely reminder around ND70, and the ongoing efforts within nursing recruitment to build resilience into the workforce.

The Committee:

1. Endorsed the Corporate Risk Register – Staff Governance Risks.

6 iMATTER REPORT UPDATE - NATIONAL

The Committee received the iMatter Report Update presented by Mr Anderson who outlined the key areas and six priorities for the benefit of members.

Mr Anderson reported the Employee Experience Index (EEI) was 77% nationally and 74% locally—a 3% difference. Team experience at State Hospital was positive, but organisational performance was not as strong overall with an indication of the need to renew focus in this area. Team relationships exceeded the national average, and action planning had risen by 30%, putting the organisation ahead of national standards. Mr Jenkins asked whether there was anything unexpected in the iMatter results that hadn't been evidenced previously, and Mr Anderson

confirmed there had been no surprises.

Ms Raghavan linked the iMatter findings to whistleblowing and noted the report helped by providing baseline data in terms of staff attitudes across the organisation, and the need to delve deeper into why there had been nil returns for whistleblowing cases over the past period. Mr Moore said the report was balanced and recognised growing importance of this area, and the work being taken forward by the Independent National Whistleblowing Officer in respect of national guidelines. He also noted the need to consider staff engagement around these results, and how to communicate these, prior to the next iMatter cycle.

Mr Anderson noted action plans from team discussions would address local reports and suggested directorate and board-level plans to demonstrate changes from staff feedback. He confirmed his department's support, with culture change activities set for April and May 2026.

Mr Wallace stressed that iMatter action plans must show real progress, and be meaningful. He suggested sharing improvement case studies so staff could see how engagement leads to change. He also acknowledged the need to refresh communication around speaking up initiatives, and that he was progressing with alignment with the Director of Nursing and Operations at present. This was aimed at strengthening confidence on the part of staff in being able to raise any concerns that they may have. Mr Jenkins added that the Director of Nursing and Operations had set up a programme of Saturday engagement sessions to speak directly to frontline staff face to face, exploring iMatter findings in more depth and that this should provide valuable feedback about staff experience.

Mr Currie noted that, given the organisation's size, there was an opportunity to develop staff engagement initiatives beyond the baseline of the annual iMatter survey. He highlighted the need for strong manager relationships, confidential channels for concerns, and a positive approach to whistleblowing to encourage staff to speak up. Mr Anderson stated that about 70% of workplace experience and wellbeing depends on the quality of managers and teams, highlighting the value of strong leadership. Staff experience dashboards could also offer regular, preventative insights supporting a more proactive approach in this regard.

Ms Radage commented that it would be helpful to combine iMatter into the wider Organisational Development (OD) approach, and that the Committee would welcome further reporting as this workstream progressed. Further, that assurance could be taken from the active consideration of speaking up initiatives, and that the output of this would return to the Committee.

The Committee:

1. Noted the iMatter Annual Report.

7 OD LEARNING & WELLBEING UPDATE (INCLUDING OD STRATEGY)

The Committee received the OD Learning and Wellbeing Update. Mr Anderson provided a summary of the content of the report including PDPR compliance as well as completion rates for statutory and mandatory training. He provided the background on the national rollout of LearnPro Modules, and how this would impact the State Hospital. He provided a summary of the implementation of the OD strategy and key initiatives in this respect, especially the culture change programme. He also gave an update about OD team development, confirming the recruitment of a Wellbeing Officer. He confirmed that Staff Excellence Awards would take place on 4 March, and that this event had produced an increase in the number of nominations for awards this year.

Mr Connor questioned whether PDPR conversations were occurring with sufficient frequency to be meaningful and asked how more regular discussions could be better recorded and reflected in reporting, beyond the annual compliance baseline. Mr Wallace advised that while PDPR compliance was measured annually at national level, the expectation was for more frequent performance and wellbeing conversations throughout the year led by line managers as a central

part of their role. Ms Clark also emphasised the need for regular review conversations instead of annual PDPR.

Ms Raghavan noted that staff feedback may be captured in new mandatory training reporting programme which would be helpful. Mr Anderson advised that further information was currently awaited at a national level in this respect. She also commented positively on the Ward Leadership Programme, and asked how this would be extended across staff groups at different levels of their careers. Mr Anderson confirmed that this was a pilot being taken forward in two wards and that the aim was to extend the programme across all wards. The key aim was to support and develop staff in understanding how they connected as leaders and as teams, and considering the culture they want to encourage. Alan Blackwood also welcomed the roll out of this programme as being a positive approach.

Ms Radage welcomed the movement of refresher periods for training cycles, and noted the importance of this particularly around cyber security and equality, diversity, and human rights training.

The Committee:

1. Noted the OD Learning and Wellbeing Report.

8.1 HEALTH AND CARE STAFFING QUARTERLY REPORT/ eROSTERING UPDATE & ROSTER COMPLIANCE AUDIT

The Committee received the Health and Care Staffing (HCSA) Quarterly Report, eRostering Update, and Annual Report from Ms Clark. She first outlined the content of the HealthCare and Staffing Update noting that this represented annual reporting for 2025/26 and provided positive assurance for the State Hospital. In this respect, she was seeking endorsement from the Committee in relation to the content.

She then described the ongoing work underway to implement SafeCare and Optima. Ms Clark reported that Optima held 42 rosters, 30 of which were active, with outdated non-nursing rosters being updated. All nursing rosters now reflected the reduced working week, and HR was addressing part-time arrangements. Loop registration was at about 83%, with most staff groups actively using it.

Ms Clark updated on the work progressed since the RSMUK internal audit of rostering practice. She advised that Lead Nurses were carrying out additional audit checks to measure compliance. She noted that continued use of both paper and digital systems risked human error in data recording around TOIL and shift swaps and therefore multiple controls were needed.

Mr Connor referred to the wording around the update of all contracts in Optima, noting that there were still discussions ongoing for part time staff. Mr Wallace confirmed in relation to the Reduced Working Week (RWW) that this was an indication of the work that required to be completed, especially with part-time staff. Mr Connor asked if nursing staff would be using Loop and Optima to request annual leave, noting that this could pose an issue as leave was planned well in advance. Mr Wallace confirmed that nursing leave would still be processed through SSTS for the moment but the intention was for nursing to also use Loop in the future.

Mr Connor acknowledged that new processes around TOIL and shift swaps were described in the report, and asked for clarification of this in terms of evidence that this had been implemented across the hospital. He asked for greater assurance around whether an improvement in practice could be demonstrated. Ms Clark acknowledged that not all Senior Charge Nurses were yet undertaking the same role in this regard, and that this had been a recent development.

Mr Jenkins noted the need to take this forward following the internal audit report findings, and to

put in place systematic changes that would give the appropriate level of assurance. It was agreed around the table that there should be focus on this, and that this would return to the Committee in May.

Action – Ms Clark

Ms Merson welcomed the improved assurance position in relation to the HCSA Report, suggesting that clear indicators and ongoing monitoring through Directorate Performance Meetings which was agreed as a useful way to keep this work on track.

Ms Raghavan noted staff concerns raised during a walkround visit she had undertaken about managing multiple systems for e-rostering, and asked about what engagement there had been with staff in this regard especially in the context of this being a national programme. Mr Wallace advised that this was a complex area and noted the position to date for the State Hospital. This included training for managing the Supplementary Staffing Register (SSR) which meant that there would be a direct interface for SSR staff and payrolls service (provided through NHS Greater Glasgow and Clyde). There was a national group looking at the full interface with two Boards running this as a pilot presently. There was a planned rollout for December for the State Hospital. He agreed that there should be greater communication with staff about their frustrations as this progressed.

Mr Blackwood noted the complexity of the discussion, and how this impacted staff. He thought it would be helpful to have clear, regular communication to staff on progress, given the implications for working hours and pay. Ms Radage echoed this, and thought this would be a supportive mechanism given the additional work required, as well as the impacts on staff in terms of working hours and pay.

Action – Mr Wallace

Ms Smith noted that this Committee routinely received quarterly Health and Care Staffing reporting prior to submission to Healthcare Improvement Scotland (HIS). The annual report was scheduled for the April Board for approval, subject to this Committee's recommendation in this respect.

Ms Radage summarised the discussion for the Committee, and the actions agreed and noted that the Committee agreed to onward submission of the draft HCSA report to the Board.

The Committee:

1. Noted the content of reporting.
2. Endorsed the Health and Care Staffing Annual Report and recommended its submission to the Board.
3. Requested further assurance reporting on rostering audit work
4. Asked for update on communication to staff on progress of e-rostering and wider staff impacts.

8.2 WORKFORCE REPORT

The Committee received the Workforce Report presented by Mr Wallace who outlined the key metrics for the benefit of members.

He reported that the average time to hire was 75 days, which met the agreed performance indicator. He reported that the nursing establishment remained in a deficit of 17 whole time equivalent (WTE) including Band 6 level with targeted recruitment underway and plans to over recruit. He noted the continued use of supplementary staffing and overtime within nursing. In terms of employability, Mr Wallace highlighted the introduction of a procurement apprentice role and initial work linked to child poverty. Mr Wallace provided an update on employee relations (ER)

cases, leavers and turnover. Job evaluation activity remained low risk; however, concern was noted regarding Working Time Directive (WTD) breaches, with a significant spike in staff working above 48 hours. He confirmed that an annual report on exit interview feedback would be prepared for the next Committee meeting in May. Ms Clark raised the value of collating feedback from staff returning to the organisation, if possible and it was agreed that this would be helpful. which Mr Wallace also noted that exit interview findings were routinely shared with Directors to address any immediate concerns.

Action (s) – Mr Wallace

Mr Jenkins added that in relation to the women's service, the experience of opening this new service had indicated the need for greater resourcing that had originally been anticipated, and that this was being explored further in terms the overall budgetary requirement of the service.

Mr Currie emphasised the importance of continuing to gather exit interview and absence data to identify emerging themes over time and highlighted the value of modern apprenticeships as a route into employment.

Mr Blackwood suggested adding gender breakdowns to workforce data on starters and leavers to better assess staffing. Mr Wallace agreed it was feasible, and Mr Jenkins supported the idea, proposing that overlaying gender data may clarify reasons staff leave certain areas.

Action – Mr Wallace

Ms Raghavan suggested more detailed insight into staff departures by ward and asked if WTD breaches were being tracked in the longer term in terms of emerging patterns. Mr Wallace confirmed that this the case, adding that there was indication of workforce pressures, with no use of agency staff and reliance on overtime. Mr Jenkins added that this was also discussed within the Partnership Forum with scrutiny of the trends. He noted the recruitment drive underway within nursing, with agreement to recruit to 105% as well as the work around the re-balancing of the resourcing required for the women's service. It was agreed that longitudinal data should be added to reporting.

Action – Mr Wallace

Ms Radage thanked Mr Wallace for the report and noted the correlation between the iMatter Report and Exit Interview information, noting how the correlation of this information could provide meaningful insight.

<u>The Committee:</u>

1. Noted the Workforce Report.
2. Noted that the Exit Interview Annual Report was due in May, and that feedback from returning staff would be a helpful addition.
3. The addition of gender split in reporting in starter/leaver data.
4. The addition of longitudinal analysis in respect of WTD.

8.3 MAXIMISING ATTENDANCE UPDATE

The Committee received the report, presented by Mr Wallace. He noted the sickness absence rate had dropped from 9.91% in December to 7.93% in January, showing improvement. He also highlighted the initiation of Human Resources (HR) communications regarding absence costs to the organisation, including a poster campaign, acknowledging that this was an area that required careful consideration.

Mr Currie welcomed the decline in long-term absences but noted that prolonged absence lowered

the likelihood of staff returning. He suggested that reporting could include projections for future absence by doing comparative analysis to past data. Ms Radage agreed, saying this type of projection data would be valuable and it was agreed that the possibility of this should be assessed.

Action – Mr Wallace

Mr Blackwood commented on the helpfulness of analysing absence data by service or ward to identify trends and commented on the differential that could be experienced in Occupational Health (OH) advice compared to that of a GP Fit Note. Mr Wallace confirmed that area-level absence analysis was conducted and reported through the Workforce Governance Group, and efforts were underway to consolidate the data. He clarified that OH offered advisory input but did not override GP Fit Notes. Ms Raghavan advised caution around having an employee return to work against the advice of a GP Fit Note and then spoke of the need to ensure that steps were in place so that the return to work was meaningful. Mr Wallace noted the importance of early meaningful engagement with staff to explore appropriate support.

Mr Connor said that sickness absence had not reached the target rate of 5%, and underlined the need to do so. Mr Wallace responded that ongoing, gradual improvements were needed rather than a single solution, and highlighted early positive trends. Ms Merson shared trend data which covered the previous five years and showed that although there had been variation across this time period, there was an overall trend downwards.

Summarising for the Committee, Ms Radage requested pulling together further trend information over the past five years, as well as reporting on specific areas of challenge within the hospital. some of that information with detail around hot spots could be helpful.

Action – Mr Wallace

The Committee:

1. Noted the Maximising Attendance Update.
2. Requested further data reporting and analysis on sickness absence.

8.4 ER CASE LEARNING

The Committee received the Employee Relations (ER) Case Learning Report, and Mr Wallace outlined organisational learnings from ER cases in 2024-2025, noting the challenges experienced which were outlined in reporting. The need for timely, transparent communication, consistent return-to-work arrangements, and clearer post-hearing guidance was emphasised.

Mr Connor noted existing staff concerns about delays in ER processes such as suspension decisions, investigation timeframes, and inconsistent use of designated contacts and stressed the need to learn from these cases to improve and prevent recurrence. Mr Blackwood added that there was a need for clear oversight and assurance to demonstrate that learning from ER cases was resulting in measurable improvement.

Ms Raghavan emphasised the need to streamline ER processes to avoid unnecessary delay and ensure cases were managed proportionately, fairly and with staff wellbeing in mind.

Mr Jenkins acknowledged the challenges experienced as well as the need for improvement, including the need for clear accountability and demonstrable, measurable improvement. He noted that work on this was progressing through discussions in partnership, and that these would help inform the way forward, and progress and developments would be reported to the Committee.

Action – Mr Wallace

Mr Wallace provided assurance that learning from recent ER cases was being actively addressed through strengthened oversight, clearer accountability, improved timeliness and a more consistent, person-centred approach to staff support, to prevent recurrence of the issues identified.

Ms Radage noted the report was helpful and that further reporting would return to the Committee.

The Committee:

1. Noted the ER Case Learning Report.
2. Requested a progress update in this respect.

9.1 OCCUPATIONAL HEALTH (OH) UPDATE

The Committee received the Occupational Health Update and Mr Wallace presented a summary overview, noting increased case management activity, which reflected earlier referral and demand, particularly for psychological and musculoskeletal support, and the continued role of OH in supporting attendance management and sustainable return to work.

In reference to the did not attend appointments data figure within the report, Ms Radage queried if staff did not place a value on the service, noting it may be helpful to ensure that staff understood the costs involved in this as they may not attend if they don't understand there is a cost involved. She noted the importance of encouraging staff to use the service more to help them.

The Committee:

1. Noted the Occupational Health Update Report

9.2 WORKFORCE EQUALITIES GROUP UPDATE

The Committee received an update on Workforce Equalities Group from Mr Wallace who advised that the Group would move to a bi-monthly meeting cycle and that work was underway to develop a formal Equality Action Plan for 2026–27, alongside ongoing awareness-raising activity and targeted training. Mr Wallace also asked the Committee to note the content of the Workforce Equality Monitoring Report.

Ms Raghavan thanked Mr Wallace for the report and welcomed the progress made by the Workforce Equalities Group which was gaining traction, and Ms Radage echoed these comments.

The Committee:

1. Noted the Once for Workforce Equalities Group Update.
2. Noted the Workforce Equality Monitoring Report.

9.3 WORKING ENVIRONMENT REPORT

The Committee received the Working Environment Report, presented by Mr Wallace. He noted the continued development of this report, and summarised the key metrics. The Nursing Partnership Forum Terms of Reference had been approved, and a first meeting was scheduled this month.

There was discussion on the metrics included in reporting, as these covered a range of areas some of which were also reporting through the Clinical Governance Committee, and there was reflection that reporting would continue to be developed to ensure the right level of assurance across the governance framework.

Action – Mr Wallace

The Committee:

1. Noted the Working Environment Report.
2. Noted the action to continue to refine reporting.

9.4 NURSE PRACTICE DEVELOPMENT UPDATE

The Committee received the Nurse Practice Development (NPD) update, presented by Ms Clark who provided an overview of the progress of the five priorities that Nursing Practice Development were focusing on over 2025-2026. Ms Clark noted the process followed to engage with staff about their training requirements, noting that NPD continued to meet with NHS Lanarkshire to explore collaborative training opportunities. Clinical supervision training had seen a steady shift, although it was acknowledged recent operational pressures had resulted in training courses being postponed. Ms Clark noted that the development of Healthcare Support Workers education and Support Programme had been successful. Key priorities for the following year would be established in March. Ms Clark further noted that NPD had been heavily involved in the multiple recruitment campaigns over recent months, which had been a big commitment, but which had been fruitful.

Mr Moore commented positively on the report, and highlighted the reported gap in physical health knowledge, noting that this was particularly relevant in the context of service models such as Hospital at Home and the Flow Navigation Centre. He expressed interest in receiving ongoing updates regarding areas where additional expertise or skills should be cultivated.

Mr Connor asked whether a formal, structured training programme was in place to support new staff joining the women's service, beyond the initial induction period, to ensure they were adequately prepared for the complexity of the service. Ms Clark advised that staff were currently supported through the newly qualified programme, but that NPD would also review in future to identify any specific training needs.

The Committee:

1. Noted the Nurse Practice Development Update.

10.1 WORKFORCE PLAN – ACTION PLAN 25/26 AND 26/27

The Committee received the Workforce Plan and Mr Wallace informed members the two plans had been compared to show the areas that had been completed and those that had been moved forward to the coming year. He emphasised that the key focus in the coming year was on organisational health and sustainability.

Mr Moore referred to the revised vacancy protocol, and asked if any service redesign opportunities had been identified. Mr Wallace advised there had been some movement in this, and that there was additional scope in this respect. He thought that this required to be at the forefront going forward to explore alternative ways of working.

The Committee:

1. Noted the Workforce Plan – Action Plan 25/26 and 26/27.

10.2 WORKFORCE GOVERNANCE GROUP UPDATE

The Committee received the Workforce Governance Group Update from Mr Wallace, who provided

an overview of the paper and noted the content of the meeting that was held on 20 January 2026. He highlighted discussions around ADP Plan, improving working environment, building a sustainable workforce and developing leadership. He further noted that there had been updates about local and national activity, performance reviews, absence, training and inductions KPI's as well as vacancy control.

The Committee:

1. Noted the Workforce Governance Group Update.

10.3 PARTNERSHIP FORUM APPROVED MINUTES

The Committee received the approved Partnership Forum minutes from 18 November 2025.

Ms Radage welcomed the minutes and noted they provided context on the issues under discussion and were well linked to papers on today's Agenda. She praised the openness of the information and noted that the concerns around raised by staff side colleagues which continued to be worked through.

The Committee:

1. Noted the Partnership Forum Minutes.

11.1 INTERNAL AUDIT REPORT: ABSENCE, DISCIPLINARY AND SUSPENSION MANAGEMENT

The Committee received and noted the Internal Audit Report on attendance, conduct and suspension compliance. Mr Wallace noted that the internal audit opinion gave reasonable assurance and highlighted four low risk actions. However, it was a positive report and positive outcome overall.

The Committee:

1. Noted the report.

11.2 COMMITTEE WORKPLAN

Members received the Committee Workplan for 2026 and there were no areas requiring discussion.

The Committee:

1. Noted the Committee Workplan 2026.

11.3 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

The Committee commended openness of discussion both at this meeting as well as the Partnership Forum, and the positive assurance of partnership working. There had been detailed and constructive discussion throughout the meeting based on the information within papers, which supported the strength of oversight.

11.4 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

The Committee noted the linkage between staff resourcing discussed within today's agenda, and the clinical impacts which would be routed through Clinical Governance Committee. Further the discussion within this meeting on the Working Environment Report, and how data was reported across the Committees which would be reviewed.

12 ANY OTHER BUSINESS

There were no other items of competent business.

13 DATE OF NEXT MEETING

The next meeting would be held on Thursday, 21 May 2026 at 9.30am.

The meeting concluded at 12.45pm

Paper No: 26/48

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 20ii

Author(s): PA to Chief Executive & Chair

Title of Report: Staff Governance Committee Summary Report

Purpose of Report: For Noting

This report provides an update on the key points arising from the Staff Governance Committee meeting that took place on 21 May 2026.

No.	Item	Summary
1	Organisational Development and Wellbeing, including OD Strategy Update	The Committee received reporting on organisational learning and wellbeing, noting reductions in PDPR and mandatory training compliance linked to workforce pressures, with actions in place. Progress was also noted in delivery of the OD strategy, including strengthened wellbeing provision and the introduction of a Staff Care and Wellbeing Officer.
2	Health Dashboards	Reporting was received on the progress made on workforce health dashboards was reviewed, through pilot working with consideration of how this will be developed further as part of the wider OD strategy.
3	Succession Planning Framework	The Committee received a draft succession planning framework was considered, nothing further engagement planned to refine inclusivity and communication. A finalised draft will return to the Committee.
4	Workforce Report	The Committee reviewed workforce metrics, noting ongoing recruitment activity and innovative approaches such as in-person interview events.
5	Maximising Attendance	Reporting was received focused on attendance levels, with some improvement in sickness absence levels noted. The Committee welcomes the addition of projected trend reporting as helpful and realistic.
6	Management of Employee Relations Cases: Improvement Plan	Progress was noted on learning from employee relations cases and implementation of improvement actions, particularly in timeliness and experience.
7	Workforce Equalities Group	The Committee received reporting outlining the draft Workforce Equalities action plan was noted, informed by lived experience feedback and national priorities. It was agreed that a finalised plan would return to the next meeting.

No.	Item	Summary
8	Fitness to Practice: Annual report	The Committee took strong assurance from reporting in this area with no concerns raised.
9	Internal Audit: Nurse Rostering Improvement Plan	A verbal update was received on the progress being made, with assurance that fully detailed reporting would come to the next meeting to outline the process and improvement plan.
10	E-Rostering Update	Progress in workforce systems was noted, though full benefits remain dependent on national system integration.
11	Staff Governance Committee: Annual Report	The Committee discussed its annual report, agreeing that it
12	Corporate Risk Register: Staff Governance Risks	The Committee confirmed the corporate risk register accurately reflected workforce risks, with sickness absence levels remaining at a high rated risk.
13	Minutes/Group Updates	The Committee received approved minutes of meetings of the Partnership Forum and a summary overview from the Workforce Governance Group.
14	Areas of good practice / concern	Revised reporting of workforce metrics, with future projections included noted as an improvement. The strength of partnership working, as well as the work of the Workforce Directorate to support delivery of the reduced working week was commended as 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.

DRAFT PENDING COMMITTEE APPROVAL

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 21

Sponsoring Director: Chair of Audit and Risk Committee

Author(s): Director of Finance and eHealth

Title of Report: Audit and Risk Committee Annual Report 2025/26

Purpose of Report: For Decision

1 SITUATION

The Report outlined in Appendix 1 is presented to the committee to meet the requirements within the Committee's Terms of Reference to submit an annual report of the work of the Committee to the Board. The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control.

2 BACKGROUND

The preparation of an Annual Report by the Audit & Risk Committee is an important assurance process for the Board in its consideration of the effectiveness of internal controls.
The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Areas of Best Practice
- Review of Terms of Reference

An effective system of internal control is fundamental to securing sound financial management of the Board's affairs.

The consideration and review of internal and external audit reports, and management responses, together with reports submitted by other officers, assist the Committee in advising the Board with regard to material risks.

3 ASSESSMENT

This report was presented to the Audit and Risk Committee for approval at its meeting of 18 June 2026, prior to submission to the Board.

4 RECOMMENDATION

The Board is asked to approve the Audit and Risk Committee Annual Report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP	Year end reporting to demonstrate that the committee has met its remit
Corporate Objective	Better Value 3(j) – Strengthen corporate governance to ensure transparency and clear direction, both within and external to the organisation in line with the Blueprint for Good Governance.
Workforce Implications	None identified as part of reporting
Financial Implications	None identified as part of reporting
Route To Board Which groups were involved in contributing to the paper and recommendations	Submitted by the Audit and Risk Committee to the Board
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	No impact identified
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impacts identified
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	□ 1 – no privacy implications

Appendix 1

THE STATE HOSPITALS BOARD FOR SCOTLAND AUDIT AND RISK

COMMITTEE ANNUAL REPORT

1 April 2025 – 31 March 2026

1 INTRODUCTION

The Audit and Risk Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

The main objectives of the Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Committee fulfils its remit, this may involve assessing the attendance and performance of each member.

New members receive a suitable induction and declares his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

2 COMMITTEE CHAIR, COMMITTEE MEMBERS AND ATTENDEES

Committee Chair:
David McConnell (Chair of Committee, Non Executive Director)

Committee Members:
Allan Connor (Employee Director) Stuart Currie (Non-Executive Director) Pam Radage (Non-Executive Director)

In attendance:
Gary Jenkins (Chief Executive)
Robin McNaught (Director of Finance and eHealth)
Monica Merson (Head of Planning and Performance) Brian Moore (Board Chair)
Margaret Smith (Head of Corporate Governance/Board Secretary)

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing and presentations.

3 MEETINGS 1 APRIL 2025 – 31 MARCH 2026

During 2025/26 the Audit and Risk Committee met on four occasions, in line with its terms of reference (Appendix 1).

Meetings were held on:

19 June 2025
2 October 2025
29 January 2026
19 March 2026

Attendance of Committee members were as follows:

	Number of Meetings Present
David McConnell	4
Allan Connor	4
Stuart Currie	4
Pam Radage	3

4 SUMMARY OF REPORTING

The Committee received and considered reports as undernoted and made recommendations and/or monitored areas as required:

Internal Audit Reports:

- Clinical Care Policy
- Restraint (Use of SRKs) – Verbal Update
- Estates and Facilities Management
- Project Management Framework Review
- Absence, Disciplinary and Suspension Management

Workplan Reporting

- Risk Strategy
- Adverse Events Action Tracker
- Attendance Management – Risk Report
- Cyber Security Report
- Committee Workplan 2026
- Financial Report

4.1 Annual Reports

Annual Reports from Governance Committees

- Audit and Risk Committee
- Remuneration Committee
- Clinical Governance
- Staff Governance

Annual Accounts

- Statutory Annual Accounts
- Patient Funds Accounts

Annual Reports

- External Audit Annual Report to the Board and the Auditor General for Scotland
- Annual Audit Committee Assurance Statement to the Board
- Internal Audit Annual Report 2024/25
- Audit Scotland Reporting, including NHS in Scotland 2025
- National Single Instance (NSI) and NSS Audits
- Review of draft Governance Statement
- Review of Scheme of Delegation and Standing Financial Instructions
- Review of Board Standing Orders and Code of Conduct
- Review of Accounting Policies
- Review of Committee Terms of Reference
- Review of Effectiveness of Committee
- Risk and Resilience Annual Report
- Climate Emergency and Sustainability Annual Report 2024/25
- Procurement Annual Report 2024/25
- Legal Claims Annual Report 2024/25

- Anchors Strategy Annual Update
- Summary of Losses and Special Payments
- Report on Waivers of SFI Tendering Requirements

Progress Updates

The Committee also received regular updates on the following –

- Completion of audit actions
- Policy review completions
- Risk register reviews
- Counter fraud activity and outcomes of fraud reviews
- Cyber security matters
- NIS audit review
- Scottish Public Finance Manual update

4.2 Standing Items Considered by the Committee during the Year

Standing Items

- Internal Audit Tracking Report
- External Audit Update
- Financial Performance Update
- Policy Update
- Corporate Risk Register
- Fraud Update and Action Plan

4.3 Notes of updates from other meetings

The Committee received and noted minutes/reports from the following:

- Security, Resilience, Health and Safety Oversight Group Update
- Finance, eHealth and Audit Group Update
- Climate Change and Sustainability Group Update

5 ACTIVITIES / RISK MANAGEMENT

5.1 Corporate Risk Register

An update on the latest progress of the Corporate Risk Register went to each Audit and Risk Committee in the 2025/26 period. The paper details any changes to current grade of the approved risks, updates on any current high and very high risks, any new risks for consideration and updates on the general development of the risk register. The latest paper in March 2026 showed that all approved risks were within their review period. Five high-rated corporate risks are currently under close review. These relate to obesity management, delayed Category 1 and 2 reviews, long-term financial sustainability, sickness absence, and nursing/staffing pressures. While some improvement work is underway, all remain significant concerns and continue to be monitored. Updates included the latest progress on the control measures in place to reduce the risk to an acceptable level. The paper provides assurance to the Audit and Risk Committee with regards to any increased areas of concern within the Corporate Risk Register as well as ensuring risks are regularly updated and reviewed.

6 AREAS OF BEST PRACTICE

Improvement

- Regular reporting now from Finance, eHealth and Audit Group, and Security,

Resilience, Health and Safety Oversight Group
- Regular reporting on TSH financial position

Concern

- The members reviewed Committee effectiveness through formal assessment in September 2025, reporting to the Audit & Risk Committee that month – a positive overall assessment of the Committee's effectiveness, confirming that its remit, membership, meeting arrangements, governance oversight, audit functions and administration are all working well, with only a note to keep future member induction and training under review.

7 CONCLUSION

From the review of performance of the Audit & Risk Committee, it can be confirmed that the Committee has met in line with the Terms of Reference, and has fulfilled its remit. Based on assurances received and information presented to the Committee, adequate and effective Audit & Risk Governance arrangements were in place throughout the year.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2025/26**.**

David McConnell
AUDIT AND RISK COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit and Risk Governance Committee

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Audit and Risk Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

2 COMPOSITION

2.1 Membership

The Committee is appointed by the Board and shall be composed of at least three Non-executive Board members.

Membership will be reviewed annually and disclosed in the Annual Report.

2.2 Appointment of Chairperson

The Chair of the Committee will be a Non-Executive Director, appointed by the Board.

2.3 Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive), Director of Finance and eHealth, Chief Internal Auditor, a representative from External Audit and any other appropriate officials shall normally attend meetings and receive all relevant papers. Other Directors may also be invited by the Chair of the Committee to attend meetings as required.

All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Committee members must regularly attend the Committee. This will be monitored, and attendance will be reported to the Board annually.

3 MEETINGS

3.1 Frequency

The Audit and Risk Committee will meet at least four times a year to fulfil its remit and shall report to the Board at least twice in each financial year.

The Chair of the Committee may convene additional meetings as necessary.

The Accountable Officer should attend all meetings but if he/she does not, be provided with a record of the discussions.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least three clear working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Audit Committee meeting. In line with Board Standing Orders, the Committee should approve the minutes prior to submission of these to the Board.

4 OTHER

In order to fulfil its remit, the Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and / or the External Auditor or Internal Auditor. It is expected that this should occur at least once in each financial year.

The Chief Internal Auditor and the representative(s) of External Audit will have free and confidential access to the Chair of the Committee.

The Chair of the Audit Committee should be available at the Board's Annual Accounts Approval Meeting to answer questions about its work.

5 REMIT

5.1 Objectives

The main objectives of the Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Committee fulfils its remit, this may involve assessing the attendance and performance of each member.
New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

5.2 Internal Control and Corporate Governance.

5.2.1 To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment; Risk management strategy, procedures and risk register;
- The effectiveness of the internal control and risk managements

systems
- Decision-making processes;
- Receive and consider stewardships reports in key business areas.
- Information;
- Monitoring and corrective action

5.2.2 To review the system of internal financial control which includes:

The safeguarding of assets against unauthorised use and disposition.

- Maintenance of proper accounting records and
- the reliability of financial information used within the organisation or for publication.

5.2.3 To have a mechanism to keep it aware of topical legal and regulatory issues and ensure the Board's activities are within the law and regulations governing the NHS.

5.2.4 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.2.5 To present an annual assurance statement on the above to the Board to support the Directors' Governance Statement on Internal Control.

5.2.6 To take account of the implications of publications detailing best audit practice.

5.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

5.2.8 To review audit reports and management action plans in relation to physical security of the Hospital.

5.2.9 To provide assurance to the Board that plans are in place to ensure service continuity and to provide contingencies for emergency situations.

5.2.10 To provide assurance to the Board that plans and mechanisms are in place to ensure that Fraud is properly monitored and reported.

5.3 Internal Audit

5.3.1 To review and approve the Internal Audit Annual Plan.

5.3.2 To review the adequacy of internal audit staffing and other resources.

5.3.3 To monitor audit progress and review audit reports.

5.3.4 To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.

5.3.5 To consider the Chief Internal Auditor's annual report and assurance statement.

5.3.6 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.3.7 To review the terms of reference and appointment of the Internal Auditors.

5.4 External Audit

5.4.1 To review the Audit Plan, including the Performance Audit Programme.

5.4.2 To consider all statutory audit material, in particular:

- Audit Reports (including Performance Audit Studies);
- Annual Reports;
- Management Letters.

5.4.3 To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies (following consideration by the Staff Governance Committee or Clinical Governance Committee where appropriate).

5.4.4 To review the extent of co-operation between External and Internal Audit.

5.4.5 Annually appraise the performance of the External Auditors.

5.4.6 To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

5.5 Standing Orders and Standing Financial Instructions

5.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

5.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

5.5.3 To review the Scheme of Delegation.

5.6 Annual Accounts

5.6.1 To review annually (and approve) the suitability of accounting policies and treatments.

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

5.6.5 To review and recommend approval to the Board of the Annual Accounts.

5.6.6 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

5.6.7 To review and recommend approval to the Board of the Patients Funds Annual Accounts.

6 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of

reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7 PERFORMANCE OF THE COMMITTEE

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

The committee shall provide guidelines and/ or pro forma concerning the format and content of the papers to be presented.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

Subject to Annual Review
Last reviewed March 2026

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 23

Sponsoring Director: Director of Finance and eHealth

Author(s): Director of Finance and eHealth

Title of Report: Patients' Funds Accounts

Purpose of Report: For Decision

1 SITUATION

The Board is required to approve the Patients' Funds annual audited accounts.

2 BACKGROUND

Patients' funds are the balances of money held by TSH on behalf of patients. The Board's Patients' Funds Annual Accounts are presented in a format directed by the Scottish Government Health & Social Care Directorate (SGHSCD) and require to be audited by external auditors, approved by the Audit & Risk Committee and authorised by the Board for signature by the Chief Executive and Finance & eHealth Director. The 31 March 2026 audit is now complete and the accounts are presented to this meeting for approval, following the approval of the Audit & Risk Committee on 18 June 2026.

3 ASSESSMENT

The accounts generally show unpredictable fluctuations in average funds held – simply due to the level of patients' spending and income being fairly inconsistent from one year to the next. The average balance held per patient therefore also fluctuates, with a net inflow of funds for the first time in five years.

	March 2026	March 2025	March 2024	March 2023	March 2022
Opening Balance	£597,411	£646,124	£670,191	£677,098	£568,095
Receipts	£669,754	£541,249	£527,390	£613,305	£559,727
Payments	£594,021	£589,962	£551,456	£621,212	£450,724
Net in/(out)flow of funds	£75,733	£(48,714)	£(24,067)	£(6,907)	£109,003
Closing Balance	£673,143	£597,411	£646,124	£670,191	£677,098
No. of patients at 31 March	108	104	98	109	113
Average funds per patient	£6,233	£5,744	£6,593	£6,148	£5,992

The Patients' Funds Accounts are audited by Wylie and Bisset who have issued an unqualified audit opinion.

4 RECOMMENDATION

The Board is invited to agree to the following recommendation – to approve the Abstract of Receipts and Payments of Patients' Private Funds for the year ended 31 March 2026, for signature by the Chief Executive and Director of Finance and eHealth.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP	Annual accounts for Board approval require to be presented to Audit and Risk Committee for approval before presentation to Board
Corporate Objectives Please note which objective is linked to this paper	Better value (3c) – Deliver all Scottish Government financial budget and resource reporting and monitoring requirements for NHSScotland national matters, through Board Chief Executive, Director of Finance and Human Resource Director groups
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	Paper prepared by the Finance and eHealth Director Approved by Audit & Risk Committee
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	1 – no privacy implications

Appendix 1 – Patient Funds Statement

STATE HOSPITAL **SFR 19.0**
PATIENTS PRIVATE FUNDS
FOR YEAR ENDED 31 MARCH 2026

ABSTRACT OF RECEIPTS AND PAYMENTS

2025 £		2026 £
	RECEIPTS	
	Opening Balances:	
641,124	Cash in Bank	593,074
1,900	Cash on Hand	3,101
3,101	Other Funds	2,437
646,124		597,411
530,036	From or on behalf of Patients	660,495
11,212	Interest on Patients' Fund Account	9,259
1,187,373	**Total Receipts**	**1,267,164**
	PAYMENTS	
589,962	To or on behalf of Patients	594,021
0	Extra Comforts etc.	0
	Closing Balances:	
593,074	Cash in Bank	669,207
1,900	Cash on Hand	1,900
2,437	Other Funds	2,036
597,411		**673,143**
1,187,373	**Total Payments**	**1,267,164**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
597,411	Credit Balances	673,143
0	*Less: Debit Balances*	0
597,411		673,143
0	Interest Received but not Credited	0
597,411	**Total Closing Balance**	**673,143**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of
Finance & eHealth _____ Date _____

The abstract of Receipts and Payments was submitted at the Board Meeting on 18th of June 2026 and duly approved

Chief Executive _____ Date _____

1. Note to SFR19

The Scottish Government Health Directorate requires The State Hospitals Board for Scotland to prepare, on an annual basis, an abstract of receipts and payments of patients' private funds administered by the Board. The abstract of receipts and payments of the patients' private funds has been prepared by the Board, on a cash basis, in accordance with the requirements of the 2025/26 NHS Board Accounts Manual.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 18 June 2026

Agenda Reference No: Item No: 24

Sponsoring Director: Chief Executive

Author(s): Head of Corporate Planning, Performance and Quality
Corporate Planning, Performance & Quality Project Support

Title of Report: Performance & Annual Delivery Plan
- Annual Report 2025/26

Purpose of Report: For Noting

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1 April 2025 until 31 March 2026. TSH corporate performance is reported through twelve Key Performance Indicators (KPIs) and progress on the Annual Delivery Plan 2025-26 The report highlights areas of success and challenges, with ongoing efforts to improve patient care, staff wellbeing, and operational efficiency, and continued commitment to align with national system reform.

2 BACKGROUND

Delivery of the ADP2025/26 represents year 1 delivery of the Medium Term Plan 2025 – 28.Trend data is provided to enable comparison with previous annual performance. The national standards directly relevant to The State Hospital are Psychological Therapies, Waiting Times, and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and are included in this report

3 ASSESSMENT

In 2025-26, 58% of KPIs met or exceeded targets (green), while 42% were off target, with two amber and three red ratings. This trend mirrors previous years, with consistent issues in weight management and staff sickness absence. A revised weight management KPI will be implemented from Q1 2026-/27.

The Annual Delivery Plan 2025-26 had 83 Board actions, of these 22 were completed. Ninety percent were recorded as on track (green), 10% amber, and none noted as red. Progress includes:

- Delivery of commitments to collaborate in and support wider system reform including sub national planning
- Delivery of actions in year 1 of implementation of the carers' strategy
- Establishing the interim Woman’s Service
- Ongoing improvements in patient clinical care including the CPA project
- Workforce development initiatives including delivery of the Organisational Development and Workforce strategies

- Adoption of a new incident management platform
- Development of digital projects including test of the Made Purple system,
- Climate sustainability efforts.

Some actions noted delays due to resource constraints and national timescale changes, with amber ratings assigned accordingly. Challenges continue around increasing uptake of physical activity for patients and elimination of Day Time Confinement. Updates are regularly reported to governance groups and the Scottish Government through the sponsorship arrangements.

4 RECOMMENDATION

The Board is invited to note the paper.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	This paper reports on performance against the deliverables noted in the Annual Delivery Plan 2025-2026 and the agreed TSH Key Performance Indicators The KPI's provide assurance to TSH Board on key areas of performance. Some of the KPI's are national targets which TSH is held accountable for performance nationally, others are local priorities for TSH Board. The TSH Performance Framework proves an overview of how performance is managed across TSH. Scottish Government will receive this report following approval from TSH Board as an indicator of TSH 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 Meeting	Strategic Planning and Performance Group

Which groups were involved in contributing to the paper and recommendations.	
Risk Assessment (Outline any significant risks and associated mitigation)	No implications identified.
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).	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).	There are no privacy implications

The State Hospital Board Corporate Performance

Key Performance Indicators & Annual Delivery Plan Annual Report

April 2025 – March 2026

CONTENTS

1 OVERVIEW

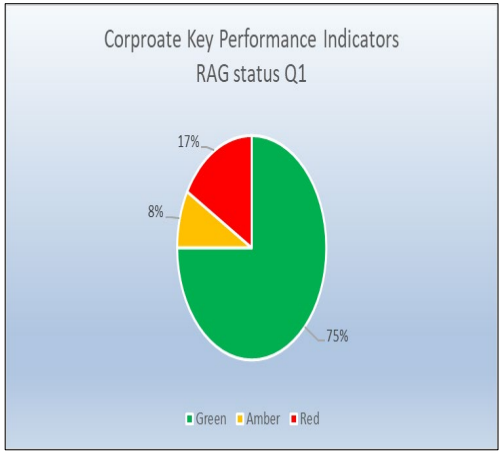
Overview	**Corporate Key Performance Indicators** The report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPIs) for 2025-26. There is a total of twelve corporate KPIs, analysing data using Red, Amber and Green RAG scale reveals that 58% (7) have reached or exceeded their target over the course of 2025-26 and assessed as green, with 42% KPI's off target, two in RAG status amber and three in RAG status red. Overall throughout 2025/26 the percentage of KPI's reaching or exceeding their target has decreased each quarter. KPI performance in 2025/26 mirrors performance in 2024/25 and 2023/24, with the same KPI's either on or off target. KPI's on weight management and staff sickness absence have been in the red RAG range for annual figures over the last five years, although the KPI on staff sickness absence reported as green in 2020/21. The Supporting Healthy Choices team (SHC) has reviewed the current weight management KPI and had identified a measure to replace it. This change will provide TSH Board with clearer assurance on weight management. From Q1 2026/27 the KPI for measuring patients' weight will change to 60% of patients will gain less than 15% of their admission body weight during their stay at The State Hospital, regardless of length of admission. KPIs operational definitions are reviewed yearly with data owners. The next review is scheduled for May 2026, as the corporate planning team develop Tableau Dashboards for future KPI reporting. **Annual Delivery Plan 2025/26** TSH has 83 Board actions identified in the Annual Delivery Plan 2025/26, 22 of these actions have been completed. From the 83 Board actions being delivered in 2025/26, 90% of these have been rated as RAG scale green and are completed or on track to be completed, 10% have been rated as amber and no actions have been identified as red within the identified timescales. . All updates on the Annual Delivery Plan 2025/26 are reported to the Strategic Planning, Performance and Governance Group and externally to Scottish Government Mental Health Directorate through the quarterly sponsorship meetings. Clinical delivery is monitored locally in Services with each of the Service Leadership Team having a range of indicators which are reviewed monthly by the Clinical Quality Team. Escalation of issues if required, is through the Board committee structure.

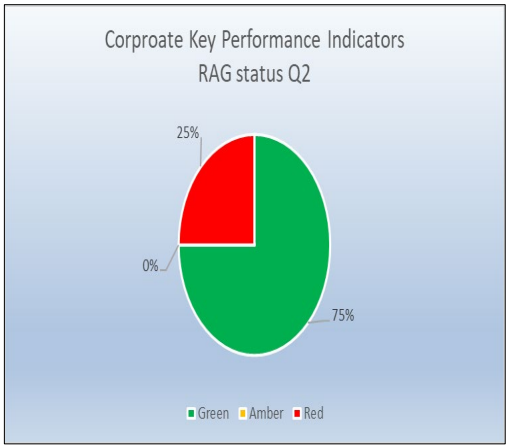
2 CORPORATE KEY PERFORMANCE INDICATORS UPDATE

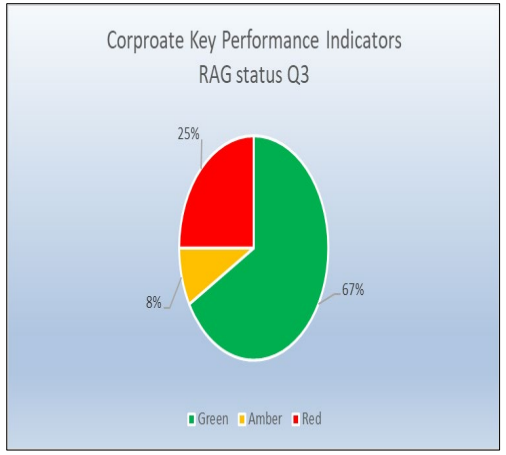
Item	Performance Indicator	Target	RAG	25/26	24/25	23/24	22/23	21/22	Comments
1	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	91.41%	91.01%	87.92%	91.70%	92.67%	Slight increase from 2024/25 annual percentage, remaining in amber range of RAG rating
2	Patients will be engaged in psychological treatment	85%	G	88.33%	94.11%	82.21%	83.2%	85.56%	Decrease from 2024/25 annual percentage although remains in green and continues to exceed the target
3	Patients will be engaged in off-hub activity centres	90%	G	95.00%	95.25%	94.50%	90.92%	92.47%	Slight decrease from 2024/25 annual percentage, remains in green range and continues to exceed its target
4	Patients will undertake an annual physical health review	90%	G	100%	100%	100%	98.2%	-	Remains in green and continues to exceed the identified target
5.2	Patients will undertake 150 minutes of moderate exercise each week	70%	R	59.5%	60.09%	61.48%	-	-	Slight decrease of from 2024/25 annual percentage and moved to red from amber range, now 10.5 % off target
6	Patients will have a healthier BMI	25%	R	10.5%	9.75%	8.92%	9.5%	10%	Slight increase from 2024/25 annual percentage and remains well under the identified target.
7	Sickness absence	5%	R	7.15%	7.51%	7.81%	7.68%	6.37%	Slight decrease of from 2024/25 annual percentage figures, remains off target
8	Staff have an approved PDR	80%	G	90.54%	88.78%	85.93%	83.35%	85.25%	Slight increase from 2024/25 annual percentage, remains in green, continues to exceed the identified target
9	Patients transferred/discharged using CPA	100%	G	100%	100%	100%	100%	100%	Remains in green and continues to meet the identified target
10	Patients requiring primary care services will have access within 48 hours	100%	G	100%	100%	100%	100%	100%	Remains in green and continues to meet the identified target
11	Patients will commence psychological therapies <18 weeks from referral date	100%	G	99.42%	99.91%	99.12%	91.43%	98.66%	Slight decrease from 2024/25 annual percentage and remains in green
14	Patients have their clinical risk assessment reviewed annually.	100%	A	94.71%	94.03%	93.79%	95.42%	96.49%	Slight increase from 2024/25 annual percentage and remains in amber range of the RAG rating
15	Attendance by all clinical staff at case reviews	Individual	-	75.5%	75.4%	66.9%	60.8%	69.7%	

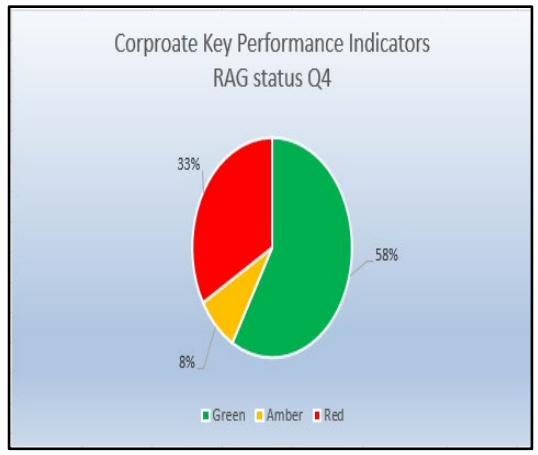
Definitions for Red, Amber and Green zones:

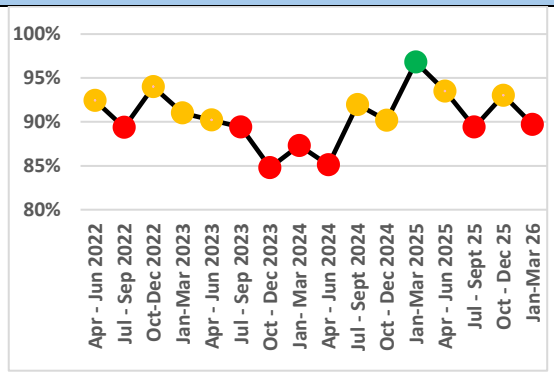
- For all but items six and seven, green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target.
- For item six (Patients have a healthier BMI) green will be 3% or less away from target, amber will be between 3.1% and 5% away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

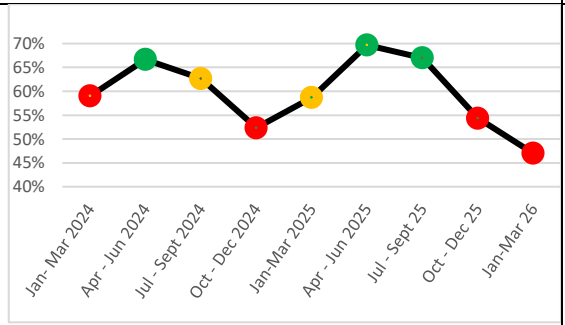
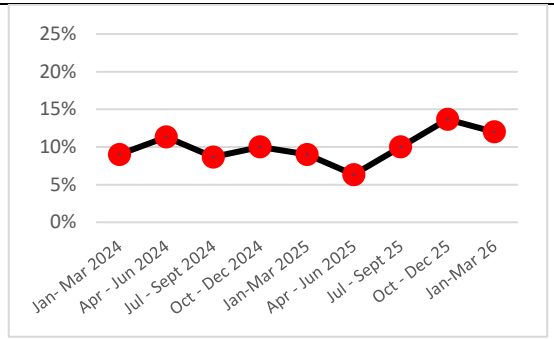


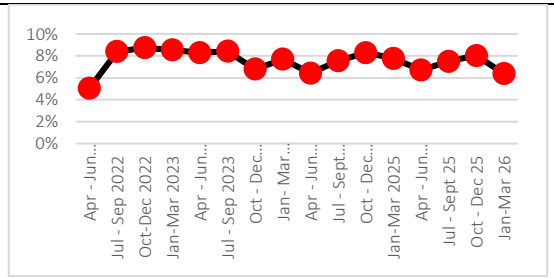




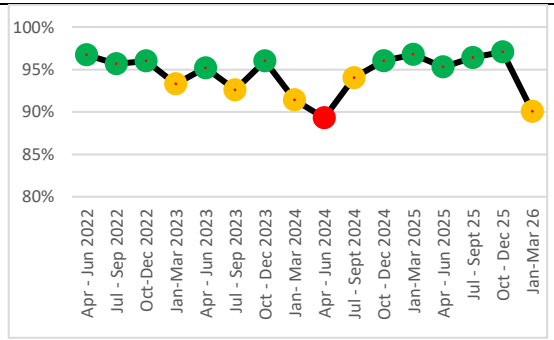


Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q4	Actions being taken	Improvement Opportunities	Corporate Risk Register
Patients have their care and treatment plans reviewed at six month intervals (Target 100%).	Red (moved from Amber Q3 to Red Q4)		This KPI is now below the amber RAG at 89.70%. By the end of quarter four. nine patients had an out date CPA 7 of these were just over the month and 2 over two months. Following up revealed a positive improvement for this	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 developed Until the handover Health Records will continue to retrospective analysis the		No risk registered identified.

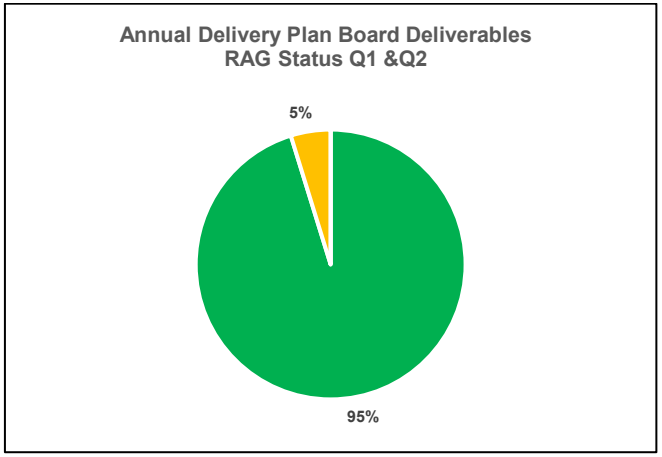
Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q4	Actions being taken	Improvement Opportunities	Corporate Risk Register
			report showed that there is currently only one outstanding since the report was submitted.	data quality and verification processes and work with services to ensure all risk assessments are appropriately signed off.		
Patients undertaken 150 minutes exercise each week (Target 70%)	Red		The KPI was not achieved in Quarter 4 of 2026, with monthly performance of 46% in January, 44% in February and 51% in March (Q4 average 47%). The highest level of achievement recorded was 59% in mid-March.	PHSG continues to work on developing formal information sharing links with Service Leadership Teams whilst Supporting Healthy Choices continue to try and get support from a senior member of nursing staff to support their work. Ongoing physical activity work being done on wards and in Skye Centre to progress activity i.e. next Couch to 5k at the end of May 2026.	Hospital working towards reduction of DTC which does impact patients being supported to carry out physical activities.	No risk registered identified
Patients will have a healthier BMI (Target 25%).	Red		The healthy BMI KPI target (25%) was not achieved in Quarter 4 of 2026, with performance remaining consistently low across the quarter (January 13%, February 11% and March 12%; Q4 average 12%). The	Patients meeting the prescribing threshold for GLP-1s for weight loss (linking in with Pharmacological Management of Obesity guidance) receiving medication. Work ongoing with Lead Nurses, SCNs and eHealth to ensure all weights/BMI are recorded	Pharmacological Weight Management group has been established to review referrals in line with the new management of obesity guidance. From Q1 2026/27 the corporate key	MD30

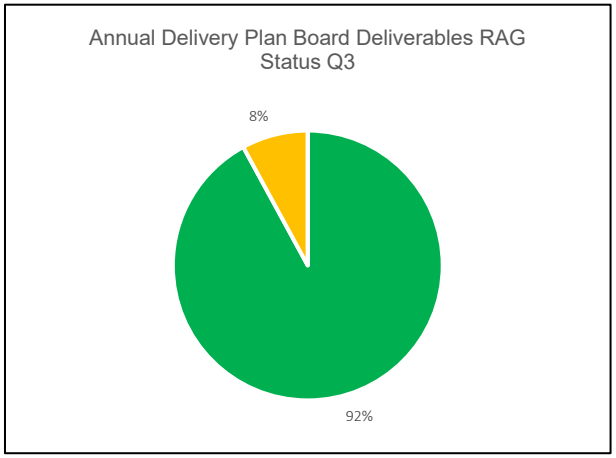
Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q4	Actions being taken	Improvement Opportunities	Corporate Risk Register
			hospital-wide BMI profile shows only minor month-to-month movement across BMI categories.	every month in keeping 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	performance indicator for measuring obesity will change to 60% of patients will gain less than 15% of their admission body weight during their stay at The State Hospital, regardless of length of admission.	
Sickness Absence rate (Target 5%)	Red		Year to date continues to underperform Q4 shows a decrease for the past 3 years	Regular RAG Reviews for escalated areas. Accountability and performance management for areas which require additional support. Continued partnership working with focus on providing a safe working environment. Recognition of departments with good attendance	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	HRD116

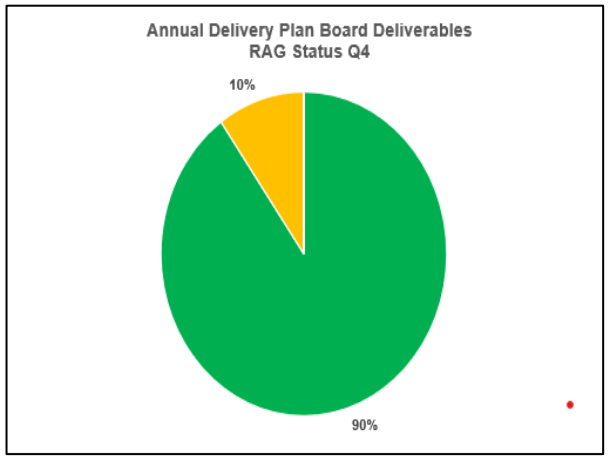
Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q4	Actions being taken	Improvement Opportunities	Corporate Risk Register
				Encouragement and reminders for pathways usage Alternative duties and reasonable adjustments common practice to avoid absence. Dedicated case management support from HR and Occupational Health for a range of individuals. Alignment across workforce directorate with support from OH, 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	sickness absence rates	

Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q4	Actions being taken	Improvement Opportunities	Corporate Risk Register
				Executive Performance Reviews.		
Patients have their clinical risk assessment reviewed annually.	Amber (moved from green Q3 TO amber Q4)		Q4 saw a deterioration in this which has brought the annual data in the amber range of the RAG rating	Monthly information is provided to the named psychologist, who reviews all outstanding risk assessments and follows up to resolve any issues. Reporting is being reviewed to ensure the statistics are clear and meaningful, with RIO being used to produce up-to-date reports and improve process efficiency.	Responsibility for producing the statistics is being transferred to Clinical Administration staff, as this is considered a more appropriate and logical arrangement	No risk registered identified

3 ANNUAL DELIVERY PLAN 2025/26 PERFORMANCE HIGHLIGHTS Q1&Q2, Q3 &Q4







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 Governance 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, 2 outstanding due to changes in national timescales and process.** Significant engagement carried out with forensic network providers and the Scottish Prison Service. A proposal for the outreach service will be submitted to the Women Project Oversight Board (WPOB) 28 May 2026. Strategic Assessment in development with plans to submit through TSH governance routes in Q1 2026/27 and onwards to Scottish Government Capital Investment Group. Action noted as amber in TSH Delivery Plan as timescale for both outline and full business cases impacted by DL 2025 (15)

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
Improving patient's outcomes from their clinical care experience	**Deliverables: 9 of 36 actions identified as completed, 28 actions being delivered.** A series of service development, clinical improvement and operational workstreams have progressed throughout the reporting period. Service Leadership Teams have presented their Year 2 plans contributing to the ADP2026/27. Agreement has been given for two admission and recovery teams (within Arran and Lewis Hubs). Reviewing of teams and operational guidance is currently under way with support from organisational development. Progress continues with embedding positive behavioural support plans within the Intellectual Disability Service. Psychology-led workstreams remain active to review the risk assessment process with monthly risk clinics now well established and an editable version of the risk assessment for patients transferring to medium secure has been developed, this will support efficient care. The process for developing outcomes measurement for patients has advanced, with effective scoping already completed. Outcomes measures have been evaluated, and a report is currently being prepared to inform future discussions and decisions. The Structured Clinical Care learn pro module is now available for staff, with further actions to be determined after a needs analysis. CPA implementation is progressing steadily, and a Peer Review panel now established with reporting arrangements agreed through clinical governance. Realistic Medicine (RM) Action Plan for 2026/27 submitted to Scottish Government together with a 2024/25 summary of actions to support RM. Quality improvement activity remains strong, with ongoing ScIL and QI training delivery, and active participation in local and national forums. TBQR panels continue to develop, while the Quality Strategy action plan is regularly monitored and reported through the Clinical Governance Committee. Two conference posters were presented at the International Forum for Quality and Safety in Healthcare in Feb 2026, demonstrating TSH's QI activities are recognised at international events. In Q4 three 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. TSH 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. New KPI has been established. TACKs is progressing, with several actions embedded across admission processes, including weight monitoring, pharmacological guidance, and early physical activity initiatives. Service progress continues and activities advancing despite some resourcing challenges. The third amber is related to increasing uptake of physical activity with activity levels impacted by staff resource issues. Monitoring and reporting of activity continues with the clinical teams.
Enhance Security, Reduce Risk and Harm	**Deliverables: Out of a total of six actions, one action has been completed, four actions are currently underway, and one action has been deferred for delivery in the 2026/27 period**. The organisation continues to strengthen its security and resilience arrangements. A comprehensive Security Standards and Framework has now been developed, ensuring that all associated processes and procedures have been reviewed and refined. The adoption and implementation of a new incident management recording platform, Inphase, is now complete and fully operational within the organisation. Several capital infrastructure projects have been delivered, including external works and roof repairs to buildings, replacement of LED lighting, and refurbishment of the animal sheds. Business continuity arrangements remain robust, with the continuity plan actively monitored through the Audit and Risk Committee
Support Learning from the views of patients and carers	**Deliverables: 3 of 3 actions being delivered** The Delivery Plan for Carers Strategy is in place and annual report presented and well received by TSH TSH presented to the Forensic Network Oversight Board to report on progress on the Forensic Networks Improving Carers Experience Group, focus was on the development of regional carers groups which are now well established in the North and West of Scotland. TSH has used Carer engagement to plan future work in the Carer Toolkit to ensure meets their needs and is accessible. Further engagement with clinical staff to ensure the toolkit is used and promoted through practice across the Forensic Network.
Support the State Hospital workforce	**Deliverables: Three of 12 actions have been identified as completed, nine actions being delivered**

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
	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. Efforts to enhance organisational health and culture are underway, supported by two pilot programmes. Activities focused on culture and leadership development continue to play a crucial role in driving improvements, with a leadership and management framework established and a cultural assessment strategy prepared for introduction during the 2026/27 period Workforce development continues through the Demonstrator programme and Modern Apprenticeships. Both schemes have shown notable success, reflected in positive participation rates and outcomes for the staff members involved The organisation is continuing to build its partnership with the Lanarkshire Employability Partnership, demonstrating ongoing commitment to collaborative approaches that support workforce development. Successful engagement events have been held to highlight roles available within TSH. Good community participation achieved through these events. Work progress over the year in preparation for full implementation of the Reduced Working Week. An action has been marked as Amber, relating to the development of performance and health dashboards aimed at decreasing the need for manual data entry.
Finance and E-health/digital development	**Deliverables: All 13 actions being delivered** 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. 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. Preparations underway for the 2026 NIS Audit cycle. .
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, RSM audit recommendations currently under review and all other associated actions reported as on track

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 25
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning, Performance and Quality
Title of Report:	Annual and Medium Term Planning
Purpose of Report:	For Noting

1 SITUATION

The Annual Delivery Plan 2026/27 (ADP) forms part of the State Hospital's (TSH's) governance and sponsorship arrangements with Scottish Government (SG). The ADP outlines what TSH will deliver across the year, with quarterly reporting on the delivery of the plan to both Scottish Government through the Sponsorship arrangement and TSH Board through Board meetings.

2 BACKGROUND

The ADP 2026/27 has been developed to reflect the second year's delivery of the key priorities in the Medium Term Plan (MTP) 2025/28. It builds on delivery in 2025/26 which saw some notable successes in terms of the completion of the security upgrade project, the establishment of the high-secure woman's interim service, completion of the Care Programme Approach (CPA) project and the development of the Organisational Development Strategy and the Workforce Plan 2025–28.

In developing the MTP, all directorates discussed and reflected on the vision and mission of TSH, which has been revised following the consultation. The critical success factors which are central to the achievement of TSH vision and mission have been used as pillars to structure the MTP and associated ADP's.

3 ASSESSMENT

The ADP was submitted to the Scottish Government Mental Health Division and the SG Health Planning Division for information on the 7th April. No formal letter of acceptance is expected from SG; however, feedback regarding the content has been positive.

SG has noted that the ADP 2026/27 maintains strong continuity with the MTP 2025/28, and contains no unexpected elements. SG also appreciated the comprehensive range of actions and the emphasis placed on patients' physical health.

The adaptability incorporated within the plan, particularly concerning the Service Reform Framework and sub-national planning, was commended. The ongoing need for flexibility was acknowledged and valued by stakeholders.

4 RECOMMENDATION

The Board is invited to note the ADP 2026/27 within the overall framework of the Medium Term Plan 2025/28.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	The ADP 2026/27 compliments the Medium Term Plan 2025/28 and provides more detail on year 2 delivery of the MTP.
Corporate Objectives Please note which objective is linked to this paper	ADP 2026/27 links to all corporate objectives
Workforce Implications	Contained in the workforce section
Financial Implications	Linked to the Finance Plan
Route to Board Which groups were involved in contributing to the paper and recommendations.	Via CMT
Risk Assessment (Outline any significant risks and associated mitigation)	CRR links to the ADP
Assessment of Impact on Stakeholder Experience	Not formally assessed however the Carers strategy is detail din the ADP
Equality Impact Assessment	Not formally 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).	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).	No privacy issues

Annual Delivery Plan 2026/27

NHS Board: The State Hospital

Contents

1. INTRODUCTION

The State Hospital (TSH) has developed its Medium Term Plan 2025/28 (MTP) which provides detail of the high-level priority actions for delivery. This Annual Delivery Plan 2026/27 (ADP 2026/27) has been developed to reflect the second year's delivery of the key priorities in the MTP. It both reflects the local needs and priorities of the State Hospital, and the Scottish Government and NHS Scotland's national priorities detailed in the Service Renewal Framework 2025/35[1], Scotland's Population Health Framework 2025/35[2] as they relate to forensic mental healthcare. This delivery plan sets out anticipated areas of risk, service change and how the long-term sustainability of services can be supported. It also highlights any national or local performance measures to evidence the anticipated impact that plans will have on service delivery.

NHS Boards are required to ensure that their delivery plans are aligned with the implementation of sub-national planning directions outlined in National Planning DL (2025) 25[3] to reflect collaboration across Boards for population and service planning. The State Hospital has also considered national strategies and service reform agenda in the development of this plan.

2. ROLE AND FUNCTION OF THE STATE HOSPITAL

The State Hospital is the national high-secure forensic mental health care provider for Scotland and Northern Ireland. The organisation provides specialist individualised assessment, treatment and care in conditions of high security for patients with major mental disorders and intellectual disabilities. The patients, because of their serious violent or criminal behaviours cannot be cared for in any other setting. Working closely with partners in the Forensic Network for Scotland, the organisation is recognised for high standards of care, treatment, research and education.

The State Hospital leads on the delivery of exceptional and innovative care, treatment and risk management to support patients in their recovery journey and improve their mental health and reduce risk. The State Hospital aims to support patients to actively participate in their treatment, experience improved overall health and well-being whilst ensuring public safety within a high-secure environment.

The provision of the Mental Health (Care and Treatment) (Scotland) Act 2003 allows for detention in hospital and compulsory medical treatment on the grounds of mental disorder. Rigorous safeguards apply which include the right to independent advocacy, an independent mental health tribunal for Scotland and the independent Mental Welfare Commission. The Scottish Government has committed to consider changes to practice and legislation to improve or simplify the delivery of forensic mental health services.

The State Hospital is based within a single site in Carstairs, South Lanarkshire. The site is in a rural location. The hospital has 120 beds available for male patients, 108 beds for patients with Major Mental Illness and 12 beds for patients with Intellectual Disabilities. In 2025 the State Hospital opened an interim high-secure inpatient service for women, engaged with stakeholders on the development of an outreach service and commenced planning for the development of a central woman's service 'treatment hub' for the coming years.

---

1 Health and Social Care Service Renewal Framework - gov.scot

2 Scotland's Population Health Framework - gov.scot

3 DL (2025) 25 Sub National Planning First Tier

An extensive consultation exercise was carried out in 2024/25 with staff, stakeholders and patients. This activity supported the development of the Medium-Term Plan 2025/28 and the revised vision, mission and critical success factors that are required to deliver excellent forensic mental health care and treatment. The following was agreed:

2.1 **The vision** is to be a leader in delivering relationally informed, person-centred, high-secure mental health care that enables recovery whilst ensuring the safety and wellbeing of staff, patients, and the public.

2.2 **The mission** of the hospital is to assess and treat major mental disorders in a secure and person-centred care environment that manages risks, supports recovery, rehabilitation and onward progression.

2.3 **Critical success factors** are the central things the State Hospital does to achieve its mission and focus on:

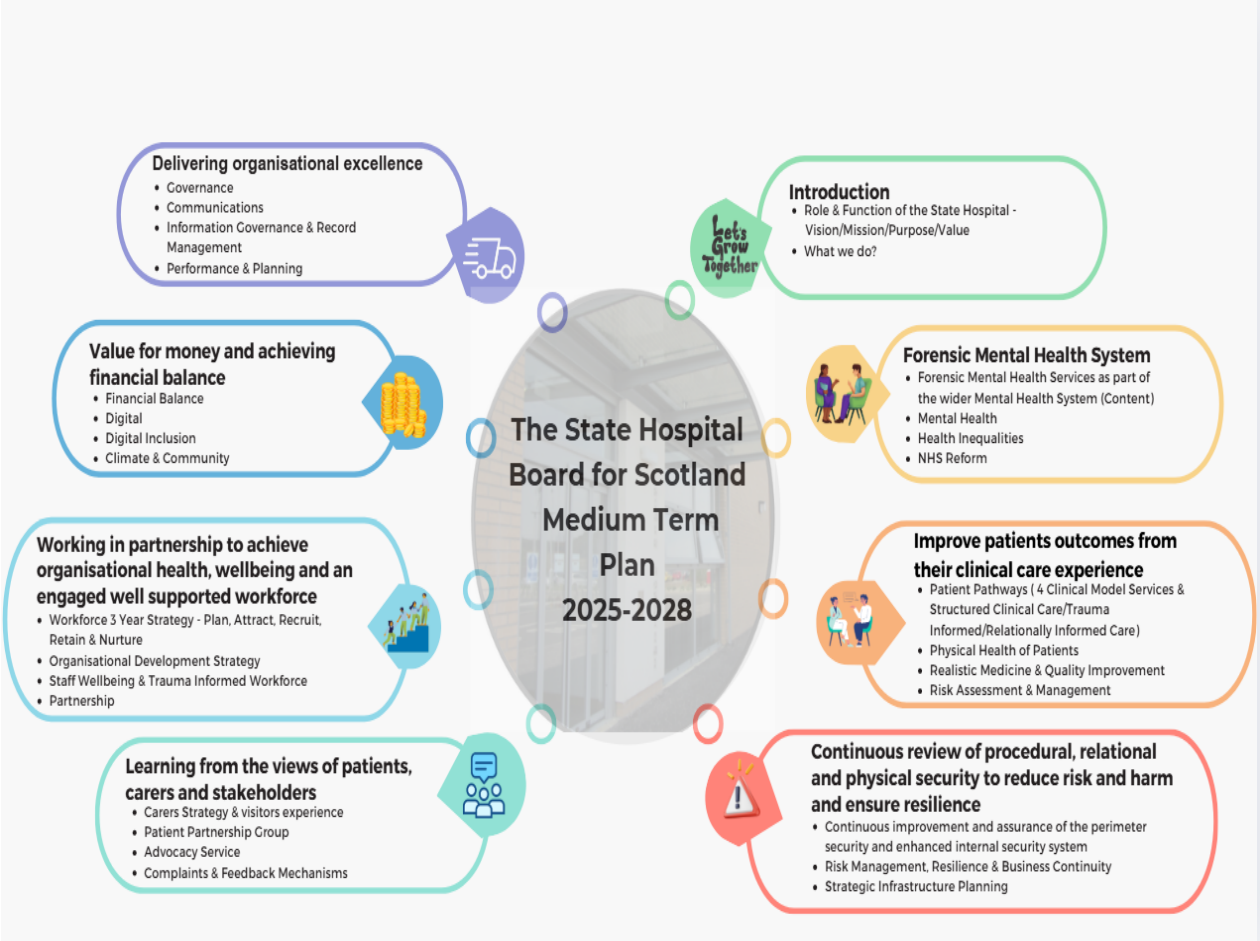
- Improving patient outcomes from their clinical care experience.
- Continuous review of procedural, relational and physical security to reduce risk and harm and ensure resilience.
- Learning from the views of patients, carers, and stakeholders.
- Working in partnership to achieve organisational health well-being and an engaged well supported workforce.
- Value for money and achieving financial balance.

The values of the State Hospital align with NHSScotland, they are:

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

3. MEDIUM TERM PLAN 2025/28

The Medium-Term Plan 2025/28 (MTP) structure is presented below and was developed through extensive engagement. The Annual Delivery Plan 2026/27 (ADP 2026/27) has been developed to reflect the second year's delivery of the key priorities in the MTP. It builds on delivery in 2025/26 which saw some notable successes in terms of the completion of the security upgrade project, the establishment of the high-secure woman's interim service, completion of the Care programme approach (CPA) project and the development of the Organisational Development Strategy and the Workforce Plan 2025–28. Three-year plans have been developed and Year 1 (2025/26) reviewed as part of the MTP. All directorates discussed and reflected on the vision and mission of the State Hospital, which has been revised following the consultation. The critical success factors which are central to the achievement of the State Hospital's vision and mission have been used as pillars to structure the MTP. Through the engagement process, and over the delivery of this MTP, the focus has been on delivering effective care and treatment whilst focusing on the balance and calibration of organisational performance and health.



4. MENTAL HEALTH

The Mental Health and Wellbeing Strategy[4], launched in 2023, outlines Scotland's legislative framework and priorities for mental health. The Scottish Government will create an updated Mental Health Delivery and Workforce Plan in 2026, merging current action and delivery plans from 2023-25. The refreshed plan will focus on strategic commitments that have the greatest impact on people's lives within broader health and social care reforms. [5]

4.1. NHS SCOTLAND REFORM

The Scottish Government published the Service Renewal Framework (SRF) 2025/35 in June 2025 to set out its strategic vision for health and social care reform over the next 10 years. The core principles are focused on prevention, person-centred care, community-based care, population level service and delivery planning and digital innovation. The SRF also compliments the Population Health Framework (PHF) 2025/35, which focuses on preventing illness, tackling social determinants of health and reducing health inequalities. The reform agenda outlines that the Scottish Government vision is to enable people to live longer healthier and more fulfilling lives. These frameworks are intended to steer short, medium and long term planning for NHS Boards, with the expectation that NHS Boards ensure that their Delivery Plans are aligned with the national priorities. The State Hospital aligns its planning and priorities to these frameworks to ensure that delivery is consistent with the national direction set for NHS Scotland. This plan demonstrates how the State Hospital will contribute to Scotland's wider transformation.

4 Mental health and wellbeing strategy - gov.scot
5 Mental Health and Wellbeing Strategy - Interim Report

4.2. CONTRIBUTION TO SERVICE RENEWAL PRIORITIES

4.2.1 Modernising and redesigning services

The State Hospital will continue to embed service improvement and redesign consistent with the national drive for renewal. This includes strengthening clinical pathways, enhancing digital capabilities within secure mental health settings, and contributing to nationally coordinated planning for specialist services, including working collaboratively with the Forensic Network for Scotland.

4.2.2 Workforce sustainability and capability

Renewal requires a resilient and well-supported workforce. Through ongoing workforce planning aligned to national guidance, the State Hospital will build capacity, develop specialist skills, and contribute to national efforts to ensure long-term service sustainability.

4.2.3 Supporting system transformation

As part of Scotland's specialist services, the hospital will actively engage in national collaboration to support transformation across forensic mental health provision and interface services, aligning with the government's call to place modern, efficient national delivery at the centre of renewal. The State Hospital has well-established partnerships including the Scottish Prison Service and criminal justices' services.

4.2.4 Sub-national Planning

The Scottish Government issued DL(2025)25 in November 2025, setting out a refreshed statutory approach to sub-national planning across NHS Scotland, aligning with the principles of service reform. The direction introduces two new collaborative sub-national structures. Each new area established a Sub-National Planning and Delivery Committee (SPDC) to progress planning and collaboration:

1. Scotland East: Borders, Fife, Grampian, Lothian, Orkney, Shetland and Tayside
2. Scotland West: Ayrshire & Arran, Dumfries & Galloway, Forth Valley, Greater Glasgow & Clyde, Highland, Lanarkshire and Western Isles

While individual NHS Boards remain responsible and accountable for all statutory functions, DL(2025)25 outlines an expectation that they align planning resources and expertise to support the new arrangements and ensure coherence with community health services and nationally commissioned programmes. NHS Boards are expected to plan above organisational interests and beyond traditional boundaries aligning workforce planning with population-level health priorities.

The sub-national planning structures will focus on four shared priorities, including Digital Front Door (MyCare.scot), orthopaedic treatment time guarantee delivery (planned care waiting times), emergency healthcare services, and a Once for Scotland approach to business systems. Both sub-national groups are required to produce consolidated financial planning for 2026/27 and provide quarterly performance reporting to Ministers commencing Quarter 1 of 2026/27.

The State Hospital is represented on both sub-national groups and will progress alignment of the forensic system with wider mental health system reform, building on previous work with Forensic Network and the Healthcare and Custody Oversight Group. The State Hospital is an active cross-boundary collaborator and connects with a range of partners in health, criminal justice, policy and resilience. The State Hospital will continue active collaboration with the Healthcare in Custody Network to ensure alignment of pathways, shared standards, and national assurance across forensic and custodial health systems.

The State Hospital Board actions in 2026/27 to address health and care system reform

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
1.1	The State Hospital will engage with the emerging sub-national planning structure	The State Hospital will engage with the Sub-national Planning Committees with membership of both East and West committees	2026/28
1.2	The State Hospital will align delivery plans with national priorities	The State Hospital will embed service improvement and redesign to ensure that transformation and sustainability are built into planning processes.	2026/28
1.3	Public service reform and cross system collaboration.	The State Hospital will actively engage in national collaboration to support transformation across forensic mental health provision and interface services	2026/28
1.4	Public service reform and cross system collaboration	The State Hospital will continue to collaborate with the Healthcare in Custody Network to ensure alignment of pathways, shared standards, and national assurance.	2026/28

5. HEALTH INEQUALITIES

There are many, diverse and interacting determinants of mental health and wellbeing, with these being driven by structural factors such as unequal distribution of income, power and wealth, global, national and local economic and political forces and priorities, and societal attitudes. Within the State Hospital individual health inequalities and health behaviours are addressed later in this plan through the supporting healthy choices and physical health projects. The more structural elements of population health and health inequalities are addressed in this section with a focus on improving health by supporting a circular economy via The State Hospital Anchors Strategy.

5.2 THE STATE HOSPITAL ANCHORS STRATEGY 2026/28

The Scottish Government commissioned all NHS Boards to produce an Anchors Strategic Plan in 2023 to demonstrate how Boards will take action to contribute to Community Wealth Building. The State Hospital Audit and Risk Committee approved a refreshed Anchors Strategy 2026/28. This strategy continues to focus on procurement, employment and sustainable use of land and assets. It has an associated action plan that is monitored and reported through the Audit and Risk Committee and onwards to the Scottish Government. The anchors' themes include:

- Progressive Procurement - The State Hospital can make direct investment into the local region through procurement practices, which in turn can create new employment locally.
- Employment - The State Hospital is a large local employer within an area of deprivation. Development of recruitment practices to encourage community members to consider employment in the State Hospital is a key area of development.
- Sustainable use of land and property - consideration given to the use of land and sustainable practices.

The State Hospital Board actions in 2026/27 to address health inequalities

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
3.1	Implement Anchors Strategy 2026/28.	Implement and explore ways to enhance the Anchors Strategy Action Plan with focus on: • Progressive procurement. • Employment. • Land and assets.	Q2 & Q4

Risks
Risks emerging from the above actions will be reviewed regularly by the Anchors Strategy Group and if required will be added to either Local Risk Registers or the Corporate Risk Register to manage risks and mitigate potential impacts on current services.

6. IMPROVED PATIENT OUTCOMES

6.1 WOMEN'S HIGH-SECURE SERVICE

6.1.1 Phase 1 – Interim Women's Service

The State Hospital established an interim high-secure service for woman in July 2025. The woman's high-secure service is segregated from the male service to protect patients and support recovery. This is in line with how similar services are delivered in England. Individual risk assessments are used to provide as much opportunity for access to the wider environment in the hospital as possible, however it should be noted that access for women to wider off ward activities is significantly limited in comparison to male patients. The woman's high-secure service has segregated arrangements to provide:

- Access to Activity.
- Grounds/Outdoor access.
- Dedicated therapeutic and recreational physical environment.
- Activities Centre.
- Access to Healthcare Services.

There is a risk that women are unlikely to move beyond 'safety and stabilisation' in their clinical treatment journey if they are within a mixed-gender environment. High-secure women's service delivery is now embedded in the State Hospital with patient's referral process through agreed routes and assessment and treatment being delivered within the service.

During the initial implementation of the service, the State Hospital conducted a comprehensive review of the resources necessary to deliver care and maintain safe service standards. Based on the initial operating experience, a revised staffing revenue profile has been submitted to the Scottish Government.

6.1.2 Phase 2 – Development of comprehensive Woman's Service Hub

Phase 2 of this service will progress through a strategic assessment process, developed in partnership with NHS Assure, to establish a comprehensive women's service hub that delivers assessment, treatment, and rehabilitation for female patients in a trauma-informed and recovery-oriented manner. This phase will be guided by the findings of a feasibility study conducted in 2025, which will underpin the development of the Strategic Assessment. The Strategic Assessment will be submitted to Scottish Governments Capital Investment Group for review, and the projects' next steps will depend on feedback from this group. Details such as

budget allocation, timelines, and milestones will be established after the assessment is complete. Throughout, the project will comply with all relevant statutory standards and regulatory requirements.

The indicative timeline is:

- Development of Strategic Assessment – Q2 2026

6.2 PATIENT PATHWAYS

6.2.1 Clinical Model

A new clinical model was introduced in July 2023 to provide patients with a recovery pathway through the hospital and address issues raised by staff around feelings of safety, confidence and practice. The new clinical model saw the establishment of four new services: Admissions and Assessment, Treatment and Recovery, Transitions, and Intellectual Disability. Service Leadership Teams were established for each service. Clinical Model Guidance was developed to guide and support implementation with detailed sections on the four new services. Referral between services is now expected with all major mental illness patients being admitted into Admission and Assessment wards, then progressing, if required, through the Treatment and Recovery and onwards to Transitions service. Patients with an Intellectual Disability are admitted directly to the Intellectual Disability service.

Each service has developed a three-year implementation plan to outline what they seek to achieve. In 2026/27 services will move to Admissions and Recovery, Learning Disabilities, Transitions and Women's services. The clinical guidance document will be reviewed as part of the maturation of each service. Any updates to the clinical guidance will be received through the Clinical Governance route.

6.2.2 Patient needs and resource review

The State Hospital will continue to prioritise resourcing and leadership development as outlined in the Organisational Development Strategy, utilising the McKinsey Seven S model. A comprehensive review of the funded establishment was conducted to ensure that available resources and the skill mix are aligned with patient needs and the delivery of safe, effective care. This renewed focus on optimising resource deployment to support patient safety, and requirements will aid in the elimination of Daytime Confinement (DTC).

6.2.3 Structured Clinical Care (SCC)

Structured Clinical Care is a whole-system framework that promotes relational working and the use of psychological formulation to enhance the care and treatment of patients, particularly those with complex relational needs. It is intended to be embedded, involving all staff who work directly with patients or support patient care. To support implementation, The State Hospital developed an e-learning module, 'Essential Relational Aspects of Care', which was launched on LearnPro in September 2025. All staff are encouraged to complete this module to build shared understanding and consistent practice.

The State Hospital will complete a needs and gap analysis in relation to SCC. This will help direct the next steps for potential implementation.

6.2.4 Risk Assessment and Trauma-informed Care

Psychological therapies including trauma-informed approaches that are evidence-based and reflect best practice are key for effective and safe care delivery. The State Hospital will continue to implement trauma-informed training. A core aspect of care planning and delivery is the

assessment and treatment of risk to ensure appropriate management. Shared objectives which cut across all services on these areas is required to be developed. An information sharing protocol with partner agencies including these areas continues to be a priority for the State Hospital.

6.2.5 Least Restrictive Practices

National guidance From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care' was published by the Scottish Government in 2018. The overarching aim of the policy is to replace traditional "enhanced observation" practices in mental health inpatient care with a more proactive, personalised, therapeutic and human-rights-based model of care. The guidance has several guiding principles to support a multidisciplinary approach to person-centred, least restrictive care that is delivered by a trauma-informed workforce and involves the patient and their families wherever possible.

This guidance formed the basis of the State Hospital's new Clinical Care Policy which was implemented on 1 May 2024. In 2025/26 the first annual audit of the Clinical Care Policy in the hospital, highlighted areas for practice improvement to ensure that the local policy did result in personalised responsive, multidisciplinary therapeutic engagement. The State Hospital will ensure that continuous improvement approaches are used to support embedding the policy with an audit being repeated in 2026/27. Oversight and monitored by the Patient Safety Group with reporting to the Clinical Governance group at six-monthly intervals.

The State Hospital will develop and monitor key performance indicators for restrictive practices, including seclusion and use of soft restraint kits, aligned to Mental Welfare Commission definitions. Quarterly assurance reporting will be provided through the Patient Safety Group.

6.2.6 Developing person-centred care through the revised Care programme approach (CPA)

All patients who are admitted to the State Hospital will have their care and treatment planned using the Care programme approach (CPA). Guidance for the application of CPA for restricted patients is contained in the Scottish Government CEL 13 (2007) and the Memorandum of Procedure on restricted patients CEL 20 (2010). In recent years the CPA process has been reviewed to be more patient centred, embed parity of input from the multidisciplinary team and be accessible through the electronic patient record (RIO) system. This new electronic system was tested over 2025/26 and a Peer Review Panel established to have oversight and provide assurance of the new CPA process. The Peer Review Panel will monitor the CPA process in 2026/27 to ensure it delivers as expected. A staff engagement process to collate information and learning about teams' experiences of using the new documentation and processes at a 'one year on' point. This will be scheduled for September 2026.

6.2.7 Realistic Medicine (RM)

Realistic Medicine (RM) is the Scottish Government's approach to delivering Value Based Health and Care (VBH&C) in Scotland. VBH&C is defined as "the delivery of better outcomes and experiences for the people we care for through the equitable, sustainable, appropriate and transparent use of available resources".

The State Hospital develops a Realistic Medicine Action Plan annually to outline the key projects associated with the approach. The State Hospital will continue to link with national networks to share practice. Priorities in 2026/27 will be to continue to champion RM, and VBH&C, embedding Shared Decision Making and championing the use and adaptation of BRAN questions (benefits, risks, alternatives and no action) within a secure setting. Team Based Quality Reviews (TBQR) are a structured approach to continuous quality improvement, enabling multidisciplinary teams to reflect on practice and identify actions for enhancement. This

collaborative process strengthens team accountability, promotes shared learning, and contributes to safe, person-centred care. TBQR panels will continue to develop across the organisation, reinforcing the State Hospital's commitment to continuous improvement and collaborative learning. Each project in the RM action plan has also been aligned with the relevant commitment from the Scottish Government's VBH&C action plan.

6.2.8 Physical Health of patients

Individuals living with severe mental health conditions frequently experience higher incidences of physical ill-health, including cardiovascular disease, respiratory disease, diabetes, obesity, digestive diseases, and cancer. The presence of mental health difficulties can exacerbate these physical health problems, further impacting overall wellbeing.

For those with severe and enduring mental illness, life expectancy is often reduced by between 15 and 20 years. A significant proportion of this reduction is attributed to physical ill-health, much of which is preventable.

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. The strategy sets out a commitment to improving physical health outcomes through evidence-based practice, prevention, and integrated whole-system approaches. The State Hospital will implement the Physical Health Strategy over 2026/27, aligning programme delivery to Key Performance Indicators. Progress will be reported through the clinical governance and performance frameworks.

The State Hospital prioritises health improvement and disease prevention, focusing on obesity and cardiovascular risk. Physical activity is emphasised as vital to patient care, and teams are increasing activity options for patients. Progress is tracked by the Clinical Quality Department and reported to clinical teams and through the clinical governance route.

To help enhance practice, the monitoring and reporting of weight management using Key Performance Indicators was reviewed during 2025/26. As a result, a more realistic and motivating target has been adopted to better address weight gain and support weight management strategies.

The State Hospital has a dedicated group which focuses predominately on improving physical health outcomes and aims to create an environment that best supports patients to engage in behaviours that support their physical health and healthy weight. The State Hospital will implement the Physical Health Strategy over 2026/27, aligning programme delivery to Key Performance Indicators. Progress will be reported through the clinical governance and performance frameworks

Priorities to progress physical health of patients include:

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.

6.2.9 Unscheduled Care

Patients in the State Hospital at times require care from other NHS Board's, predominately, but not exclusively from NHS Lanarkshire. In 2024/25 the State Hospital reviewed its arrangement for unscheduled care outings of patients to identify areas for improvement. The review identified areas to further test which include use of the Flow Navigation Centre (FNC). The purpose of a Flow Navigation Centre (FNC) in healthcare, particularly within NHS Scotland, is to provide urgent, non-life-threatening care by directing patients to the right place at the right time, often bypassing Emergency Departments (ED).The FNC would provide a single point of contact for emergency outings with the ability to time ambulance arrivals at the State Hospital with the receiving hospital appointment to lessen time waiting for the State Hospital patients and staff at external venues. The recommendations from the unscheduled care group, which are in the process of being implemented in 2025/26 will continue to be taken forward in 2026/27 and improvements, where found, adopted.

6.2.10 Evidence-based care and treatment

The State Hospital launched its Research Strategy 2025-2029 in August 2025 and has an active Research Committee who support and review clinical research. The action plan for the strategy will continue to be developed and implemented with a strategic focus to patient involvement in all stages of the research process.

The State Hospital Board actions in 2026/27 to improve patient outcomes

No	Planning Commitment	The State Hospital Board actions	2026/27 Delivery timescale
4.1	Woman's service Phase 1	Embed principles of trauma-informed care If resource available, continue to develop outreach service and build relationships across woman's pathway	2026/27
4.2	Woman's service Phase 2	Strategic Assessment – The State Hospital will submit the SA for consideration by the SG Capitol investment group, as per timelines outlined in DL 14 (2025)	Q2
4.3	Continue to embed the clinical model.	Each service will review the Clinical guidance and update as required. Each service will review its 3 year plan at end Y2, Y3 and take part in forward planning as appropriate. Hub based leadership approaches will be implemented over 2026/27.	2026/27 Q3 2026/27
4.4	Review of resource to match patient needs	Continue to review the available resources and skill mix to ensure alignment with	2026/27

No	Planning Commitment	The State Hospital Board actions	2026/27 Delivery timescale
		patient needs and the delivery of safe, effective care	
4.5	The Intellectual Disability service will develop its care approach using positive behaviour support planning.	Continue to deliver training to develop staff skills and capabilities on Positive Behaviour Support Planning.	2026/27
4.6	Review of Risk Assessment Process.	The State Hospital will improve the quality of risk assessments including. • identify a Police Scotland SPOC for provision of information, • collaborate on the introduction of MAPPS. • implement a peer review process for completed assessments. • improve use of risk assessment information to inform decision making	Q4
4.7	Review of Psychological Therapies Group Work and Patients Needs	Review the needs of the patient group and the current suite of psychological group work interventions to assess if they continue to meet the needs of the State Hospital patients	Q2
4.8	Outcomes focus.	Develop recommendations for a suite of outcomes for patients	Q2
4.9	The State Hospital will review new frameworks of care e.g. Structured Clinical Care/ Relationally Informed Care and develop most appropriate pathway.	Complete a needs and gap analysis in relation to SCC to direct next steps	Q2
4.10	Pharmacy	Advance the clinical and educational role of pharmacy team. Implement the Protocol for Prevention and Management of Obesity	Q1 & Q4 2026/27
4.11	Clinical Care Policy	The State Hospital will ensure that continuous improvement approaches are used to support embedding the policy with an audit being repeated in the financial year.	2026/27
4.12	Least Restrictive Practices	The State Hospital will develop and monitor key performance indicators for restrictive practices, including seclusion and use of soft restraint kit, aligned to Mental Welfare Commission definitions.	Q2 & Q4

No	Planning Commitment	The State Hospital Board actions	2026/27 Delivery timescale
4.13	CPA process	Staff engagement process to collate learning and feedback from Year 1 implementation of new process.	Q2
4.14	Development of evidence-based care and treatment.	Implement approach to expand the range of patient involvement within research process and inform a co-productive approach	Q2 & Q4
4.15	Unscheduled care.	Monitor and report on effectiveness of Flow Navigation Centre.	Q2
4.16	Physical Health Strategy - Reduce weight gain.	Implement prevention efforts, particularly limiting weight gain via medication review, early metformin co-prescribing, and enhanced lifestyle interventions for limiting patient weight gain and support weight management strategies	2026/27
4.17	Physical Health Strategy – screening and vaccination	Promote screening and vaccination uptake	Q2 & Q4
4.18	Physical Health Strategy Increase uptake of activity for patients.	Enhance physical activity uptake through personalised programmes and support from Clinical Teams.	2026/27
4.19	Progress RM and VBH&C principles.	Implement Realistic Medicine (RM) Action Plan 2026/27 and update the Scottish Government 6 monthly on progress. Submit RM Action Plan 2027/28 to the Scottish Government.	Q2 & Q4 Q4
4.20	Progress RM and VBH&C principles.	Continue to promote Shared Decision Making by increasing the uptake of the learning module and increase the use of BRAN questions through nursing care plans	2026/27
4.21	Build capacity and champion quality improvement (QI)	Establish Team Based Quality Review process across each service (TBQR): Review process. Deliver and support QI training	Q2 Q4 Q3 & Q4
4.22	TSH3030 – Organisational approach to QI.	• Plan and implement a cycle of TSH3030. • Support sustainability of projects started through TSH3030.	Q1 Q2- Q4
4.23	Champion quality assurance and improvement.	Monitor and implement actions from the Clinical Quality Strategy Action Plan.	2026/27

Risks

Risks emerging from the above actions will be reviewed regularly. If required, risks will be added to either Local Risk Registers or escalation to the Corporate Risk Register to manage risks and mitigate potential impacts. Specific Directorate Risks and Issues will be escalated and reported through the quarterly Directorate Performance Meetings.

Risks emerging from the development of a high-secure woman's service is a significant addition to The State Hospital function. As a complex project it has a Project Management and Governance systems in place, including risk and issues registers. The State Hospital will report significant risk to the Scottish Government Mental Health Policy Team through the sponsorship arrangements.

7. CONTINUOUS REVIEW OF PROCEDURAL, RELATIONAL AND PHYSICAL SECURITY TO REDUCE RISK AND HARM AND ENSURE RESILIENCE

7.1 Security

The purpose of security in forensic mental healthcare is to provide a safe and secure environment for patients, staff, volunteers and visitors which facilitates appropriate treatment for patients and protects the wider public. This involves maintaining a secure environment where mental health care can be delivered, mitigating risks, preventing violence or self-harm and responding effectively to incidents. There are unique challenges posed within a high-secure setting and security measures require to be both effective and respectful of people's dignity and mental health needs.

All patients in the State Hospital have been assessed as requiring high-secure care.

The specific features of high security are categorised into three domains: physical, procedural, and relational. These are interdependent and essential for the delivery of safe and secure care:

1) Physical security - A multi-layered approach, including fences, gates, locks, surveillance (CCTV), security personnel, and access control systems to restrict, detect, and respond to threats.
2) Procedural security - The range of policies and procedures that control access/egress, movement across the hospital site, patient communication, patient possessions, and visits, etc.
3) Relational security - The ability of staff to develop therapeutic relationships with patients, leading to trust and engagement between staff and patients.

In addition to the measures in place across the site, all patients are subject to a range of security measures tailored to their clinical and risk evaluation needs and the stage of their treatment journey.

The State Hospital completed the Perimeter Security and Enhanced Internal Security Systems initiative in 2025. The State Hospital has developed a security framework through standard procedures, staff training, and quality assurance, aligning with standards from high-secure UK hospitals and Scottish legislation. The framework will include core Security Quality Indicators (SQIs) to measure physical, procedural, and relational security. Policies will be refined to ensure trauma-informed interventions, proactive threat assessments, and tailored security planning.

7.2 Risk Management System

The State Hospital aims to reduce risks for staff and patients while promoting a positive risk culture. In 2025/26, the State Hospital transitioned to a new risk management platform that records incidents and risks. InPhase will launch in March/April 2026, supported by staff training. The priority in 2026/27 is to embed and monitor the new system, addressing any issues that arise.

7.3 Health and Safety, Resilience

The State Hospital follows a structured method for overseeing, evaluating, and updating its health and safety processes, procedures, and practices. In 2025/26, a system review was

completed. Identified areas for improvement will guide enhancements in 2026/27, adopting changes and upgrades. The State Hospital also has a focused approach to resilience, with a multi-faceted suite of plans that align to recognised risks that can affect the hospital during day-to-day operations. These plans are reviewed regularly and updated accordingly.

7.4 Strategic Infrastructure Planning

The Scottish Government have introduced a new approach to strategic infrastructure planning and investment across NHS Scotland. Each NHS Board were required to submit a Programme Initial Agreement which sets out a deliverable whole-system service and infrastructure change plan for the next 20-30 years. The first phase of this new approach to planning was the development and submission of a maintenance only business continuity plan (BCP) based on the risk assessment of the boards existing infrastructure.

The State Hospital has carried out a risk- based assessment of essential maintenance, which is prioritised as part of the completed BCP. Each risk has been considered through their probability and impact in the key areas of Business/Financial, Staff/Health and Safety/Injury, Clinical/Service and Reputational/Adverse Publicity/Complaint and Claims.

The work incorporated in the State Hospital's BCP investment programme will support the work identified within the existing Capital Allocation. The BCP investment will allow the hospital to maintain a good standard of accommodation to support the clinical demand.

The Capital Group at the State Hospital oversees the management and distribution of the capital allocation. For 2026/27, the allocation is set to fund projects such as enhancing security in patient rooms, upgrading systems and lighting, and refurbishing building, digital inclusion and digital platforms.

The State Hospital Board actions for 2026/27 to enhance security, reduce risk and harm

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
5.1	Security.	Audit of the State Hospital security processes, procedures and practice against new security standards. Implementation of audit action plan	Q2-Q4
5.2	Security Quality Assurance Framework	The State Hospital will define, adopt, and report against a core set of Security Quality Indicators (SQIs) to provide measurable assurance of physical, procedural, and relational security following completion of the security upgrade programme.	Q2
5.3	Risk Management.	Embed and monitor the new incident reporting system, addressing any issues that arise.	Q2-Q4
5.4	Health and Safety	Confirm and agree refreshed Health and Safety Training Plan Implement revised Health and Safety Training Plan	Q2 Q4

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
		Complete transition to new Health and Safety platform	Q4
5.5	Strategic Infrastructure Planning.	Business Continuity Planning/ Programme Initiation Assessment - assess current situation – prepare submission for November 2026 to set out planning priorities for 2027/28 Deliver Capital budget commitments for 2026/27 (digital inclusion, vehicles, and digital platforms)	Q3-Q4 Q4

Risks
Risks emerging from the above actions will be reviewed regularly through the quarterly Directorate Performance Meetings.

8. LEARNING FROM THE VIEWS OF THE STATE HOSPITAL'S PATIENTS, CARERS AND STAKEHOLDERS

Hearing from and learning about the views of the State Hospital's patients, carers and stakeholders is an important aspect of designing and delivering care and treatment for the hospital. Engagement and feedback help to develop an awareness and understanding of the impact of care and treatment on patients, their carers, friends and family members. Understanding the views and experiences of patients and carers also enables the State Hospital to identify areas for improvement.

A detailed overview of the activities and processes in place across the State Hospital to support effective engagement with patients, carers and stakeholders can be found in the MTP. The State Hospital Board regularly receive updates on patients and carers experiences through patient / carer agenda item at the Board Meetings and through regular attendance at the Patient Partnership Group meeting

Progress has been made in 2025/26 with notable engagement from the PPG in the TSH3030 QI sprint and their ongoing commitment to improving communication across the patient group. The State Hospital also supported the work of the Forensic Network Improving Carer Experience Group, the State Hospital worked collaboratively with NHS Tayside's Rohallion Medium Secure Unit to contribute to revision of the 'Carer support and involvement in secure mental health services - A Toolkit'.

8.1 Carer Strategy

The State Hospital has developed a Carer Strategy 2025-2028 to meet the specific needs of carers involved in a high-secure forensic setting. It is essential to recognise the unique experiences of carers navigating the judicial and forensic health settings, to understand their needs and respond appropriately.

Following the Visitor Experience audit and subsequent engagement with carers conducted in 2024, four priority areas were identified, in 2026/27 the continued focus will be on the following:

1) The Triangle of Care – Audit completed in 2025/26, priority for 2026 /27 is to implement actions form the self-assessment.

2) Carer communication and sharing of information – Information for carers has been updated on the internet, in 2026/27 the Carer Information Pack will be updated to include information specific to each clinical area including the new woman's service.
3) Enhancing the experience for carers during visits. Collaboration with patients and carers to improve visiting will remain ongoing, with a particular emphasis on child visitors—a focus that began in 2025/26 and will continue through 2026/27. Additionally, the State Hospital will maintain its practice of offering visitors a post-visit check-in and provide onward signposting to other support services.
4) Carer Pathway – Link carers with the wider Forensic Network through the Forensic Network Improving Carer Experience Group.

The State Hospital Board actions for 2026/27 to support learning from the views of patients and carers

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
6.1	Implementation of the Carers Strategy.	Triangle of care - implement the actions from the self-assessment	2026/27
6.2	Communication with Carers.	Review carer information packs and include the child friendly literature in relation to the State Hospital to support child visits. Establish carer's support group.	2026/27
6.3	Stakeholder awareness and skills development.	Carer and Workforce Training and Development. Developing relationships with Partner Agencies.	2026/27

Risks
Risks emerging from the above actions will be reviewed regularly through the quarterly Directorate Performance Meetings.

9. WORKING IN PARTNERSHIP TO PRIORITISE ORGANISATIONAL HEALTH, SUPPORT STAFF WELLBEING AND DEVELOP AN ENGAGED SUSTAINABLE WORKFORCE

9.1 Workforce

The State Hospital has developed its Workforce Plan 2025-2028 aligned with service planning priorities of the State Hospital's Medium Term Plan and national priorities. The Workforce Plan describes how the State Hospital will shape, support and implement change in its workforce. The Scottish Government will create an updated Mental Health Delivery and Workforce Plan in 2026 to ensure alignment between the delivery and workforce plans, and with cross portfolio work. The State Hospital Workforce Plan 2025/28 aligns with the five pillars of workforce planning:

1) Plan.
2) Attract.
3) Train.
4) Employ.
5) Nurture.

As of April 2025, the State Hospital employed 698 staff (593.65 WTE) and was funded for 608.13 WTE. Just over two thirds of the workforce are in clinical roles, with nursing staff comprising the majority of these roles with the remainder providing key support and board wide services.

The State Hospital workforce vision is that it works in partnership to achieve organisational health, wellbeing and an engaged and well supported workforce. The State Hospital aims to be the healthiest, most inclusive and engaged NHS Board in Scotland and considered to be an employer of choice. To achieve this, the State Hospital aims to prioritise organisational health and enhance its performance.

Despite the relative scale of the Board, there is an opportunity to ensure that the State Hospital staff are at the forefront of everything the State Hospital does, that it is closely aligned to its service objectives and that its focus in these areas will be demonstrated by the levels of patient care offered.

The key strategic themes for the Workforce Directorate over this 3 year period will be:

1) Prioritise Organisational Health
The State Hospital prioritisation of Organisational Health will focus on direction, leadership and work environment. The State Hospital aims to support staff health through management practices that can promote a positive culture.

2) Become more data focused.
A key theme to support workforce strategic development is the ongoing progression of how the State Hospital uses its data. A priority for the State Hospital is the development of data literacy, use of data visualisation tools to understand patterns and trends and integration of data driven processes into workflows. By collecting and analysing relevant data and transforming insights into actionable steps, the State Hospital will improve planning, performance and accountability through evidence-based practice. The State Hospital aims to improve accessibility and quality of workforce data available to managers to support decision making and workforce planning

3) Strategically Aligned and champion a culture of improvement and innovation
The State Hospital will progress work to ensure that a culture of improvement and innovation is embedded in how it supports workforce development. A significant service development over 2026/27 will be to change the workforce service support to Business Partner model, across all the hospital services. This will allow the workforce team to become more involved and integrated in the delivery of key service, adding value in all key activities.

4) Sustainable Workforce
The State Hospital is committed to ensuring that it has the right people with the right skills and training in the right place at the right time to support its services. This strategic theme will cover:

- Recruitment and Retention.
- Develop leadership and managerial capabilities and capacity.
- Employability/Career Pathways/Anchor organisation.
- Building resilience and succession planning.
- Focused approach to Learning and Education which meets service needs.
- Ensuring a safe, fair, and inclusive working environment for staff.

The State Hospital will complete the adoption and local implementation of the ‘Once for Scotland’ suite of HR policies during 2026/27, ensuring consistent application through Workforce Governance oversight and staff awareness activities.

The Workforce Equalities Group will develop and implement the 2026/27 Equalities Action Plan, ensuring mainstreaming of equality duties and delivery of associated outcomes, with mid-year and end-year progress reporting.

The State Hospital will enhance access to Occupational Health and staff support services, publishing service standards, strengthening referral pathways and monitoring utilisation metrics quarterly.

9.2 Whistleblowing

The State Hospital will implement the refreshed local approach to the Independent National Whistleblowing Standards, including awareness sessions for staff and quarterly reporting to Workforce Governance Group

The State Hospital Board actions for 2026/27 to support The State Hospital workforce

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
7.1	Sustainable workforce.	Continue to focus on maximising attendance, with linkage to proactive approaches	2026/27
7.2	Sustainable workforce.	Continue to implement actions to progress Recruitment and Retention	2026/27
7.3	Organisational Health	Roll out of Board Cultural Assessment Tool	2026/27
7.4	Organisational Health	Integration of Leadership Development Programme and approach for the State Hospital	Q1
7.5	Sustainable workforce.	Develop a robust approach to succession planning	Q3
7.6	Culture of improvement and innovation	Fully implement Protected Learning Time	Q2
7.7	Sustainable workforce.	Develop and implement the 2026/27 Equalities Action Plan, ensuring mainstreaming of equality duties and development of a calendar of training activity to support equalities	Q1
7.8	Sustainable workforce.	Develop capacity and capability to support robust ‘partnering’ model focused on value and solutions	2026/27
7.9	Data focused	Continue to review and develop Performance and Health Dashboards to enable utilisation of metrics to support effective monitoring and decision making.	Q3
7.10	Organisational Health	Develop bespoke Wellbeing Action Plans for each Service	Q2

Risks
Risks emerging from the above actions will be reviewed regularly. If required risks will be added to either Local Risk Registers or escalation to the Corporate Risk Register to manage risks and mitigate potential impacts. Specific Directorate Risks and Issues will be escalated and reported through the quarterly Directorate Performance Meetings.

10 VALUE FOR MONEY AND ACHIEVING FINANCIAL BALANCE

10.1 Financial Balance

The Scottish Government continues to highlight the challenging national financial position for NHS Scotland. The Scottish Government published the Scottish Spending Review 2026[6] which sets out the indicative spending plans up to 2028/29 for capital spending. The spending review highlights that NHS Boards are expected to deliver more with constrained growth, align with the priorities of the SRF including modernising. The spending review emphasises that:

- Stable funding growth is provided, but accompanied by significant pressure to deliver efficiencies, redesign services, and reduce the cost base through productivity, digital transformation, and collaborative planning.
- Boards are expected to reorient services away from acute care toward prevention and community-based models, redesign pathways, and collaborate regionally to reduce long-term demand and improve population health outcomes.
- Boards should prepare for a period of substantial capital change, upgraded infrastructure, and integration of digital tools—aligning estate decisions with climate goals, service redesign, and long-term sustainability.

As in previous years, Boards have been instructed to achieve breakeven, with no brokerage option available and the Support and Intervention Framework continues to be in operation. The requirement for recurring savings on baseline budgets is increasingly challenging given the ongoing national financial position.

The State Hospital has developed its three year finance plan to outline the high-level Revenue and Capital budget spending plans with known budget pressures outlined. The State Hospital Finance Plan is subject to review and approval by the Scottish Government and will align with both the Delivery and Workforce plans.

The State Hospital has consistently achieved financial balance, however this has become increasingly challenging and forecast to remain so with the requirement to achieve recurring savings. It is noteworthy that only 14% of the State Hospital's budget of costs are non-pay related.

The State Hospital has in place a range of approaches to support managers to have oversight and management of budgets. A consistent pressure for the State Hospital has been costs associated with staffing. A review of the requirements for staffing within nursing, which has the biggest pressure, has been carried out and high-level oversight in place to better understand and deploy resource for this budget.

Digital and e-health

There has been significant focus on developing the organisations digital and e-health function over the last few years. The State Hospital remains fully committed to digital development and enablement, however the NHS's financially challenging position has impact on the State Hospital ability to deliver its digital inclusion ambitions. The hospital aims to make the best use of digital technologies in the design and delivery of services delivering greater access, better insight and improved outcomes for patients.

The State Hospital Business Intelligence Team continues to develop dashboards to support clinical and managerial decisions by providing accessible data. For 2026/27, the team will focus on financial dashboards for clinical staff to aid financial planning.

The State Hospital is dedicated to making relevant data easily accessible. E-health teams focus on training staff to use data-driven tools effectively, involving them in tool design to enhance patient outcomes and confidence in handling data responsibly. The State Hospital will continue

6 Scottish Spending Review 2026 - gov.scot

to develop the digital workforce with the right leadership and skills, improve infrastructure, and maintain strong standards and governance for secure operations. The State Hospital aim to transition all records to a digital system.

Cyber security continues to be recognised as a high risk and concern for all Boards, with significant focus for the State Hospital. The Network Information and Security Regulations (NIS) guides priorities. The State Hospital was audited against the NIS standards in 2023 and 2024 with the next audit cycle due in 2026.

The State Hospital has engaged with the adoption and implementation of national digital programmes including M365, SharePoint and e-roster. The State Hospital will continue to link in with the national programmes as they develop with the requirement to ensure preparatory work is on track for these systems.

10.2 Digital Inclusion

The State Hospital is keen to progress digital inclusion for patients, both to improve the patients' experience and to support care and treatment. Presently, patients within the State Hospital are at a disadvantage in terms of digital inclusion compared to patients being cared for within other forensic settings across NHSScotland. In November 2018, the Forensic Network produced a key report "Supporting Communication and Technology Use in Mental Health Settings", and post pandemic this was updated in May 2021.
In January 2024, the Scottish Government indicated that they would engage with the Forensic Network to develop a Delivery Plan based on the recommendations from the above reports.

The State Hospital developed a Digital Inclusion Strategy in 2023/24. Progress has been stymied due to financial constraints. However, the State Hospital sourced funding in 2025/26 to carry out a 'proof of concept' test on an electronic platform, Made Purple Operating System. The aim of this test was to evaluate the systems effectiveness in enhancing patient engagement and digital inclusion and contribute to strengthening the business case for consideration for future funding opportunities. The business case for the Made Purple Operating System will be developed over 2026/27 and funding sought to fully implement this system across the State Hospital.

The State Hospital will deliver the 2026/27 Information Governance and Records Management workplan, including a refreshed retention schedule, mandatory information governance training, and enhanced audit processes, with monitoring through Audit & Risk Committee.

The State Hospital Board action 2026/27 for Finance and e-health/digital developments

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
8.1	3 year finance plan 2025 - 2028.	Action plan associated with 3 year finance plan.	2025-2028
8.2	Financial management.	Development of local dashboards to support financial analysis and management of nursing and non-clinical areas. Security, HR, Finance, Nursing and other areas	Q4
8.3	Patient finance system.	Patient funds. Finance system that is currently used will not be supported past March 2027 – work will be taken forward to progress a new finance system	Q4

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
8.4	Digital Inclusion.	Develop business case for embedding Made Purple Operating System across the hospital	Q1
8.5	Digital Infrastructure.	Ensuring that regulations, standards and governance are in place to ensure robust and secure delivery.	2025-2028
8.6	Business Service Transformation.	Development and support implementation of systems for HR, payroll, Finance and Procurement.	2026/27-2027/28
8.7	Business Service Transformation.	Support implementation of the public contracts tender portal and any new DI system.	2026/27
8.8	National digital programmes.	The State Hospital will continue to link in with the national programmes (M365, Sharepoint, Allocate, Loop, co-pilot) as they develop. The State Hospital will move from a centralised resource management approach to a ward based approach, giving the SCN overview and management of rosters via allocate.	2025-2028 Q2 - Q4
8.9	Network security.	NIS audit – preparation for next audit scheduled in 2026.	2026/27

Risks
Risks emerging from the above actions will be reviewed regularly. Specific Directorate Risks and Issues will be escalated and reported through the quarterly Directorate Performance Meetings.

11. CLIMATE AND SUSTAINABILITY

The State Hospital recognises the role it plays in NHS Scotland's approach to the climate emergency as set out in DL (2021) 38. The State Hospital operates from 15 buildings including patient accommodation, off ward therapy areas, offices, carers' facilities, security buildings and estates buildings. The State Hospital also manages land and buildings covering an area of 63 hectares.

As a relatively modern hospital, the State Hospital does not require an extensive plan of works to reach national targets on climate change. However, the State Hospital continues to develop and implement work to reduce the hospital's impact on climate and improve sustainability. The State Hospital's buildings will also need lifecycle maintenance. Maintenance costs will inevitably increase as the facility ages. These costs now need to be planned for to maintain standards of building quality for patients and staff to enable a level of care. The State Hospital will require to develop a planned maintenance programme to ensure that buildings continue to be fit for purpose.

The State Hospital is obliged to meet decarbonisation targets set by NHS Scotland Assure. The most critical targets are:

- 75% reduction in emissions by 2030.
- Decarbonised heat by 2038.
- Net Zero by 2040.

The State Hospital has already reduced emissions by 83.7% against the baseline year 1993/94, which is within the five year 1990 Kyoto window. Therefore, the State Hospital is well-ahead of the 2030 target. However, without targeted decarbonisation measures the health board would

not meet the other two key targets. The State Hospital continues to focus on reducing use of fossil fuels. In the medium term a feasibility study will be commissioned to explore use of new technologies to meet the decarbonisation target.

Recent development has included changing many the State Hospital's fleet vehicles to Electric Vehicles (EV). EV charging points have now been extended to the Car Park for staff use and additional points have been added internally for EV's. The State Hospital are transitioning to a new EV charging partner as required by the national NHS Framework, since Charge Place Scotland (current, government-sponsored supplier) will end by March 2026. For staff welfare, a salary sacrifice scheme for private electric vehicles is progressing and has received preliminary approval from GGC. It will be presented through governance channels for final sign-off and aims to support workforce wellbeing

The State Hospital has reviewed improvements to support waste management, with the State Hospital's Waste Management Route Map developed in 2025/26. Implementation of this is now progressing with priorities including development of food waste management. A mini tender was carried out under the new National Framework for General Waste and Recyclates and contracts awarded to two different companies, and new equipment ordered.

New LED lighting is also being introduced across non-clinical areas with plans being developed to address clinical areas within 2026/28. High-level decarbonisation plan submitted to the Scottish Government with a more detailed funding request to support transition to LED lighting submitted to the Scottish Government in early 2026, budget allocation likely to be based on NRAC formula (NHS Scotland Resource Allocation Committee Formula).

The State Hospital Board action 2026/27 for climate

No	Planning Commitment	The State Hospital Board action	2026/27 Delivery timescale
9.1	Net zero target.	• Progress an active travel agenda. • Increase biodiversity/greenspace awareness. • Fully implement an EMS for the State Hospital.	2026/27
9.2	Planned maintenance programme.	The State Hospital has a planned maintenance programme to ensure that buildings continue to be fit for purpose. Proactive monitoring and delivery of planned maintenance system to be carried out to ensure that the State Hospital meets maintenance targets.	Q2

Governance for the Climate Change and Sustainability agenda is through the newly established Climate Change and Sustainability Group which has the lead responsibility and is accountable to the Security, Resilience, Health and Safety Oversight Group. The Group ensures an integrated approach to sustainable development,

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	18 June 2026
Agenda Reference No:	Item No: 26
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Corporate Governance
Title of Report:	Board Improvement Plan
Purpose of Report:	For Noting

1 SITUATION

The NHSScotland Blueprint for Good Governance outlines a model for effective corporate governance to deliver good governance in healthcare. The model supports NHS Boards to take a consistent and systematic approach to assessing their governance arrangements, and to identify emerging concerns.

2 BACKGROUND

The State Hospital created its current Board Improvement Plan in early 2024, and submitted it to Scottish Government as required. This is attached as **Appendix 1**. The Board has monitored progress against completion of the plan at six monthly intervals taking assurance from the developments made across a range of workstreams, as well as identifying where further work should be progressed.

At its last review, the Board noted the need to make further progress in the following areas:

Risk Management: streamline the position of risk with performance and governance.

Engaging Stakeholders: develop organisational wide stakeholder mapping, define stakeholder groups and how engagement is progressed in different forums.

Influencing Culture: raise awareness of whistleblowing, supporting staff to feel confident about speaking up. The Board also recognised the more wide-ranging work led through Organisational Development (OD).

Diversity, Skills, and Experience: focus on succession planning as a key area of risk in a small NHS Board.

3 ASSESSMENT

Risk Management
The Risk Team has made progress working across directorates to ensure that reviews of existing risks have been completed, with this being finalised with Risk MD30, which relates to levels of patient obesity. This has been part of the wider work in respect of measurement of this as a Key Performance Metric (KPI) in a meaningful way, with a new agreed KPI introduced on 1

April 2026. The risk assessment has now been reviewed following the introduction of this change, and this is reported to the Board as part of the Corporate Risk Register.

The Board has continued to consider how to consider risk, and the assurance mechanisms in place taking in consequential risk impacts across the Corporate Risk Register, and how this can be used effectively to take a strategic view of risk and overall risk appetite. The approach to risk continues to develop, as well as placement of the department within the organisational structure.

Stakeholder Engagement:
The Board has considered stakeholder engagement as part of the Board Improvement Plan in terms of existing stakeholder groups across a wide range of workstreams over the life of this plan, with detailed assurance reporting to identify their required engagement along with their interdependencies across workstreams. This has included key developments particularly the implementation of the Women's Service, as well as the Carers Strategy and recruitment initiatives.

Following this, a stakeholder map has been developed as a key tool in this process **and** is attached as **Appendix 2.** This gives a structured understanding of who the State Hospital's stakeholders are and how the hospital engages with them in different forums and across a range of workstreams. This includes key internal and external stakeholders, and is a tool to help clarify these relationships and to develop transparent and clear engagement with those who influence or are affected the hospital's services. The overall aim is to support informed decision-making and to strengthen accountability, aligned to risk and performance considerations.

Influencing Culture
The Board Improvement Plan identified the need to refresh the approach by the State Hospital to its implementation of the whistleblowing standards. This has been developed further to align with development and implementation of the Organisational Development (OD) Strategy.

This refreshed approach has been demonstrated both through formal quarterly and annual reporting for 2025/26, alongside the letters of assurance from the Whistleblowing Champion, and the Chief Executive Officer, provided to the Cabinet Secretary for Health and Social Care Within, there has been strong focus on how best to support staff to speak up, management of cases, and liaison with the Independent National Whistleblowing Officer.

The Staff Governance Committee monitors implementation of the OD Strategy, and this was reviewed and discussed in detail at its last meeting in May 2026. The key aspects of the Culture Change Approach are noted below, and attached as **Appendix 3.**

<u>Stabilisation:</u>
This is immediate focus on Speak Up and psychological safety actions to reduce risk, improve consistency in how concerns are handled, and provide visible leadership assurance.

<u>Transformation:</u>
From October this year, there will be a transition to a formal programme beginning with an evidence-based diagnosis using the Affina OD Culture Assessment Tool.
This will be followed by:

- A shared definition of the desired future culture
- Identification of practical enablers of behaviour change

<u>Embedding:</u>
To sustain this approach, culture will be embedded within leadership expectations, people processes and team development, ensuring a long-term, partnership-owned shift.

Diversity, Skills, and Experience
The Board Improvement Plan focuses on succession planning as an area of potential risk, and the need to take steps to build resilience within a small NHS Board, particularly around leadership roles which could be single points of failure. This is identified within the Workforce Plan as a critical component of building a sustainable workforce and ensuring the organisation has the right people, with the right skills, in the right roles at the right time.

A draft Succession Planning Framework has been developed to establish a structured and consistent approach to identifying, developing, and preparing staff to fill key leadership and business-critical roles across the organisation.

This approach is crucial to:

- Mitigating organisational risk in critical roles
- Improving continuity of leadership and service delivery
- Increase internal opportunities and retention of high potential employees.
- Enhancing workforce planning with better data and insight.

It is based on a six-stage succession planning process:

1. Identify critical roles
2. Define role requirements
3. Identify and assess talent
4. Develop individuals
5. Actively develop and track successors
6. Governance and review

The draft Framework was submitted to the Staff Governance Committee in May. The next stage is engagement with stakeholders, before returning to the Committee at its next meeting in August 2026.

4 RECOMMENDATION

The Board is invited to note the substantial progress made against the original plan, which was developed in March 2024, and to consider next steps in self-assessment to help inform future improvement work.

Further guidance has not yet been made available through Public Delivery Scotland on a nationally led programme in this respect, and the Board is asked to consider whether a bespoke assessment tailored specifically to its needs and that of the standing committees would be well timed, with further consideration of this being channelled through the next upcoming Board Development Session in August 2026.

MONITORING FORM

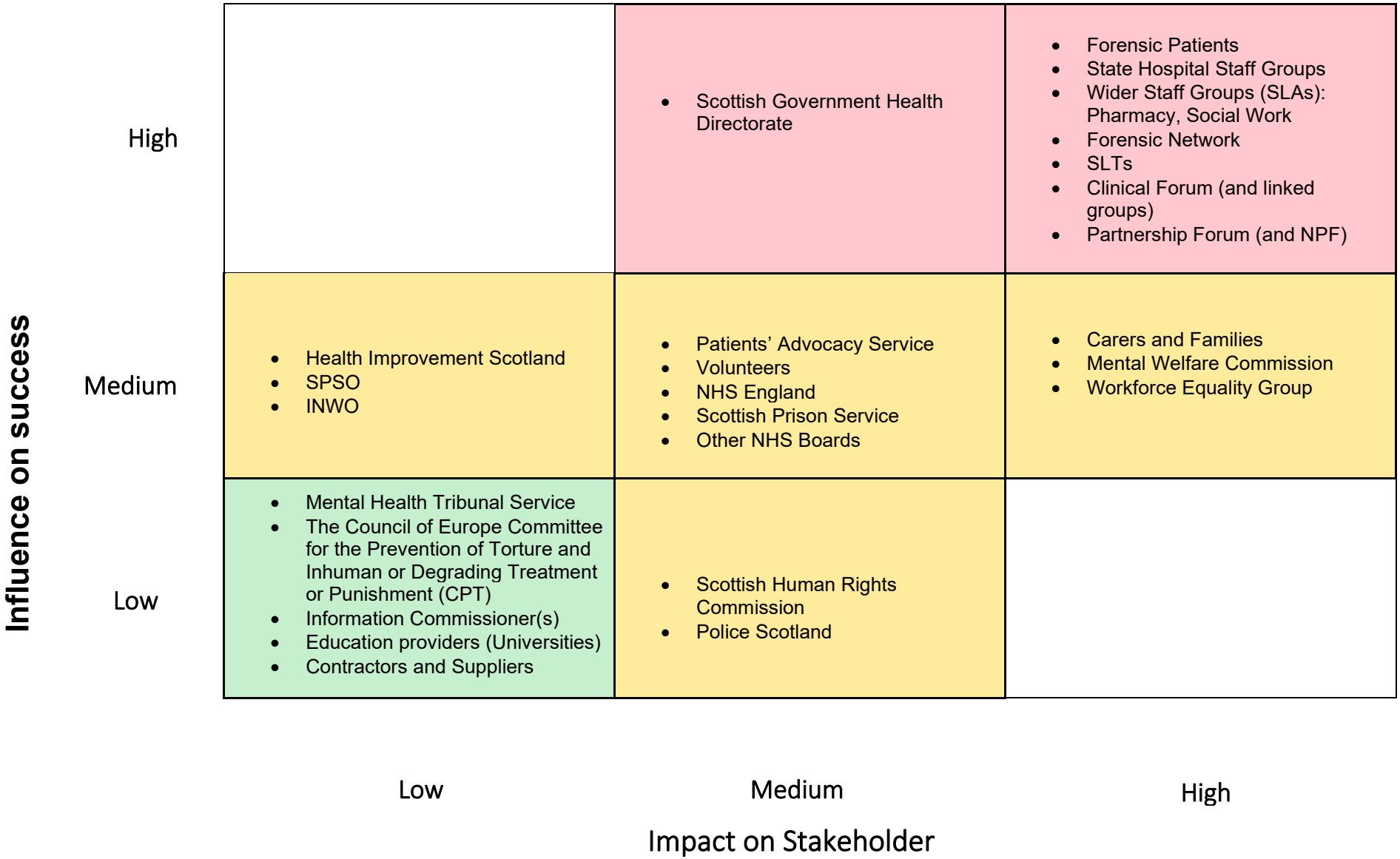
How does the proposal support current Policy / Strategy / ADP /	This supports the Board's approach to assurance, based on self-assurance exercise and development of plan for improvement across key identified areas.
Corporate Objectives Please note which objective is linked to this paper	**3. Better Value** j) to embed continuous improvement of governance arrangements as part of the Blueprint of Good Governance
Workforce Implications	No issues identified in terms of staff resourcing
Financial Implications	There are no direct financial impacts related to progressing this plan
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	As per national guidance, and the Board has ownership directly. The Executive Team provide input and approval to content, which summarises ongoing workstreams
Risk Assessment (Outline any significant risks and associated mitigation)	This is a continuous improvement mechanism, and should not present additional risks to the Board.
Assessment of Impact on Stakeholder Experience	Stakeholder engagement is a key part of the plan, and will be reviewed as part of the proposed governance arrangements
Equality Impact Assessment	This is not required as part of this workstream
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 to this workstream
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).	Option 1

Appendix 1

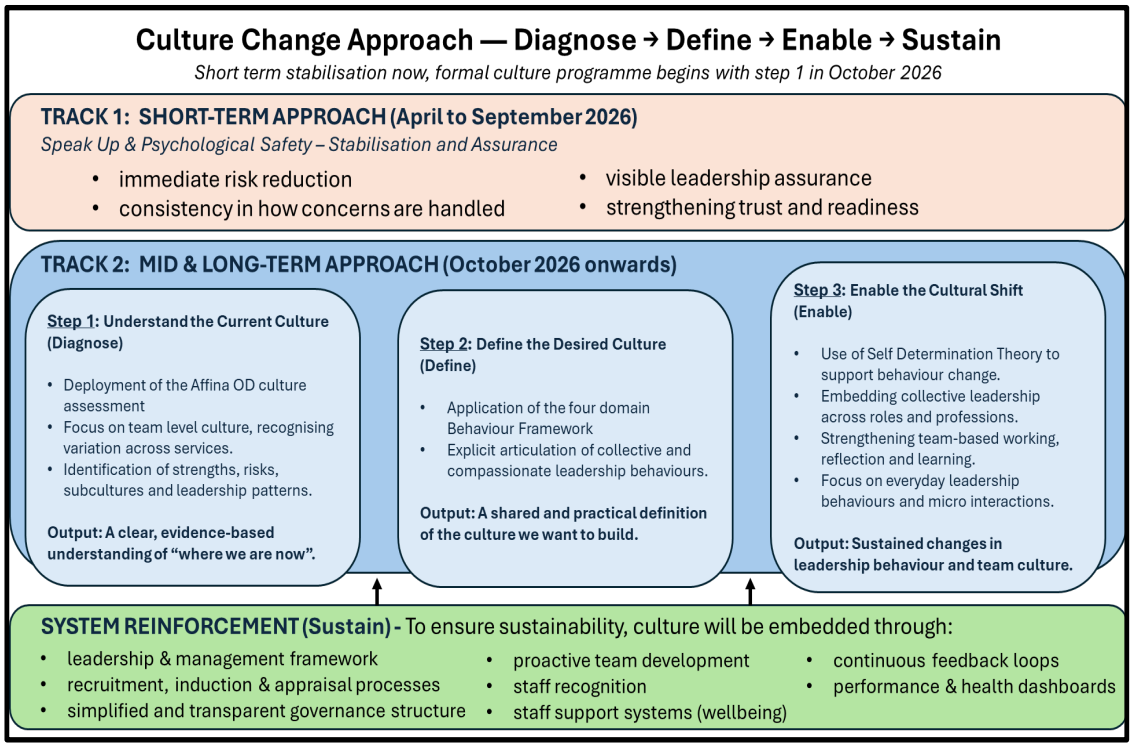
Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Status
Functions	Risk Management	Review the Board risk appetite in light of current financial and operational pressures. Ensure that this is agreed and the risk management approach is embedded across the organisation, including through the development of local risk registers, and linking Corporate Risk Register to Corporate Objectives.	Standing committees	Director of Security, Resilience and Estates	Feb-25	Underway with regular updates to Board and Standing Committees. To continue to develop across each directorate locally and bring together in CRR.
Functions	Engaging Stakeholders	Produce a stakeholder map to define who our stakeholders and the purpose of our engagement. Review our Anchor strategy as a mechanism to develop community engagement and help with visibility and impact.	External agencies e.g. MWC, patients and carer groups, government, elected representatives and wider public	Director of Nursing and Operations/Head of Planning, Performance & Quality/OD	Feb-25	This is new workstream - stakeholder map leads to be agreed then developed, building on existing workstreams. Anchor Plan agreed and baseline metrics in place.
Functions	Influencing culture	Raise awareness of Whistleblowing Champion to improve levels of psychological safety and support staff to raise concerns.	INWO, Scottish Government	Director of Workforce (to be reviewed?)	Aug-24	TSH to respond to INWO advice in respect of executive leadership of whistleblowing i.e. not an HR function. Need for Exec leads to work with HRD to develop planning for staff support.

Priority Area	Blueprint Function	High level Action	Interdependency	Lead	Timeline	Status
Enablers	Diversity, Skills, and Experience	Include succession planning through Staff Governance Committee	Link to communications planning, and public perceptions	Director of Workforce	May-24	Build on work initiate in Workforce Governance Group - add to next SGC agenda as starting point, and to scope issues and key risks. Strategy and action plan to be developed.
Delivery	The Assurance Framework	Explore further benchmarking opportunities and tools, keeping the Board updated.	NHS England High Secure, Forensic Network,	All Directors through CMT	Oct-24	Covers range of areas and underway across directorates- single lead to be agreed for more coherence: e.g. attendance management, digital inclusion, security, complaints, HR policy implementation.
Evaluation	Evaluation	Better promote our work to national Boards through raising our profile, hosting visitors and bespoke work. Opportunity to observe Board meetings in other areas to see how they function and identify any areas of learning.	National Boards Collaborative forums e.g. CEO, DoFs, Planning Leads	All Directors through CMT	Nov-24	Covers range of areas - single lead to be agreed to give more structure and coherence: e.g. finance, procurement, SLAs, healthcare in custody, forensic network, information governance, PMVA techniques

Appendix 2


Influence on success
High
Medium
Low
Scottish Government Health Directorate
Forensic Patients
State Hospital Staff Groups
Wider Staff Groups (SLAs): Pharmacy, Social Work
Forensic Network
SLTs
Clinical Forum (and linked groups)
Partnership Forum (and NPF)
Health Improvement Scotland
SPSO
INWO
Patients' Advocacy Service
Volunteers
NHS England
Scottish Prison Service
Other NHS Boards
Carers and Families
Mental Welfare Commission
Workforce Equality Group
Mental Health Tribunal Service
The Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)
Information Commissioner(s)
Education providers (Universities)
Contractors and Suppliers
Scottish Human Rights Commission
Police Scotland
Low
Medium
High
Impact on Stakeholder

Appendix 3


Culture Change Approach — Diagnose → Define → Enable → Sustain
Short term stabilisation now, formal culture programme begins with step 1 in October 2026
TRACK 1: SHORT-TERM APPROACH (April to September 2026)
Speak Up & Psychological Safety – Stabilisation and Assurance
immediate risk reduction
consistency in how concerns are handled
visible leadership assurance
strengthening trust and readiness
TRACK 2: MID & LONG-TERM APPROACH (October 2026 onwards)
Step 1: Understand the Current Culture (Diagnose)
Deployment of the Affina OD culture assessment
Focus on team level culture, recognising variation across services.
Identification of strengths, risks, subcultures and leadership patterns.
Output: A clear, evidence-based understanding of "where we are now".
Step 2: Define the Desired Culture (Define)
Application of the four domain Behaviour Framework
Explicit articulation of collective and compassionate leadership behaviours.
Output: A shared and practical definition of the culture we want to build.
Step 3: Enable the Cultural Shift (Enable)
Use of Self Determination Theory to support behaviour change.
Embedding collective leadership across roles and professions.
Strengthening team-based working, reflection and learning.
Focus on everyday leadership behaviours and micro interactions.
Output: Sustained changes in leadership behaviour and team culture.
SYSTEM REINFORCEMENT (Sustain) - To ensure sustainability, culture will be embedded through:
leadership & management framework
recruitment, induction & appraisal processes
simplified and transparent governance structure
proactive team development
staff recognition
staff support systems (wellbeing)
continuous feedback loops
performance & health dashboards

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **ARC(M) 26/02**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 19 March 2026.

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

Chair:	
Vice Board Chair	David McConnell
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Pam Radage
In Attendance:	
Corporate Business Manager	Anne Donnelly [Minute]
Acting Director of Security, Estates and Resilience,	Allan Hardy
Internal Auditor, RSMUK	Asam Hussain
Internal Auditor, RSMUK	Laura Gough [for Item 5 and 6b)
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
External Auditor, KPMG	Matthew Moore
External Auditor, KPMG	Michael Wilkie
Head of Corporate Governance	Margaret Smith
Performance and Planning Officer	Tracy Tait [for Item 13]

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting and noted apologies from Mr Brian Moore, Board Chair and Ms Monica Merson, Head of Corporate Planning, Performance & Quality.

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 29 January 2026 were noted to be an accurate record of the meeting.

In response to Mr McConnell's question regarding the minute of the private meeting, Ms Smith confirmed that the minute had been circulated to members for approval separately.

The Committee:

1. Approved the minute of the meeting held on 29 January 2026.

4 MATTERS ARISING – ROLLING ACTIONS LIST UPDATE

There were no matters arising from the previous minute.

The Committee reviewed the Rolling Actions List and noted the progress of the actions that had either closed or would be picked up as part of the agenda for today's meeting.

The Committee:

1. Noted the updates from the Rolling Action List.

INTERNAL AUDIT

5 INTERNAL AUDIT REPORT

1. Resilience Planning and Training

Ms Gough of RSM UK presented the Resilience Planning and Training Audit, reporting a positive rating of reasonable assurance with one medium and three low-priority actions identified. The audit reviewed resilience arrangements, including documentation, plan development and testing, training, and learning from incidents and exercises. Overall, the report noted that a well-established and well governed framework was in place, with resulting actions focused on strengthening document approval, retaining multi-agency debrief records, ensuring consistent recording and follow-up of learning exercises.

Mr McConnell thanked Ms Gough for the update and asked Mr Hardy for his reflections on the audit before questions. Mr Hardy noted the audit was positive and expressed satisfaction with the progress made and that the findings had highlighted housekeeping matters which could be addressed to improve accuracy and support continued improvement.

Mr Currie welcomed the report and noted assurance that the actions identified were low and medium priority and related primarily to housekeeping matters. He emphasised the importance of ensuring information was readily accessible and well-organised and suggested that a more continuous internal self-assessment approach could help identify issues earlier and reduce audit actions. He concluded that the report was positive and indicated a move in the right direction.

Ms Radage also welcomed the positive report and the extensive training and tabletop exercises undertaken, including those relating to cyber security. She emphasised the importance of capturing learning promptly from debriefs and suggested consideration of alternative approaches to ensure lessons were recorded more quickly and highlighted the critical importance of resilience and business continuity in the current environment.

Mr McConnell thanked members for their contributions and added that he was pleased to see that reasonable assurance was achieved and acknowledged the volume of work involved in audits. In response to Mr McConnell's request for assurance, Mr Hardy confirmed that the actions with a target date for 31 March 2026 would be achieved.

The Committee:

1. Noted the outcome of internal audit report on Resilience Planning and Training which had an outcome of reasonable assurance.

6 INTERNAL AUDIT

a) Draft Annual Internal Audit Report 2025/26

Mr Hussain presented the draft Internal Audit Annual Report 2025–26 and advised that the proposed opinion was that of positive assurance, confirming an adequate and effective framework for governance, risk management and internal control, with some areas for further enhancement. He highlighted positive audit opinions in relation to absence, disciplinary and suspension management, resilience planning and the rolling follow-up, alongside an advisory review of project management. He noted that the Estates and Facilities Management review received a partial assurance, with progress made against actions, including the completion of two medium and two low priority actions and that the remaining high-priority action relating to skills and resource assessment had been extended to March 2027 due to capacity constraints.

Mr McConnell thanked Mr Hussain for the report and opened for questions. Mr Currie commented that the report provided appropriate assurance by identifying any weaknesses and a clear path to improvement. He emphasised the importance of realistic timescales, transparent progress tracking, and early identification of potential delays. He added that it appropriately highlighted that addressing issues was a collective organisational responsibility and overall positive assurance was provided.

Mr McConnell also echoed the importance of having clear visibility of future developments and direction. He welcomed the positive assurance overall and noted that the matters raised would be addressed and reflected further within the Draft Governance Statement on today's agenda.

b) Action Tracking Report

Ms Gough provided a verbal update confirming a positive position. Two actions from the previous meeting relating to rostering had been superseded and were now treated as business as usual, with assurance through the Staff Governance Committee.

The Committee:

1. Noted the Resilience Planning and Training Audit.
2. Noted the Draft Annual Internal Audit Report.
3. Noted the Action Tracking Report.

7 DRAFT ANNUAL INTERNAL AUDIT PLAN 2026/27

Mr Hussain presented the Internal Audit Plan for 2026–27, advising that it had been developed in consultation with Executive Leadership and prioritised to enable delivery from 1 April 2026. He outlined four key areas of focus: Freedom of Information and Subject Access Requests, Prevention and Management of Violence and Aggression, Occupational Health, and e-Health and Cyber Security.

Mr McConnell thanked Mr Hussain and welcomed progress on the programme. He noted that it was helpful to understand which areas had been considered but not included in the plan, particularly Daytime Confinement (DTC). Mr Hussain advised that DTC had been considered but, due to review and improvement work already carried out or underway, was not included in the current plan, although it could be prioritised if circumstances changed, otherwise it was intended as a focus for 2027/28.

The Committee:

1. Noted the draft Annual Internal Audit Plan for 2026-27.

INTERNAL CONTROL

8 CORPORATE RISK REGISTER

Mr Hardy presented the Corporate Risk Register and advised that the only change during the quarter related to a workforce risk associated with PVG disclosures, which had been resolved promptly. He reported that five corporate risks remained rated as high and outlined progress across these areas. He noted the successful implementation of the Inphase incident management system, with local risks transitioning to the system to support refreshed review by Heads of Service.

Mr McConnell thanked Mr Hardy for the update and opened for comments or questions. Mr Currie welcomed the update and noted that the enhanced reporting had improved clarity on governance and scrutiny. He emphasised the importance of focusing on high-rated risks, recognising their interdependencies and potential organisational impacts, and highlighted the need for clear oversight, realistic risk trajectories and transparent monitoring of progress.

Mr Hussain suggested that context could be provided within the high-risk table by including indicative dates for when risks were expected to reach their target dates. Mr Jenkins supported the discussion on risk trajectories and emphasised the importance of understanding both expected risk reduction pathways and the factors that could prevent progress. He highlighted the need to recognise consequential risks and suggested that risk reporting could be strengthened by providing greater contextual narrative, including the wider risk landscape, consequential impacts and anticipated trajectories, to support clearer scrutiny and assurance. Mr Currie agreed with the suggestions and emphasised the importance of understanding risk trajectories rather than relying solely on binary target indicators. He highlighted the value of contextual narrative to demonstrate progress, clarify whether risks were nearing resolution, and explain the wider organisational impact of both progress and delay and welcomed the proposed approach as a more meaningful aid to scrutiny and assurance. This was agreed as an action for future reporting.

Action – A Hardy

Mr McConnell thanked everyone for the discussion and noted that while some high-risk narratives appeared static across reports, this did not reflect a lack of activity. He asked specifically about Risk SD57 (Failure to complete Category 1 and 2 Reviews on Time), and whether this was now capable of review given the work undertaken to date. Mr Hardy confirmed that the new process for managing Serious Adverse Event Reviews was currently being tested and that this would be kept under review.

The Committee:

1. Endorsed the Corporate Risk Register as an accurate statement of risk.
2. Agreed that reporting should be reviewed as outlined.

9 FINANCIAL POSITION UPDATE

Mr McNaught presented the financial position update to Month 11, reporting a small variance with a year-end break-even position and a small underspend anticipated. He advised that budget and savings plan for 2026–27 were well advanced and had been communicated to the Scottish Government. He noted ongoing financial pressures, including nursing expenditure and staffing within the Women's Service, and confirmed that discussions with the Scottish Government regarding future funding were continuing, with a response awaited. Additional pressures included the potential financial impact of changes associated with the Reduced Working Week and the need to maintain staffing. He also noted the position relating to patients from Northern Ireland, in preparation for charging as from 1 April 2026. He further reported that the Scottish Government was satisfied with the current financial position and forecasts, that capital works for the current year were progressing within budget, and that assessment of capital requirements for 2026–27 was underway.

Mr McConnell welcomed the report noting the positive position and opened for questions. Mr Currie noted that the financial position was broadly as expected and welcomed the absence of unexpected issues. He highlighted ongoing uncertainty regarding funding for the Women's Service as the key financial pressure and emphasised the importance of securing clear, sustainable funding to support effective service planning and delivery, rather than reliance on short-term or interim arrangements. Ms Radage thanked Mr McNaught for the update and noted that it aligned with previous discussions. She highlighted recent increases in energy costs and asked whether any support or mitigation measures were being considered in response to this. Mr McNaught replied that current energy prices were largely covered by forward-purchased contracts, providing short-term cost certainty. He noted ongoing uncertainty regarding the duration of wider energy price increases and confirmed that, while energy costs would continue to be treated as a potential risk, there was no immediate impact on the current year outturn.

Mr McConnell thanked everyone for their contributions noting the key areas of uncertainty related to funding for the Women's Service and future energy costs.

The Committee:

1. Noted the Financial Position Update.

10 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 counter fraud activity and advised that relevant Counter Fraud Services (CFS) alerts and virtual sessions continued to be reviewed and circulated to appropriate departments. He reported that two matters from the previous quarter had been investigated and found to be unfounded, requiring no further action, and had been reported back to CFS and that the counter fraud action plan had been updated and agreed with CFS.

Mr McConnell thanked Mr McNaught for the update and opened for questions.

Mr Connor sought clarification on whether the investigations referred to under 3.2 had been undertaken independently by appropriate directorates. Mr McNaught clarified that the investigations had been undertaken at Associate Director level specifically within the Nursing Directorate, and while the relevant Director had been involved in reviewing and confirming findings, they had not conducted the investigation directly, and appropriate oversight was maintained.

The Committee:

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

11 CYBER CRIME UPDATE

The Committee received the Cyber Crime Update presented by Mr McNaught who provided an update noting that no significant national or local cyber risks had arisen during the quarter. He reported that threats continued to be effectively monitored, detected and contained as required. A recent cyber incident affecting a major NHS supplier was noted; however, this posed no risk to the organisation as there was no contractual relationship with the supplier. Cyber security training continued to be delivered through mandatory requirements and remained at an acceptable level.

Mr McConnell asked whether the volume of local system alerts recorded over the previous three months indicated any discernible trend, or whether the data was considered too variable to support meaningful trend analysis. Mr McNaught replied that the volume of system alerts was too variable

and unpredictable from quarter to quarter to identify meaningful trends. He confirmed that, as no consistent pattern had emerged, the data did not indicate any additional actions beyond the controls already in place.

The Committee:

1. Noted the Cyber Crime Update.

12 POLICY UPDATE

Mr McNaught presented the report and noted continued progress and that outstanding policies were at an acceptable level. He reported that overdue policies were now subject to review at quarterly Executive Director performance meetings, ensuring increased oversight and follow-up. He further advised that some policies were being revised as procedures where more appropriate, and that Executives were aware of and addressing policies due in the forthcoming quarter. He acknowledged the valuable administrative support provided by the Planning, Performance and Quality Team in managing the process which had contributed significantly to maintaining the current position.

Mr McConnell thanked Mr McNaught for the update and opened for questions. Ms Radage commented that it was helpful to see a more flexible and proportionate approach being taken and welcomed the consideration of whether policies could be streamlined, merged, archived or converted into procedures which reduced the risk of being reviewed routinely without sufficient challenge and expressed support for the revised approach.

Mr Currie also supported the approach and welcomed a more purposeful review focused on relevance, effectiveness and continued need. He emphasised the importance of assessing whether policies remained appropriate or could be streamlined, merged, converted into procedures or archived, rather than being renewed routinely. He welcomed the proportionate, quality-focused approach and thanked officers for the significant work undertaken to ensure policies remained fit for purpose.

Mr McNaught added that consideration was given to whether policies could be combined, converted into procedures or otherwise streamlined, rather than reviewed solely as a formality.

Mr McConnell echoed the comments made by Ms Radage and Mr Currie and thanked everyone for their contribution.

The Committee:

1. Noted the Policy Update.

13 ANCHORS STRATEGY UPDATE

Ms Tait joined the meeting and presented the six-month update on delivery of the Anchors Strategy. She highlighted that the Strategy supported the Scottish Government’s community wealth-building agenda and focused on procurement, workforce, and the sustainable use of land and assets. Progress over the period included continued engagement with local suppliers, expansion of apprenticeship opportunities, and growth of the demonstrator programme. Ms Tait noted that delivery remained dependent on the development of national data arrangements by the Scottish Government.

Mr McConnell thanked Ms Tait for the update, welcomed the progress and opened for questions.

Mr Currie noted that the assessment demonstrated the organisation’s significant positive impact on local communities, despite its relatively small size within NHS Scotland. He highlighted the local

economic benefits arising from procurement, employment and spending, which should be considered alongside cost, environmental and climate factors, and suggested that this impact could compare favourably against NHS Scotland as a whole, especially given the small size of the State Hospital.

Mr McConnell asked whether performance against the key activities was in line with expectations, or ahead of plan currently, and suggested that this progress could be reflected in the annual report to show how delivery compared with the original plan. Ms Tait replied that progress was positive and achievements to date were encouraging at present with no concerns. She acknowledged that there was always room for improvement and confirmed that specific detail would be reflected in the annual report.

Action – M Merson/T Tait

The Committee:

1. Noted and approved the Anchor Strategy Update for submission to Scottish Government.
2. Requested progress reporting against the original plan in the annual report.

EXTERNAL AUDIT

14 INTERIM AUDIT UPDATE/EXTERNAL AUDIT PLAN

Mr McConnell noted that the External Audit Plan had been tabled for the meeting in place of an interim audit update and that the paper had been circulated to members that morning. He remarked that this timing was normally discouraged as it limited members' ability to review it in advance, but that it was always important and useful to see the External Audit Plan at this point in the year.

Mr Wilkie outlined the audit approach, confirming that materiality had been set consistently with the prior year and that lower thresholds were used to manage aggregation risk. He highlighted the key audit risks identified, including the full five-year valuation of land and buildings and the fraud risk relating to expenditure and advised the audit would focus on assessing key controls, undertaking substantive testing, and reviewing valuation assumptions.

Mr Moore advised that the wider scope assessment covered financial management, financial sustainability, vision, leadership and governance, and the use of resources to improve outcomes. He reported no significant weaknesses, with effective budget setting and monitoring and savings on track to support a projected break-even position. He noted that, while some performance indicators remained rated red, risks were being managed, and the future funding of the Women's Service remained important for medium-term planning.

Mr Wilkie added that in light of earlier discussions, the audit strategy had been updated to include consideration of any new transactions, balances or approaches relating to the female provision and confirmed that these matters would be reviewed as part of the audit as a matter of course. Mr Moore added that this marked the start of the final phase of audit work and that a commentary would be included in the final report to be presented to the Committee in June, providing a further opportunity for questions, while confirming that no new issues were anticipated.

Mr Currie remarked that the paper was helpful at a headline level and suggested that members review it in more detail following the meeting to raise any matters arising. Overall, he took reassurance from the absence of issues.

Mr McConnell welcomed the audit plan and asked whether any specific risks or concerns arose from this being a full five-year revaluation of fixed assets, particularly given recent asset developments such as the security project. He sought assurance that any valuation-related risks and relevant external guidance were being appropriately addressed. Mr Wilkie explained that, as part of the audit

approach for the full valuation year, additional work had been undertaken to review the Board's process for appointing a valuer and the basis on which different categories of assets were valued and that audit work would be focused on assessing the judgements applied to asset classification before the detailed valuation was carried out.

Mr McNaught added that the accounting policies had been updated to reflect a full five-year valuation rather than indexation. He added that the valuers had completed their work but had sought clarification on how recent security additions should be categorised, as this affected the overall valuation. Differences of view had been discussed with NHS colleagues, and further clarification had been requested from the valuer, and the Committee would be kept informed once an agreed position was reached, given the potential need for additional audit focus during this valuation year.

Mr Wilkie confirmed that asset classification was a key initial step before valuation and that differences of professional judgement between auditors, management and valuers were not unusual. He added that such judgements would be reported to the Committee, who would then consider the respective views and reach a decision where required.

Mr McConnell thanked everyone for their contribution and noted that it was close to final, with only a minor amendment identified. He added that any further comments or questions from the Committee could be directed through the Chair or the Finance Director.

The Committee:

1. Noted the Audit Risk and Analysis Plan.

15 DRAFT GOVERNANCE STATEMENT

The Committee received the Draft Governance Statement presented by Mr McNaught who outlined the key points and noted that it was presented for comment ahead of finalisation for the Annual Report and Accounts. He explained that Board members' interests and land values would be updated once outstanding work, including the five-year valuation, was completed. Mr McNaught highlighted that references to the funding risk for the Women's Service would be amended as clarity emerged, while risks were reported at 31 March 2026. The replacement of the Risk Management System (Inphase) was noted, along with the inclusion of internal audit outcomes, including one high-rated action. Overall, only minor updates were expected before signing. He highlighted that, from a non-executive perspective, the governance statement appropriately summarised the Board's key activities for the year and confirmed that this section had been reviewed by the Head of Corporate Governance/Board Secretary to ensure all significant activities were accurately captured.

Mr McConnell thanked Mr McNaught for the report and acknowledged that it was helpful to receive it at this stage to allow sufficient time for consideration ahead of the final accounts.

The Committee:

1. Noted the Draft Governance Statement and the proposed updates for the final version.

16 REVIEW OF ACCOUNTING POLICIES

The Committee received the Review of Accounting Policies presented by Mr McNaught who noted that there were no significant changes to the policies. He highlighted that the only update related to reflecting the current five-year valuation rather than indexation, and confirmed that the valuation was largely complete, with final figures to be updated once outstanding discussions were concluded.

Mr McConnell thanked Mr McNaught for the update and opened for questions.

Ms Radage queried whether the reference to IFRS 14 (Page 1) being applicable from January 2016 was correct. Mr McNaught confirmed the date was correct, but he would clarify if there was still a requirement for the disclosure to be included the before the accounting policies were finalised.

Action: R McNaught

The Committee:

1. Approved the Review of Accounting Policies subject to the proposed updates.

17 ANNUAL REVIEW OF STANDING DOCUMENTATION

a) **Scheme Of Delegation**
b) **Standing Financial Instructions**

The Committee received the Review of Scheme of Delegation and Standing Financial Instructions presented by Mr McNaught who confirmed that no updates were required to the Standing Documentation under the Scottish Public Finance Manual or NHS Finance guidance. He explained that, despite rising prices, approval thresholds would remain unchanged for the current year while the Scottish Government procurement thresholds were under national review. Minor updates were noted to the Scheme of Delegation to reflect current Committee titles and governance arrangements, and the revised Scheme of Financial Instructions were for approval prior to submission to the Board in April.

Mr McConnell thanked Mr McNaught for the update and opened for questions. Ms Radage commented that it was helpful to review the documentation periodically and was reassured that financial authority limits were being reviewed by the Scottish Government, particularly in light of wider cost-of-living increases.

The Committee:

1. Approved the review of the Scheme of Delegation and the Standing Financial Instructions, for onward submission to the Board for its approval.

18 REVIEW OF BOARD STANDING ORDERS AND CODE OF CONDUCT

The Committee received the Review of the Board Standing Orders and Code of Conduct presented by Ms Smith who confirmed that the Board Standing Orders and members' Code of Conduct remained aligned with national guidance and required no changes. She remarked that, despite wider pressures reported by other Boards, she felt assured about the Board's position and asked the Committee to endorse the documents for submission to the Board the following month.

The Committee:

1. Approved the Review of Board Standing Orders and Code of Conduct, for onward submission to the Board for its approval.

19 REVIEW OF COMMITTEE TERMS OF REFERENCE

Ms Smith presented the review of the Committee Terms of Reference and confirmed that there were no proposed changes and advised that assurance could be taken from the committee's ongoing performance and self-assessment, which informed its annual report to the Board. She noted that the Chair of the Committee was due to stand down later in the year and that arrangements were in hand to appoint a new Chair and address the upcoming non-executive vacancy. The Committee was

asked to note this position and endorse the terms of reference for inclusion in its annual reporting to the Board.

The Committee:

1. Endorsed the Committee's Terms of Reference for inclusion in its annual report to the Board.

20 SECURITY, RESILIENCE, HEALTH AND SAFETY OVERSIGHT GROUP

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

Mr McConnell thanked Mr Hardy and noted the Committees' appreciation for the work undertaken.

The Committee:

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

21 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.

Mr McConnell thanked Mr McNaught and noted the Committees' appreciation for the work undertaken.

The Committee:

1. Noted the Finance, eHealth and Audit Group Update.

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

Mr McConnell noted that there were no additional issues to be shared with other governance committees beyond the standing documentation already approved, subject to final Board approval.

23 ANY OTHER BUSINESS

There was no other competent business noted.

24 DATE OF NEXT MEETING

The next meeting would take place at 09:00 on Thursday 18 June 2026.

The meeting ended at 11:29