THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

BOARD MEETING
THURSDAY, 27 AUGUST 2026

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THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 26/04**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 18 June 2026

This meeting took place by way of MS Teams and commenced at 12.30pm.

Chair:	Brian Moore
Present:	
Employee Director	Allan Connor
Non- Executive Director	Stuart Currie
Chief Executive Officer	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Finance and eHealth Director	Robin McNaught
Non- Executive Director	Pam Radage
In attendance:	
Acting Director of Security, Estates & Resilience	Allan Hardy
Head of Communications	Caroline McCarron
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minute]
Consultant Psychologist	Dr Louise Tansey [Item 7]
Programme Director	David Walker [Items 7 and 8]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone and noted apologies from Ms Cathy Fallon and Ms Shalinay Raghavan (Non-Executive Directors) as well as Professor Lindsay Thomson (Medical Director) and Dr Joe Judge (Clinical Forum Chair).

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 16 April 2026 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minutes of the meeting held on 16 April 2026.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the rolling action list (Paper No. 26/35) and were content with the updates provided, with consideration as to whether item 4 required any further clarification.

The Board:

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

5 CHAIR'S REPORT

Mr Moore advised that following the recent parliamentary election, he and Mr Jenkins had attended a briefing session with Scottish Government colleagues. The session had included discussion of the new Government's first 100-day priorities, health and social care commitments, and the restatement of operational priorities for 2026–2027. He noted that several of these priorities had been relevant to the State Hospital, including digital access and modernisation, becoming a population health organisation, and improving support and services around mental health. He indicated that there would be opportunities to revisit these matters at the forthcoming Board Development Session.

Mr Moore also reported that he had attended and observed the patients' 5K outdoor run, which he described as a positive example of the organisation's emphasis on physical activity. He had been pleased to present patients with their awards following the event.

Mr Moore had attended the Clinical Forum with Ms McCaffrey to discuss the response to the Forum's letter regarding daytime confinement. He noted that this issue was already included on the agenda, and said that he considered the meeting to have been positive and helpful. He suggested that the original letter and his response should be shared with Non-Executive members to provide further context.

Action – Ms Smith

He also reported that he had attended a Board Chairs' Group on 25 April, where there had been discussion about the proposed process for becoming a population health organisation, and noted that this had been shared with Ms Merson for future consideration. He further advised that Mr McConnell had attended the April Board Chairs' meeting on his behalf and would provide a brief summary of the issues discussed. Mr McConnell noted that the first part of the meeting had focused on the Nursing and Midwifery Services, led by the Chief Nursing Officer, with particular reference to the work of the Nursing and Midwifery Task Force. He advised that the meeting had then moved on to the financial position, with discussion focused on the year-end position and the wider pressures facing NHS Boards. He noted that service pressures, reform and development agendas would remain challenging in the context of national funding prospects, and that new approaches would be required. He further advised that capital investment was expected to remain very constrained, with gaps between available capital resources and planned replacements or developments. The Group had considered whether improved digital development, non-hospital delivery models and wider Once for Scotland approaches could contribute to addressing these pressures.

Mr Moore then provided a further update saying that, earlier in the day, he had attended the Board Chairs' first meeting with the new Cabinet Secretary for Health and Social Care, Ms Angela Constance. Mr Moore advised that a number of key messages had been shared regarding the Cabinet Secretary's approach, including a strong emphasis on delivery and the view that public service reform was necessary rather than optional. He noted that there had also been reference to the new East/West sub-national planning structures, the government's first 100-day commitments and the importance of focusing on outcomes.

He explained that the meeting had included a lengthy discussion on maternity services, which, while not directly relevant to the State Hospital, had raised wider issues around governance and control of services. Lastly, Mr Moore congratulated Professor Lindsay Thomson on receiving the Rudiger Muller Isberner Award in recognition of her contribution to the International Association of Forensic Mental Health.

<u>The Board:</u>

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an overview of his activities since the date of the last Board meeting, including that he had hosted NHS Scotland Board Chief Executives at a national mental health development session on 23 April, which had focused on future priorities and the collective role of Chief Executives and Boards. He advised that a follow-up session with Board Chairs was scheduled to consider how the launch had progressed. He also reported that he had visited Foxgrove, the

adolescent secure service in Ayrshire, describing it as an impressive unit.

Mr Jenkins advised that an incident had taken place at the State Hospital on 24 April and noted that a special Partnership Forum had been held on 5 May to consider the challenges arising from the event, with subsequent focused Directors' meetings intended to help bring related actions to a conclusion.

He also highlighted that a national gold command structure had been established in relation to the current challenges around court assessments and confirmed that the State Hospital had engaged directly with this. He further reported on women's services planning and subsequent discussions with the Scottish Government regarding the funding position. Mr Jenkins also reported on wider national and sub-national planning matters, including the expected circulation of the sub-national committee handbook in July, digital developments such as 'My Care' and discussion of the population health organisation framework.

He advised that the memorandum of understanding between NHS Scotland, the Scottish Prison Service and Integrated Joint Boards had been signed, bringing that matter to a conclusion. He also referred to Scottish Government's first 100 days priorities and the forthcoming Programme for Government. He also referred to a recent session with Police Scotland on mental health, distress and vulnerability prior to hospital admission. He explained that he had been asked to draft a joint commission with Police Scotland for consideration by Board Chief Executives in July, aimed at developing a combined offer to improve support for people experiencing mental health distress.

He concluded by noting that the NHS Board Chief Executives Executive Group had covered service reform, the public health framework and system alignment, and that members had marked Ms Caroline Lamb's final meeting as Director General for Health and Social Care in Scotland.

The Board:

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

7 NATIONAL HIGH SECURE FORENSIC HEALTHCARE SERVICES FOR WOMEN IN SCOTLAND

The Board received a paper (Paper No. 26/36) from the Programme Director in respect of this project, and Mr Walker joined the meeting along with Dr Tansey. Mr Walker introduced the paper and reported that the Women's Project Oversight Board had last met on 28 May and continued to meet bi-monthly.

Mr Walker reported that the medium to long-term plan (Phase 2) had progressed since the previous Board meeting. He advised that the draft feasibility study had been completed and that the Strategic Assessment had been reviewed with NHS Assure. This had subsequently been approved by the Women's Project Oversight Board and by the Corporate Management Team. This was now being presented to the Board for consideration and agreement so that it could be submitted to the Scottish Government Capital Investment Group. Mr Walker advised that there were no particular concerns to highlight in relation to the financial position, and that there had been no changes to the risk register. He noted that stakeholder mapping and communications activity had continued with internal and external stakeholders. He also thanked Dr Tansey and the wider team for the extensive work undertaken, including engagement with other service providers, and highlighted that the proposed outreach model would make a significant difference for women in community and custodial settings.

Dr Tansey provided further background to the above and reported that an extensive consultation process had been undertaken with colleagues from the Scottish Prison Service, medium and low secure services, and community services. She explained that a consistent theme had emerged in relation to women who posed a risk of harm, particularly the presumption against custody for many women and the limited availability of services with expertise in trauma-informed risk management, mental disorder and risk. She noted that, although the consultation had initially focused on medium secure services and the Scottish Prison Service, the needs identified across services had proved to be broadly similar. She advised that there had been strong demand for training on mental health and mental disorder among this group of women, particularly for staff whose professional training had not focused on mental health. She explained that services had also sought support in applying

training in practice and in developing psychological formulations to understand risk within this complex group. Given the small numbers of women within individual Health Board or local areas, she considered that the expertise required should be developed and made available nationally rather than locally.

Dr Tansey outlined three main elements of the proposed outreach service. The first related to training, including support for staff without specialist mental health backgrounds, coordination of training across forensic mental health services for women, and the continuation of short continuing professional development events and webinars. The second involved complex multi-agency case discussions for women who posed a risk of harm to others and had mental health difficulties, using risk assessment to support psychological formulation and inform future risk management plans. The third involved more ongoing support to services where risk issues could otherwise act as a barrier to women accessing care, including support for services such as addictions or general adult inpatient services and, where required, more complex risk assessments using structured professional judgement approaches.

She explained that the proposal was for a three-year pilot, which would allow sufficient time to establish training, develop the service, undertake case discussions and risk assessments, and evaluate whether the service had an impact on women's care and risk management plans. She reported that the resource profile was mainly based around clinical psychology, due to the competencies required for psychological formulation, alongside forensic psychiatry and nursing input. She noted that the risk assessment tools required input from clinical psychologists or forensic psychiatrists who were able to use the full tools autonomously.

Mr Moore opened discussions, noting the informative nature of this update which was thorough and which helped to define the rationale for the outreach service proposal. Mr Currie agreed, noting that the focus on patient centred care was heartening. It was helpful to see a practical proposal at this stage that would benefit patient care, and which could be adapted to any future changes. He offered the view that this was a good fit with the national focus on collaborative working, and that the State Hospital could be a leader in the context.

Mr Moore sought to clarify the costs outline of the outreach service, in terms of whether this was additional to the State Hospital's existing budget allocation and if so, how this may impact on other NHS Boards. Mr Jenkins advised that this proposal would be for a service which was hosted by the State Hospital, not part of existing service provision. It was intended to supplement the existing demand, and to challenge the existing inequity of provision and to be a national service. Therefore, the funding required was entirely separate to that of the State Hospital. Mr Moore noted that as such, the service could be hosted elsewhere and that it be essential to establish clear oversight and governance arrangements, should the proposal be successful. Mr Jenkins also noted that the Mental Health Directorate were fully aware of this and had provided the funding to date to support development of the proposal. However, if there was no funding at a national level for the service, it would require to be routed via NHS Scotland Board Chief Executives to consider how funding may be identified from existing Board allocations.

Mr Moore summed up for the Board, with agreement around the table to note the updates provided and to approve the Strategic Assessment and the Outreach Proposal as presented. He also highlighted the effectiveness of the Women's Service Project Oversight Group, chaired by Mr Currie, as well as thanking everyone involved in developing this work. He thanked Dr Tansey for her detailed and helpful contribution.

<u>The Board:</u>

1. Noted the updates provided.
2. Approved the Strategic Assessment for submission to the Scottish Government Capital Investment Group.
3. Approved the Outreach Proposal.

8 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a paper (Paper No. 26/37) from the Programme Director in respect of this project, and Mr Walker provided a high-level summary of the content. He noted that the main

outstanding issue related to cameras affected by a power fluctuation. He recalled that, at the previous Board meeting, the organisation had sought clarity on the nature of the fault and where responsibility for it lay through external expertise. He advised that discussions had since taken place with Securitas, following consideration of the expert report, and that Securitas had accepted that the fault related to the complex configuration of the various power supplies at the base of the camera poles.

Mr Walker explained that Securitas had undertaken to install power supply units to the affected camera poles. However, at the present time, further detail was still awaited in this respect. He advised that the project was not far from practical completion, but that a Project Oversight Board would still be required to confirm that members were content for the proposal to enter the Defects and Liability period. He reported that focused weekly discussions were taking place with Securitas to work through the remaining detail. Once the necessary information had been received, the matter would be taken to the Project Oversight Board for approval and then brought back to the State Hospital's Board. He also confirmed that the financial position remained unchanged, as no work was currently taking place on site and activity was focused on resolving the camera power fluctuation issue.

Mr Moore thanked Mr Walker for this update, noting that the project was nearing finalisation. Mr Currie acknowledged this as well and asked at what point it was likely that practical completion would be reached in terms of the related risk profile. He also put this in the context of the future need to test and update the existing components in the future. Mr Walker underlined the practical component related to power issue, and the way this could be resolved leading to practical completion without risk to the overall security provision. He also noted the business-as-usual security arrangements that would be in place going forward. Mr Jenkins and Mr Hardy supported this, as part of overall physical security audit work.

Mr Moore summarised the discussion and noted the need to consider the lessons to be learned, following completion of this project; as well as the review of the risk assessment which remained an outstanding action to be taken forward.

The Board:

1. Noted the content of the report.

9 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 26/38) 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 highlighting that there had been some positive movement within the risk profile, with two high risks having reduced to medium, while three high risks remained in relation to finance, absence management and workforce demand, which he noted were interlinked to some extent and would need to be considered together in developing solutions. He explained that consequential risk had been added to the paper, clarifying that this referred to the impact on the organisation where risks were not properly understood or managed. He advised that there were ten risks not currently at target, although seven were within the organisation's tolerable level, with the remaining three exceeding that level and corresponding to the high risks identified.

There was agreement that the report presented outlined the current risk profile of the organisation. It was noted that this report had also been reviewed in detail by the Audit and Risk Committee who had been content with the information presented.

The Board:

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

10 ANNUAL REPORT 2025/26: RISK AND RESILIENCE

The Board received a paper (Paper No. 26/39) from the Acting Director of Security, Resilience and Estates in the form of annual reporting in respect of the risk and resilience functions. He advised

that it had been a busy year for the Risk and Resilience team, noting that, although the team was small, it had continued to support a wide range of activity across the organisation and had worked effectively with Board and governance groups. He reported that risk management arrangements had become well embedded and highlighted the transition from Datix to Inphase as a positive development for risk, which had been delivered on time and within budget.

Mr Hardy further advised that changes to the approach to serious adverse events had contributed to a reduction in the relevant risk rating from high to medium over the previous 12 months. He noted that resilience arrangements had remained strong, supported by effective links with partner agencies, and that the organisation had maintained a positive position in relation to health and safety, supported by the Health and Safety Advisor. He acknowledged, however, that incidents had continued to rise and stated that ongoing work would focus on reducing incidents and improving the organisation's understanding of the factors contributing to them.

The Board noted reporting, and thanked the team for its contribution throughout the year.

The Board:

1. Noted the content of the report.

11 FINANCE REPORT

The Board received a paper (Paper No. 26/40) from the Director of Finance and eHealth, presenting the financial position for the current year to 30 April 2026 (Month 1).

Mr McNaught provided a summary overview of the report, and noted that the year-end accounts for 2025/26 were covered under a separate paper for the meeting. He confirmed that the revenue and capital break-even targets had been achieved.

He reported that there was a focus currently on finalising savings plans. He advised that these plans were close to completion and that a substantial proportion of the required savings for the year had already been identified. Mr McNaught explained that there had been a small overspend at the end of the first month, with areas of pressure outlined in the report. He highlighted nursing spend and the Women's Service as particular areas of focus. He advised that discussions had taken place with the Scottish Government regarding funding for the Women's Service, and that confirmation had been received that funding would continue at the previous year's level, with any additional in-year demand to be addressed as it arose.

Mr McNaught also reported that discussions were continuing regarding charges for Northern Ireland, with the organisation was awaiting progress on the service level agreement that had previously been submitted. He advised that the most recent finance meeting with the Scottish Government had noted satisfaction with the organisation's current position, projections and savings plans for 2026/27. He further reported that capital demands were under review against current-year priorities, and that costs arising from the April incident were being finalised, with assurance received that these would be covered separately and would not affect recurring capital demands.

The Board were content to note the update provided.

The Board:

1. Noted the content of the report.

12 ANNUAL REPORT 2025/26: CLINICAL GOVERNANCE COMMITTEE

On behalf of the Committee, Mr McConnell advised that this was the first of the annual governance reports from the main committees and noted that it had been considered by the Audit and Risk Committee earlier that morning before being formally submitted to the Board. He said that it summarised the work of the Clinical Governance Committee during the year, including its role, membership, attendance and the range of matters considered. He stated that the report concluded that the Committee had fulfilled its remit and that effective clinical governance arrangements had been in place throughout the year, providing assurance which would contribute to the wider

collection of assurances considered later as part of overall annual reporting.

Mr Moore noted that the report did not specify any areas of note concern throughout the year, and Mr McConnell concurred but highlighted that this meant that although there had been no issues for formal escalation, the Committee had considered in detail a number of challenging areas across the course of the year. This element of reporting would be re-considered in terms of presentation in the future.

Action – Ms Smith

The Board:

1. Approved the Clinical Governance Committee Annual Report 2025/26

13 DAYTIME CONFINEMENT (DTC) REPORT

The Board received a paper from the Director of Nursing and Operations (Paper No. 26/42) summarising levels of DTC across the hospital, and Ms McCaffrey advised that the report covered the period up to and including 31 May. This showed that levels of DTC had remained high, affecting a significant number of patients. She noted that, since the report had been written, the process mapping exercise had concluded and that the process had been substantially streamlined. This had reduced the number of staff required to participate in daily resource-related meetings and was intended to support a more effective approach. She indicated that the Daytime Confinement Oversight Group would monitor the impact of these changes and that this would be reflected in future reports.

In relation to recruitment, Ms McCaffrey reported that activity had remained positive and that the most recent recruitment campaign had been successful. She stated that offers had been made to a further 13 Band 5 nursing staff, demonstrating continued progress in addressing workforce requirements. She also addressed the impact on patients, noting that 14 complaints relating to DTC had been received during the reporting period. She further advised that she had attended the Patient Partnership Group (PPG) that morning to discuss daytime confinement and other matters, and had requested that regular feedback from the group, supported by the Person-Centred Improvement Team, be included in future reports so that patient experience could be understood beyond the formal complaints process.

Mr Moore acknowledged the proactive work undertaken, but that it was clear that the position was not changing. He referenced the update that had been provided for Non-Executive Directors by Ms Raghavan, who had attended the PPG this month, and which had highlighted the ongoing impacts being experienced by patients. Mr Jenkins noted the work under development currently to develop an interim operating model, to address this challenge, and that further background to this would be brought to the Board Development Session on 23 June, as well as wider proposed changes to existing ways of working within clinical services. He emphasised the need for a revised approach, given the challenges experienced presently and noting the concerns raised through the Clinical Forum as previously referenced in the meeting.

Mr Moore noted the challenges presented and that this was a concern for the Board, and that an interim operating model was underdevelopment, with further updates required to the Board.

The Board:

1. Noted the Daytime Confinement Report, and the challenging position reported.

14 QUALITY ASSURANCE AND QUALITY IMPROVEMENT REPORT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 26/43) and Ms Merson advised that this covered activity during April and May across quality improvement and quality assurance.

She reported that four clinical audits had been completed during the period, three of which had provided significant assurance, while one had provided moderate assurance with an agreed

improvement plan sitting with the commissioning group. She also noted that CPA oversight monitoring had shown some variation in multidisciplinary team attendance and had identified areas requiring improvement, including nursing post-CPA discussions and some professional attendance targets.

She highlighted the TSH 3030 quality improvement workstream as a significant area of activity during the reporting period, with 17 teams having registered. She stated that midway posters had been reviewed and judged, supported by weekly summaries which had provided insight into team progress, and that 11 final posters had subsequently been submitted and judged. Ms Merson further advised that an Oscars event had been planned for the following week to recognise and celebrate the achievements of teams. She reported that quality improvement training had continued, with recruitment under way for QI Essentials starting in September, and that recruitment for the national ScIL training programme had opened, with the intention of putting forward two members of staff. She also noted that four staff were due to attend the Realistic Medicine conference, where one poster had been accepted, and that 29 guidance documents had been reviewed over the previous two months, with five requiring either gap analysis or further action by relevant groups.

Ms Radage provided positive feedback on the TSH3030 project and the way that this was firmly embedded within the organisation, as this helped as a foundational piece for the ongoing culture change programme. She also asked about patient involvement, and Ms Merson confirmed that the PPG had formed a team, and that there were also a number of patients involved across other teams working alongside staff.

Mr Moore noted that the report provided a helpful overview of activity, and asked about the post-CPA nursing discussions and how these were followed up. Ms McCaffrey advised that oversight of this was through Senior Charge Nurses, and that this was an area of focus in terms of the improvement required.

The Board:

1. Noted the Quality Assurance and Quality Improvement Report.

15 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 19 February 2026; as well as a summary report (Paper No 26/44) of the key areas of reporting and discussion at the meeting which had taken place on 14 May 26.

The Board:

1. Noted the approved minutes and reporting.

16 CLINICAL FORUM

The Board received the approved minute of the meeting that took place on 10 March 2026.

Mr Moore highlighted that the minutes included reference to the issues highlighted in the recent letter he had received from the Forum, and had responded to. He also commented more widely on the important role the Clinical Forum played within the governance structure of the Board, and that it was very positive that it had been refreshed recently and was actively engaging with the Board.

The Board:

1. Noted the approved minutes.

17 ANNUAL REPORT 2025/26: STAFF GOVERNANCE COMMITTEE

The Board received the Staff Governance Committee Annual Report (Paper No 26/45) and Ms Radage, as the Committee Chair, advised that the paper reflected a very busy year and demonstrated the significant breadth and depth of areas considered by the Committee. She noted that the report highlighted a number of areas of improvement, the working environment, equalities,

and the work undertaken in relation to the Protecting Vulnerable Groups (PVG) process. She thought that the Committee had demonstrated open and transparent communication throughout the year, with effective links to other standing committees, and she acknowledged the contribution of Mr Wallace and his team in providing succinct papers which had supported meaningful discussion. Ms Radage also thanked all those who had been involved in the work of the Committee during the year.

Mr Currie supported these comments, saying that the Committee had developed well and supported constructive discussion and had shown flexibility in its approach, whilst giving strong oversight on some challenging areas. Mr Moore added his agreement and noted his appreciation to all of those involved.

The Board:

1. Approved the Staff Governance Committee Annual Report 2025/26

18 ANNUAL REPORT 2025/26: REMUNERATION COMMITTEE

The Board received the Remuneration Committee Annual Report (Paper No 26/46) and Mr McConnell advised that the report set out the Committee's role and work during the year, particularly in relation to the performance, pay and conditions of Executive and Senior Managers. He noted that the report also covered membership, attendance and a summary of the matters considered by the Committee throughout the year, and concluded that the Committee had discharged its responsibilities in those areas. Mr McConnell also thanked those who had attended and supported the work of the Committee.

Mr Moore added his appreciation of Mr McConnell's contribution as Committee Chair, and the detailed rigorous approach taken, and Ms Radage concurred noting that it had been helpful to received national feedback and benchmarking in terms of the Executive and Senior Manager pay, which supported the approach taken.

The Board:

1. Approved the Remuneration Committee Annual Report 2025/26

19 STAFF GOVERNANCE REPORT

The Board received a paper (Paper No 26/47) from the Director of Workforce which provided an overview of workforce performance across key staff governance indicators.

Mr Wallace provided a high-level overview of the key areas of focus within the report, noting that sickness absence had increased slightly in May, with a rise of 0.25%, and emphasised the importance of understanding the reasons behind peaks and troughs rather than reacting disproportionately to short-term changes. He stated that the team's focus had been on preventing short-term absence from becoming long-term absence and on maintaining efforts to reduce absence overall. Mr Wallace highlighted that, in the national context, the organisation's absence position had improved, with performance moving ahead of some territorial Boards. He acknowledged that the projected position had not been included in the report and indicated that this would be addressed at the next Staff Governance Committee meeting. He also advised that anxiety, stress and mental health remained areas of significant focus, as these continued to feature in both short and long-term absence. He noted that the organisation had an established pathway in place and that the post of Staff Care Specialist had been recruited to recently to support work in this area.

Mr Wallace reported that recruitment remained within key performance indicators, with nursing continuing to be the main focus. He noted the success of the Careers Fair held on 10 June and advised that, since the start of the year, 27 nursing appointments had been made across Bands 3 and 5, which represented significant progress. He further advised that employee relations activity remained low, although there continued to be challenges in concluding cases as timeously as desired. He highlighted that staff turnover remained below the national average, while Working Time Regulation breaches continued to present a challenge, particularly in relation to nursing, although these appeared to be plateauing and reducing. He concluded by noting that PDPR compliance had increased slightly to 87%, which was a positive position, and that although the organisation

continued to aspire to performance above 90%, it remained ahead of the national target of 80%.

There was discussion on sickness absence levels with some areas demonstrating positive improvement, whilst others remained of significant concern. Mr Wallace confirmed that movement in the reporting data were closely reviewed for any action required, or lessons learned, and the Board acknowledged these efforts.

The Board:

1. Noted the content of reporting.

20 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 12 February 2026; as well as a summary report (Paper No 26/48) of the key areas of reporting and discussion at the meeting which had taken place on 21 May 26.

Ms Radage noted that it had been helpful for the Committee to review health dashboards at its May meeting, as these were shared with managers and supported them in managing their teams. She also welcomed the discussion on succession planning and the Equalities Action Plan. She further noted the work being undertaken by Mr Wallace and his team on absence forecasting and commended the innovative approaches to recruitment, including same-day interviews, which were intended to support the continued appointment of high quality staff.

The Board:

1. Noted the content of the minutes and reporting.

21 ANNUAL REPORT 2025/26: AUDIT AND RISK COMMITTEE

The Board received the Audit and Risk Annual Report (Paper No 26/49) and the Committee Chair Mr McConnell highlighted the way in which this formed part of the wider suite of annual committee reports, alongside those for the Remuneration, Staff Governance and Clinical Governance Committees.

He said that the report set out the Committee's role, purpose, membership, attendance and the range of work undertaken during the year, and concluded that the Committee had fulfilled its remit. He noted that the report also confirmed that adequate and effective audit and risk governance arrangements had been in place throughout the year, which he described as a key conclusion. Mr McConnell thanked Mr McNaught as well as all of the Directors who had contributed, and their teams for their work. He also thanked the internal and external auditors for their reports and contributions throughout what had been a very busy and successful year.

The Board:

1. Approved the Audit and Risk Committee Annual Report.

22 REPORT ON THE ANNUAL ACCOUNTS 2025/26

The Board received a paper (Paper No 26/50) reporting on the position for the 2025/26 year. Mr McNaught presented the content to the Board and advised that the cover paper confirmed that the Annual Accounts had received an unqualified audit opinion from the external auditors, KPMG. He reported that the accounts had been approved at the Audit and Risk Committee meeting held earlier that morning and were being presented to the Board for adoption. Mr McNaught explained that the paper also referred to the governance statement and the statement of Board members' responsibilities. He noted that the Audit and Risk Committee had responsibility for reporting to the Board that the accounts should be adopted, that it was on this basis that the Board was therefore being asked to provide the appropriate authority for the accounts to be signed by the Chief Executive and the Director of Finance and eHealth, alongside the external auditors. He thanked the external auditors as well as the Finance Team for all of the work they had undertaken throughout this process.

Mr Moore commented on the performance report and highlighted a number of key achievements, including progress in relation to the Women's Service, the emphasis on collaboration, and the achievement of savings of 3.9%, which exceeded the 3% target set for the organisation. He noted the report's reference to improvements in operational productivity and stated that this would remain an important area of focus going forward. He also observed that the Annual Accounts had highlighted some of the pressures facing the organisation, and welcomed the emphasis on reform throughout the document. He also highlighted the key challenge faced given that approximately 85% of the overall budget related to staffing costs meaning that there was limited opportunity to achieve savings and as a result, there would be a need to review the overall operating model. He also complimented the work undertaken by the Finance Team, and thought that the performance report and governance statement were well presented, and also indicated future projections.

Mr McNaught added that the key message was the organisation's achievement of its three financial targets in relation to revenue spend, savings and capital. Mr McConnell echoed the comments made at the Audit and Risk Committee earlier that morning and noted that it was positive to have reached the stage of signing off the accounts on time, having achieved all resource limits and other targets. He expressed his thanks to Mr McNaught and the wider team for the work undertaken, and also acknowledged the contribution of both the internal and external auditors, who had supported and reported on these activities. He concluded by recognising the collective effort that had enabled the organisation to reach this stage successfully. Mr Jenkins advised that he would write to the Deputy Director of Finance to express his thanks, especially as she had been recently appointed to this role.

Mr Moore noted that the Board was being invited to consider the recommendation set out in reporting.

The Board:

1. Adopted the Annual Accounts for the year ended 31 March 2025 and approved submission to the Scottish Government Health and Social Care Directorate.

2. Authorised: (a) the Chief Executive to sign the Performance Report (b) the Chief Executive to sign the Accountability Report (c) the Chief Executive and Director of Finance and e-Health to sign the Statement of Financial Position

23 PATIENTS FUNDS ACCOUNTS

The Board received a paper (Paper No 26/51) from the Director of Finance and eHealth, and Mr McNaught noted that the organisation held a significant amount of money on behalf of individual patients, with the balances reflecting patients' collective funds. He advised that, due to the nature of these accounts, an independent annual audit had been undertaken by Wylie and Bissett, who had provided an unqualified opinion on the figures. He noted that fluctuations in the amounts held reflected the different sums received by individual patients, including weekly benefits and occasional family monies. He stated that, following the unqualified audit clearance, the Board was asked to support the Audit and Risk Committee's recommendation that the Chief Executive and the Director of Finance and eHealth be authorised to sign the statements alongside the external auditors.

The Board:

1. Approved the signing of the summary patient funds accounts by the Chief Executive and the Director of Finance and eHealth.

24 ANNUAL REPORT 2025/26: PERFORMANCE AND ANNUAL DELIVERY PLAN (ADP)

The Board received a paper (Paper No 26/52) from the Head of Planning, Performance and Quality which provided an overview of performance against agreed 12 organisational key performance indicators (KPIs) as well as a progress against the ADP over the course of 2025/26. Ms Merson summarised the content explaining that, as this was the annual report, performance was shown as a comparison against the previous four years to allow the Board to consider trends over time. She noted that there had been sustained green performance across a number of key indicators, but

there had nevertheless been deterioration in some KPIs with three sitting at red and two at amber. She highlighted that the quarterly RAG status showed a deterioration across the year, particularly between quarters one and four. She highlighted these, providing further context and background in this regard.

Ms Merson then outlined progress against the ADP 2025/26 which represented year one of the Medium-Term Plan (MTP). She reported that there had been 83 Board actions across the critical success factors and main themes with 90% rated green, 10% rated amber and none rated red. She noted that there had been some slippage during the year, with amber actions increasing from 5% in Q1and Q2 to 10% in Q4. She highlighted that improving patient outcomes from the clinical care experience was a significant part of the plan, and advised that the amber areas related to matters already recognised by the Board, including the elimination of daytime confinement which had been affected by operational resource pressures.

Mr Moore welcomed the report on behalf of the Board, and it was noted that the issues highlighted were areas in which the Board received regular reporting in terms of the associated risks, and improvement work underway.

The Board:

1. Noted the content of the report.

25 ANNUAL AND MEDIUM-TERM PLANNING

The Board received a paper (Paper No 26/53) from the Head of Planning, Performance and Quality which provided an overview of the ADP for 2026/27 which represented year two of the MTP and translated that plan into phased delivery. Ms Merson provided an overview of the key points, explaining that whereas year one had focused largely on planning and implementation, year two would begin to embed a number of activities. She reported that the plan had been developed by asking teams to review progress against year one of their three-year plans and to update their planned activity for year two. She noted that most teams' plans had remained consistent with their original intentions, with only limited slippage in some areas. She emphasised that the process had helped to maintain a clear connection between the ADP and local team development.

Ms Merson stated that the plan provided a line of sight between the organisation's aims and the national reform framework, including service renewal and population health frameworks. She confirmed that, although the ADP would not receive formal sign-off from the Scottish Government due to evolving national planning arrangements, it had been presented to the Mental Health Policy Unit and would be monitored through existing sponsorship arrangements. She added that the Mental Health Policy Unit had recognised that the plan reflected the expected delivery priorities, aligned with the MTP and provided a coherent strategic direction based on the organisation's critical success factors and strategic pillars. She also highlighted a number of key themes within the plan, including national and sub-national planning arrangements, collaboration across the forensic system, and the need for flexibility as those arrangements developed. She advised that continued focus would be given to improving patient outcomes and clinical care, including the reshaping of two hubs into hub-based working, and review and monitoring of the operational model. She also noted that patient activity levels, mental wellbeing and access to activities supporting progression would continue to be monitored, alongside the introduction of the new Physical Health Strategy and work to address inequalities in health and patient outcomes.

Ms Merson further advised that the plan recognised the strategic significance of the Women's Service, noting the detailed reporting at this meeting in this regard. She concluded that the plan reflected national priorities and policy direction while setting out a comprehensive programme of delivery across clinical transformation, quality improvement, workforce and organisational development, and noted that progress would be reported quarterly during the year.

Mr Moore commented on the way in which the ADP helped to focus on key workstreams for the next year, as well as giving a sense of the progression being made. It was helpful that it was placed within the context of the wider public services reform agenda. He asked for clarification on the likely timescales for progressing implementation of the Structured Clinical Care proposal, and Ms Merson provided feedback that this was an ambitious plan being led through the Mental Health Practice

Steering Group and required further development in terms of current readiness to bring it to fruition. Mr Jenkins added that it would be helpful if the group provided quarterly planning reporting to define their aims in this respect.

Mr Moore also asked about the section on unscheduled care and the further opportunities indicated to link to the Flow Navigation Centre in NHS Lanarkshire, and referred to how the principles of Hospital at Home and the changes being made to emergency care nationally, could be adopted within the State Hospital. Mr Jenkins noted that although virtual beds were not yet a realistic function, some components like remote monitoring were underway and that this was a positive development.

The Board:

Noted the content of the approved minutes of the

26 BOARD IMPROVEMENT PLAN

The Board received a paper (Paper No 26/54) from the Head of Corporate Governance and Ms smith provided an overview of the key points. She said that the report provided an update on the Board Improvement Plan, which had been developed in 2024 following a self-assessment exercise. She further noted that, more than two years on, significant progress had been made against the plan

Ms Smith highlighted that risk had been a recurring theme throughout the day's discussions and stated that progress had been made in embedding consideration of risk across the organisation's governance structure. She reported that considerable stakeholder engagement had taken place over the previous 24 months across a range of workstreams, including the Women's Service, the Carers' Strategy and recruitment activity. She said that, although this work had progressed well, the organisation had not previously had a formal stakeholder map. She advised that the stakeholder map included at Appendix 2 followed the national template and provided a structured tool for assessing stakeholder influence and impact, which could be embedded into future workstreams to support informed decision-making. Ms Smith further advised that the remaining areas of the plan reflected work recently considered by the Staff Governance Committee, including culture change and succession planning.

She concluded that the current Improvement Plan was now reaching the end of its useful life and suggested that the Board should consider its future approach to self-assessment and the development of a new improvement plan, taking account of any emerging national direction. Mr Jenkins added his agreement and noted some work was progressing through the auspices of the Board Development Team within Public Delivery Scotland presently.

Mr Currie reflected on the changes expected across NHS Scotland through the reform agenda, and that this may impact the skills and experience required of Board members, especially given the fast-paced change coming in technology and innovation. There may be a recalibration of risk appetite within Boards as a result of this. Mr Moore agreed and noted the changing governance landscape which was likely to develop. Ms Radage commented positively on the report which helped to support reflect on the progress already made, as well as future aims. It was agreed that the Board would link with the emerging national position to take forward future self-assessment and related improvement planning.

The Board:

1. Noted the content of reporting.

27 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 26/55) of the key areas of reporting and discussion at the meeting which had taken place on 19 March 26. As Committee Chair, Mr McConnell advised that the key matters considered at the 19 March meeting had included an internal audit report on resilience planning and training, which had received a positive rating of reasonable assurance, the draft

Annual Internal Audit Assurance Report, the Internal Audit Plan for 2026/27 and the External Audit Plan. He further advised that the Committee had received its standard suite of updates, alongside a range of matters preparatory to the Annual Accounts process. Mr McConnell also reported that the Committee had met earlier that morning and had received an internal audit report on Freedom of Information and Subject Access Requests, which had also received a positive conclusion of reasonable assurance. He noted that, alongside other standing matters, the Committee had considered the range of reports and assurances relating to the Annual Report and Accounts, which had been brought forward to the Board as part of the business considered at the meeting.

The Board:

1. Noted the approved minutes and verbal update.

28 ANY OTHER BUSINESS

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

29 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 27 August 2026.

30 CLOSE OF MEETING

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

The meeting ended at 3.05pm

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 as part of Corporate Risk Register	A Hardy	August 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 2026:** project still ongoing and progress and action to be considered at completion. **April Update 2026:** project completion is imminent and action to be completed thereafter. **June Update 2026:** Await practical completion – anticipated late June. **August Update 2026:** project has reached practical completion and reporting on agenda outlining next steps

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
2	December 2025	Patient Advisory (PAS) 12 Month Report	Provide feedback if possible on how advocacy services operate at other UK Sites	K McCaffrey	December 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 **August Update:** Will be included in reporting in next 12 month report
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	October 2026	**April Update:** Discussed at Board Development Session in March 26, with further areas of review outlined in respect of risk appetite and approach, going forward. To return to development session.
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. Action reviewed and no further clarification required. **CLOSE ACTION**

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
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. **CLOSED**
6	June 2026	Chair's Report	Circulate Clinical Forum letter and Chair's response	M Smith	Immediate	**August Update:** circulated as required. **CLOSED**
7	Annual Report	Clinical Governance Committee Report	Review how to present areas of challenge for escalation that have been considered through year	M Smith/ Secretariat/ Clinical Eff. Lead	Immediate	**August Update:** highlighted to clinical effectiveness lead as well as secretariat to ensure change is included in future meeting minutes and in future annual reporting. **CLOSED**

Last updated – 19.08.26 MS

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 8
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.

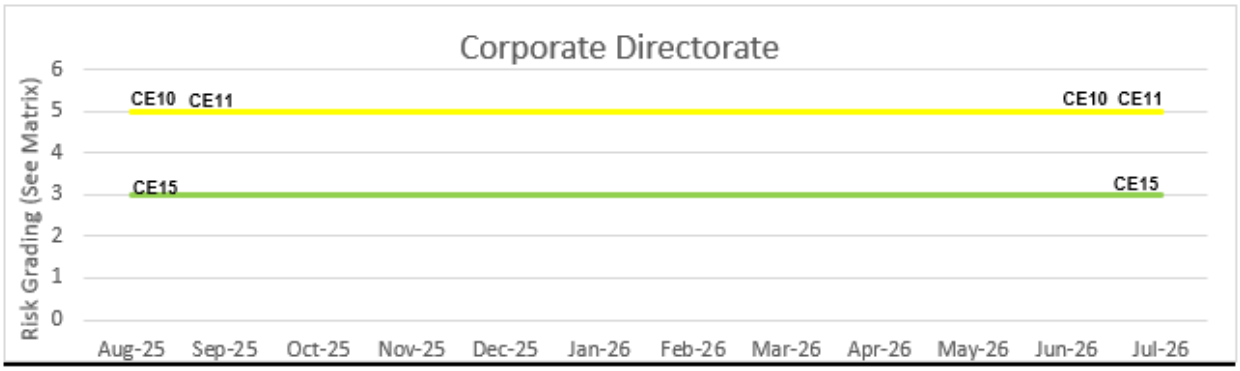
3.3.1 Risk Matrix

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

3.3.2 Corporate

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

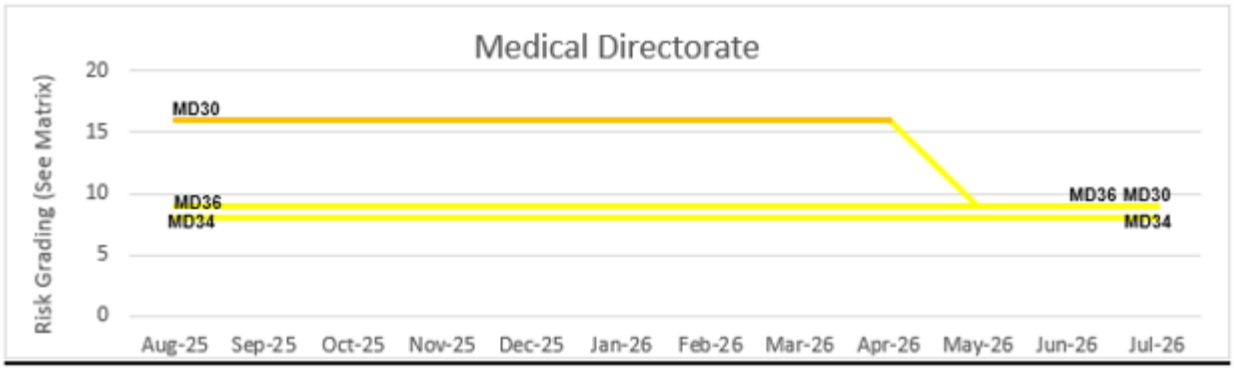


Risk key

CE10 Severe Breakdown in Corporate Governance
CE11 Risk of patient injury occurring which is categorised as extreme injury or death
CE15 Risk of patient injury occurring which is categorised as extreme injury or death

3.3.3 Medical

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

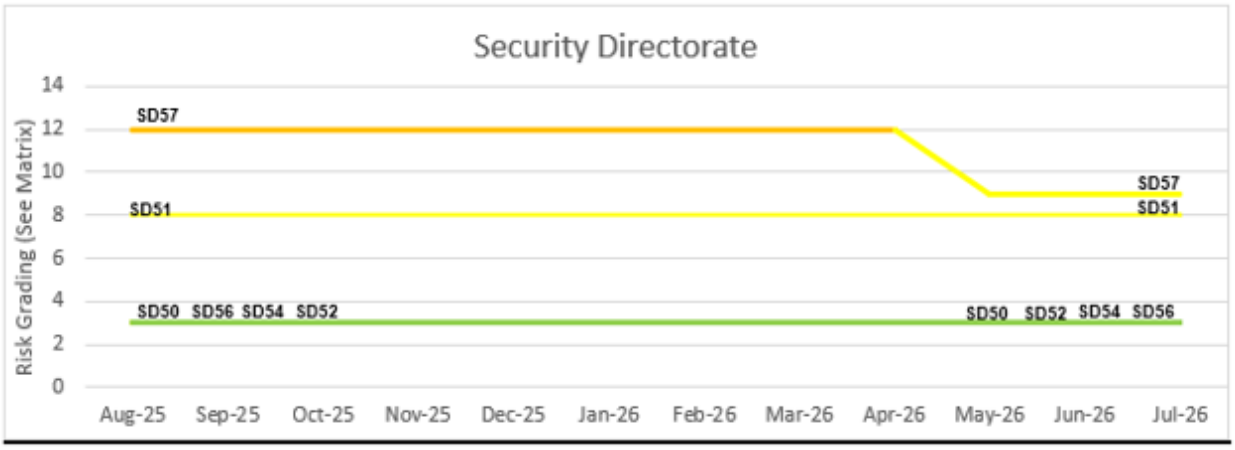


Risk key

MD30 Failure to mitigate excessive weight gain
MD34 Lack of out of hours on site medical cover
MD36 Impact on patients within Female Service if long term model is not fully implemented

3.3.4 Security

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

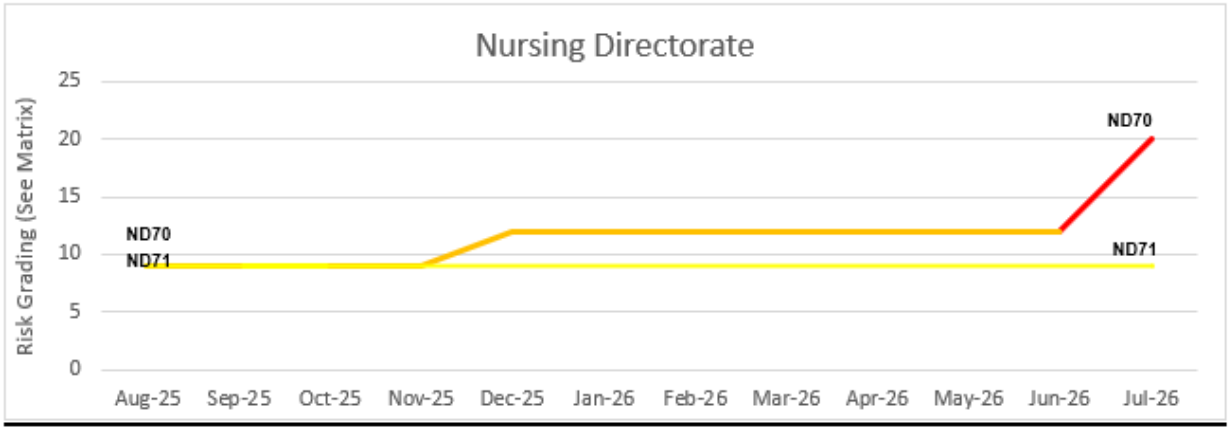


Risk key

SD50 Risk of Serious Indiscipline, Security Incident or Breach of Security
SD51 Major or Extreme Failure of Physical or Electronic Security System
SD52 Resilience Arrangements are not fit for purpose
SD54 Implementing Sustainable Development in Response to the Global Climate Emergency
SD56 Water Management
SD57 Failure to complete Adverse Reviews within timescale

3.3.5 Nursing

ND70 has been reviewed and is now graded as Major x Almost Certain giving a 'Very High' rating. Full details on the changes in section 3.5. This risk rating was upgraded as of the 31st July 2026.

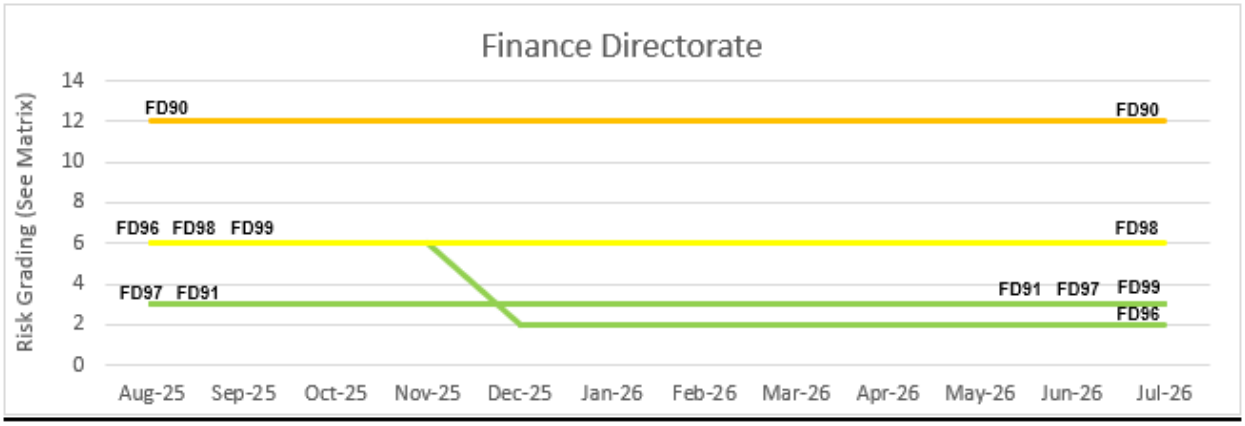


Risk key

ND70 Failure to utilise our staffing resources to optimise excellent patient care and experience
ND71 Serious Injury or Death as a Result of Violence and Aggression

3.3.6 Finance

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

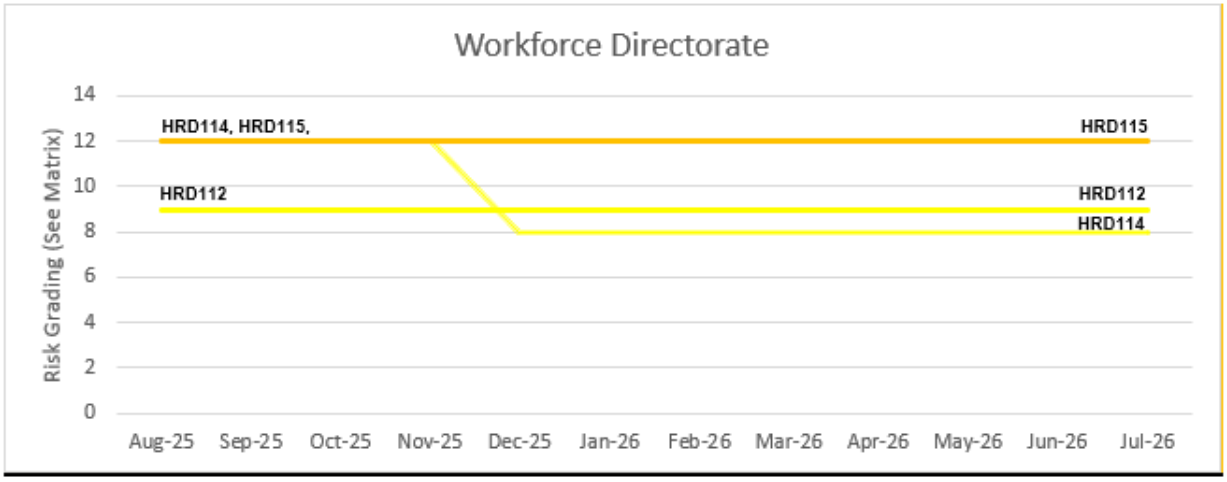


Risk key

FD90 Failure to implement a sustainable financial model
FD91 IT System failure
FD96 Cyber Security Breach
FD97 Management of unmanaged devices accessing TSH data
FD98 Information Governance – Failure to comply with statutory requirements
FD99 Compliance with NIS Audit

3.3.7 Workforce

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



Risk key

HRD112 Compliance with Mandatory PMVA Level 2 Refresher Training
HRD114 Impact of Reduced Working Week
HRD115 Sickness Absence Levels within TSH increase above acceptable levels

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 1 “Very High” rated risk and 2 ‘High’ graded risks. Updates on the progress to reduce from High and Very High are outlined in this section.

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.

3.5.1 Very High

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

Following review of recent data and current staffing pressures, this risk has been escalated to “Very High”. This reflects the scale of current organisational staffing challenges. DTC is now at its highest level since recording began. Increased complaints and wider operational resilience pressures further support the need to raise the risk rating.

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 well above the funded establishment and has remained over the funded establishment since August 2025. Ongoing vacancies further exacerbate these challenges. Recruitment efforts are ongoing, with approval granted to over-recruit nursing staff by up to 5% of the funded establishment. Additionally, initiatives are in progress to address broader issues related to gender and clinical acuity.

An action plan has been developed to manage and monitor the increased risk rating. This will support oversight during this challenging period and help reduce the risk to an acceptable level in a timely manner. The action plan focuses on the following areas:

- Introduction of Interim Operating Protocol.
- Introduction of Clinical Operations Group (COG). Group is referenced in the Interim Operating Protocol.
- Further development of the Daily Site Safety Meeting is ongoing.

Consequential Risk

Failure to effectively utilise hospital resources may result in reduced quality of patient experience. Additionally, there is an increased risk of adverse events, complaints, and restrictive practices, with associated impacts on patient 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. 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.

3.5.2 High

FD90 - Failure to implement a sustainable long-term model

FD90 reflects ongoing national financial challenges and expected budget constraints from the Scottish Government for 2025/2026. Quarterly meetings with the Scottish Government and monthly internal reviews are in place. Recurring funding for women's service remains a risk, so the overall risk level still remains 'High'.

Consequential Risk

Reliance on non-recurring savings and constraints on service capacity, reducing the organisation's ability to deliver safe, effective and sustainable care. Although funding has been agreed to for Women's Service there remains a significant shortfall in the baseline funding compared to the current run-rate of the staff required. This shortfall increases the reliance on short-term measures like the interim operating model and causes disruption the other male wards.

HRD115 - Sickness Absence

HRD115 remains at 'High'. Despite sustained improvement over the last 12 months (a 1% reduction), there has been a recent spike in absence (linked to nursing and in particular long-term absence). We continue to proactively manage absence and are working to see a reduction in the next few months (in advance of winter).

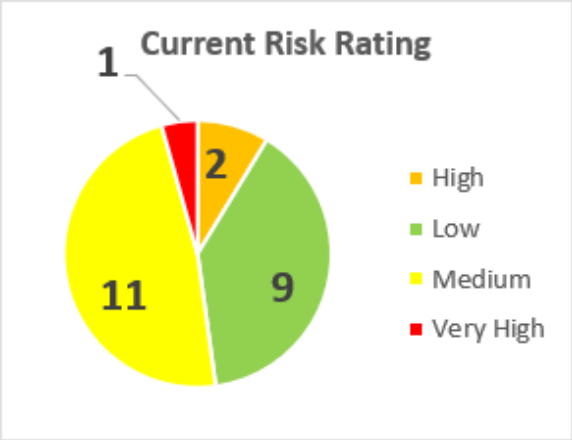
Focused work will continue to reduce the absence baseline.

Consequential Risk

Persistent sickness absence above target is weakening workforce resilience, increasing operational and financial pressures, and driving reliance on supplementary staffing and overtime.

Mitigating the risk would support safe staffing, improve patient experience and continuity of care, enhance staff wellbeing and morale, reduce operational and financial pressures.

3.6 Risk Distribution



Currently 13 Corporate Risks have achieved their target grading, with 10 currently not at target level. Note that only three 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 point 3.5.2.

- **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: recruitment plan has commenced but this will take time to introduce, also the current impact the Interim Female Service is having on the wider hospital population. When 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. The risk is also being reviewed to embed areas of risk that have been passed over post project. The risk will be fully reviewed and rewritten to reflect the new BAU systems.

- **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 meet the criteria of a 'Moderate' impact within the risk matrix.

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, 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 is due to ongoing attempts to backfill vacancies, 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				ND70	
Likely				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

3.6.1 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 currently being tested on the system.

The Risk and Resilience Department reported capacity pressures at the last Directorate Performance Meeting. The team is currently managing five Significant Adverse Event Reviews, which have substantially increased workload. Given the nature of these reviews, they are being prioritised over planned development work. The team is also operating within a temporary structure, which has further reduced capacity.

The Chief Executive has approved contact with other Boards to seek support with outstanding development work on the Corporate Risk Register and Local Risk Register. Initial contact has been made with the National Risk Group.

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).	There are no privacy implications (1).

APPENDIX 1

Very 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 ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Major x Almost Certain	Major x Almost Certain	Minor x Likely	Director of Nursing, AHP and Operations	Director of Nursing & AHP	Aug 26	Clinical Governance Committee	Clinical Governance Group	Not at Target

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	Aug 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	Aug 26	Staff Governance Committee	Workforce Governance Group	Not at Target

Medium Risks – Reviewed 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

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	Governance Group	Target Level Achieved
Corporate MD36	Medical	Impact on patients within Female Service if long term model is not fully implemented	Major x Likely	Moderate x Possible	Minor x Rare	Medical Director	Lead RMO – Female Service	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
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 Six 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
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 & Performance 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 Performance Director	Head of eHealth	Dec 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 Performance 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 Performance Director	Head of eHealth	Dec 26	Audit and Risk Committee	Finance, eHealth and Audit Group Audit and Risk Committee	At Target

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 9
Sponsoring Director:	Acting Director of Security, Resilience and Estates
Author(s):	Acting Director of Security, Resilience and Estates Programme Director
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1 SITUATION

The Perimeter Security and Enhanced Internal Security Systems Project was formally completed on 30 June 2026 with the Defects and Liability (D&L) period of two years commencing immediately thereafter. This paper provides updates on the outstanding works deferred to the D&L period, the post project evaluation as set out in the Scottish Capital Investment Manual, the post project governance arrangements for the D&L period and the financial position at completion.

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 (POB) met on 2 July 2026 where updates were provided on the project completion process, post occupancy evaluation arrangements, and the works to be carried out during the defects and liability period.

3 ASSESSMENT

3.1 General Project Update

The project was formally completed by Thomson Gray, on behalf of the State Hospital on 30 June 2026. The three remaining works to formally complete are:

- F2K Cameras.
- Water ingress to Cable Ducts.
- Cameras affected by power fluctuations at generator tests.

Works on these outstanding matters commenced on 27 July 2026 and are expected to be completed by early 2027 as all works are subject to weather conditions.

3.2 Governance Arrangements

At the meeting of 2 July, the POB finalised all outstanding actions and agreed that all risks had achieved target grading. The post occupancy evaluation required as part of the Scottish Capital Investment Manual (SCIM) process was outlined. The Board will be kept updated on progress.

The 'Business As Usual' arrangements were also outlined with two fortnightly meetings taking place, one to monitor progress against the outstanding works and the second to oversee the ongoing maintenance and any defects during the D&L Period.

As there were no further actions or outstanding works to oversee the Project Oversight Board was formally closed and all members thanked for their participation.

3.3 Defects and Liability Period/Maintenance

The D&L period of two years begins on the award of completion. A defect is defined in the contract as:

- *A part of the works which is not in accordance with the Works Information or*
- *A part of the works designed by the Contractor which is not in accordance with the applicable law or the Contractor's design which the Contractor Project Manager has accepted.*

A defect is anything that does not meet what was asked for, is contrary to legislation or is contrary to the designs that the contractor provided and accepted by the State Hospital. As regards the contractor's response to a defect:

"The Contractor corrects a notified Defect before the end of the Defect correction period (24 months). The Defects correction period begins at Completion for the Defects notified before Completion and when the Defect is notified for other Defects."

Any other issues that are identified throughout the two-year period will be raised through the appropriate contractual mechanisms and escalation routes.

3.3.1 Maintenance

In addition to the D&L period of two years, Securitas are also contracted to provide maintenance for the two years following completion, either directly or by the installer / manufacturer. On call arrangements and an embedded engineer based on site have been provided to ensure that a prompt response takes place in line with the agreed response times.

3.3.2 Next Steps

A Post Occupancy Evaluation meeting has taken place, and the draft report is being finalised for review and comment by the Corporate Management Team. The final report will be presented to the Board at the next available meeting.

3.4 Finance – Project cost

The contract with Securitas has underspent 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. The overspend is entirely composed of State Hospital costs for Lead Advisors, management, and escort staff.

The key project financial outline at 26 June 2026, prior to finalisation of all accounting is:

Project Start Date	April 2020
Planned Completion Date	May 2022
Contract Completion Date	June 2026
Main Contractor	Securitas Technology Limited
Lead Advisor	Thomson Gray
Programme Director	Doug Irwin
Total Project Cost Projection (Exc. VAT) at 26/06/26	£9,997,128
Total costs to date (exc. VAT & retention) at 02/04/26	£9,991,505

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

3.5 Corporate Risk Register

Considering practical completion, the Acting Director of Security, Estates and Resilience has commenced a review of the corporate risks relevant to the systems and components introduced during the period of the project. Any updated risks will be highlighted in the Corporate Risk Register paper.

4 RECOMMENDATION

The Board is invited to note completion of 'The Perimeter Security and Enhanced Internal Security Systems Project' and the post project arrangements.

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	**Better Value** 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)	As the project has now reached practical completion the previous increased financial risk as a result of delays has now been mitigated.
Assessment of Impact on Stakeholder Experience	N/A.
Equality Impact Assessment	N/A.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Contract agreement stipulates compliance with Fairer Scotland Duty in respect of the remuneration of staff and contractors.
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	There are no privacy implications (1).

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 10
Sponsoring Director:	Chief Executive
Author(s):	Head of Corporate Planning, Performance and Quality Corporate Planning, Performance and Quality Project Support Manager
Title of Report:	Performance and ADP Report - Quarter 1 2026/27
Purpose of Report:	For Noting

1 SITUATION

This report provides an overview of organisational performance for Quarter 1 (April –June 2026), summarising progress against Key Performance Indicators (KPIs) and the 2026/27 Annual Delivery Plan (ADP) commitments. It highlights performance against the two national standards relevant to the State Hospital these include Psychological Therapies Waiting Times and Sickness Absence alongside additional local KPIs monitored by the Board. Performance and delivery remain subject to oversight by Scottish Government through the 2026–27 Annual Delivery Plan.

2 BACKGROUND

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

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

3 ASSESSMENT

The following sections contain:

- Quarter 1 KPI data and highlight areas for improvement through an analysis of KPIs that have missed their targets.
- Quarter 1 ADP performance highlights.

4 RECOMMENDATION

The Board has been asked to note the contents of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Monitoring of the State Hospital Key Performance Indicators links to both the State Hospital corporate objectives and the Annual Delivery Plan 2026-2027. The KPIs provide assurance to the State Hospital Board on key areas of performance. Some of the KPIs are national targets which the State Hospital is held accountable for performance nationally, others are local priorities for the State Hospital Board. The Annual Delivery Plan sets out in the State Hospital Board delivery commitments, these are monitored and reported to provide an overview of performance against plan. The State Hospital Performance Framework proves an overview of how performance is managed across the State Hospital. Scottish Government will receive this report following approval from the State Hospital Board as an indicator of the State Hospital performance.
Corporate Objectives **Please note which objective is linked to this paper**	**Better care:** 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. 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:** Tackle and address the challenge of obesity, through delivery of the Supporting Healthy Choices programme. Continued improvement of the physical health opportunities for patients. Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient. Utilise connections with other health care systems to ensure patients receive a full range of healthcare support. **Better Value:** Support quality improvement approaches, embedding a cohesive approach. Ensure the continued delivery and development of the organisation's performance management framework. **Better Workforce:** Continue to support training and development for all staff at every level across the organisation.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.

Route to Board **Which groups were involved in contributing to the paper and recommendations.**	Via Strategic Planning and Performance Group
Risk Assessment **(Outline any significant risks and associated mitigation)**	If KPIs are off target the improvement plan to address this is detailed in the paper.
Assessment of Impact on Stakeholder Experience	Not formally assessed.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty **(The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).**	
Data Protection Impact Assessment (DPIA) See IG 16. **1. There are no privacy implications.** **2. There are privacy implications, but full DPIA not needed** **3. There are privacy implications, full DPIA included** **Please state which option above applies (i.e. 1, 2 or 3).**	There are no privacy implications (1).

The State Hospital Board Corporate Performance

Quarterly Update Report
Q1 KPI Performance & Annual Delivery Plan Update

2026/27

CONTENTS

1 EXECUTIVE OVERVIEW

1.1 Corporate Key Performance Indicators

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPIs) for Q1 (April 2026 to June 2026). There is a total of twelve corporate KPIs. Analysis of the data using Red, Amber and Green (RAG) scale reveals that 66.7% (eight) have reached and / or exceeded their target this quarter and assessed as green, with 33.4% (four) KPI's off target, two in RAG status amber and two in RAG status red.

Following review by the Supporting Healthy Choices Group and approval by the Supporting Choices Oversight Group and the Board, the patient weight monitoring KPI has been revised. The previous target required 25% of patients to achieve a healthier BMI, this has been replaced with a measure that 60% of patients gain less than 15% of their admission body weight during admission, regardless of length of stay. Given the evidence linking 5% or more weight loss with improved cardiometabolic risk factors, and as this is the first reporting period for the revised indicator, trend data from December 2026 has been included for context.

This report includes an additional section on professional attendance at CPA meetings performance across some professional groups has fallen significantly below the agreed target and is therefore being brought to the Board's attention for awareness.

Corporate KPI operational definitions are reviewed annually with data owners to ensure they remain robust, meaningful and aligned with organisational reporting requirements. The 2026/27 review is being progressed in collaboration with eHealth colleagues and will inform the development of Tableau dashboards, supporting improved timeliness, consistency and accessibility of corporate performance information from key data sources.

The information provided within the reported by exception. The Planning, Performance, and Quality Team reviews all corporate KPIs data monthly, with areas to note highlighted in this report.

1.2 Annual Delivery Plan 2026/27

Meetings have taken place between the Corporate Planning and Performance Team and Directors to provide updates for quarter one. 68 Board actions identified in the Annual Delivery Plan 2026/27 and four actions have been carried forward from 2025/26 given a total of 72 actions to be completed over the coming year

Of the 43 ADP actions progressed in Quarter 1, 50% (36) are rated green and are either complete or on track, 8% (6) are rated amber, and one is rated red. The red rating relates to DTC, reflecting staffing pressures associated with the reduced working week, demands from the Women's Service, and wider workforce challenges. A patient incident in April had an impact on organisational delivery, including impacting DTC hours and overall patient activity levels. This is being reported separately, with associated SEAR's underway to identify learning.

All updates on the Annual Delivery Plan 2026/27 are reported to the Strategic Planning and Performance Group and externally to Scottish Government Mental Health Directorate through the quarterly sponsorship meetings.

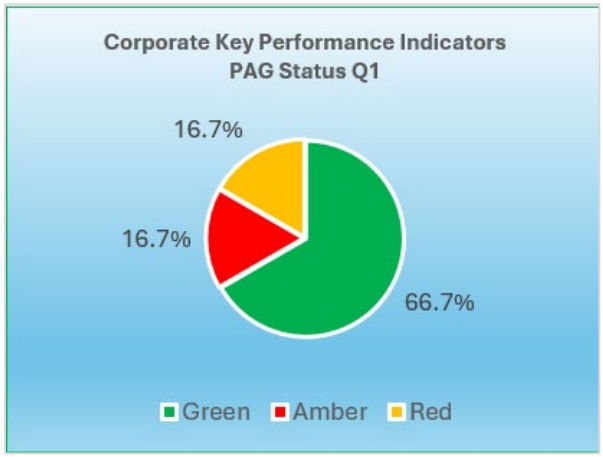
Clinical delivery is monitored locally in Services with each of the Service Leadership Team having a range of indicators which are reviewed monthly by the Clinical Quality Team. Escalation of issues if required, is through the Board committee structure.

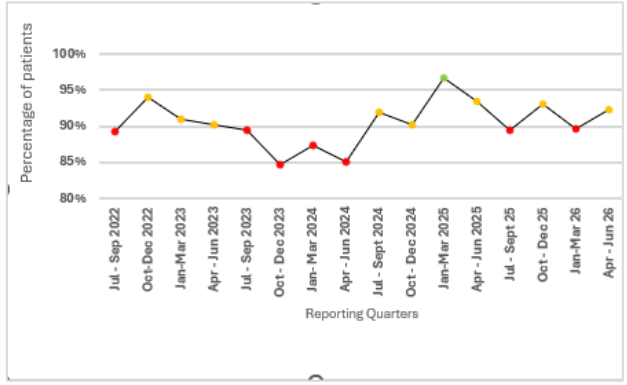
2 CORPORATE KEY PERFORMANCE INDICATORS QUARTER ONE UPDATE

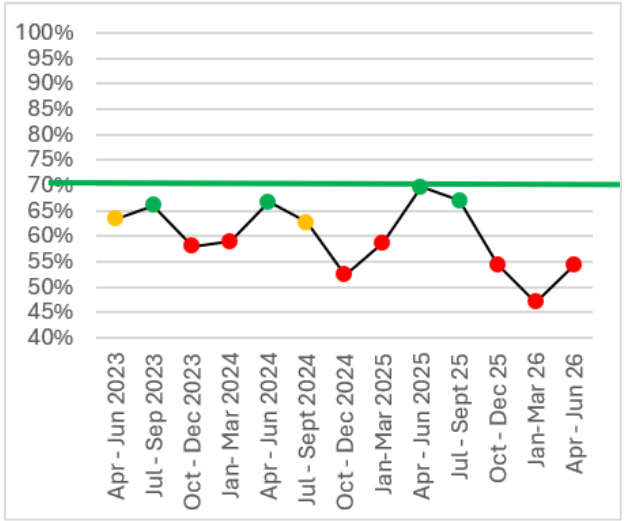
	Performance Indicator	Target	RAG Q2 25/26	RAG Q3 25/26	RAG Q4 25/26	RAG Q1 26/27	Actual Q1 26/27
1	Patients have their care and treatment plans reviewed at six monthly intervals.	100%	R	A	R	A	92.33%
2	Patients will be engaged in psychological treatment.	85%	G	G	G	G	85.17%
3	Patients will be engaged in off-hub activity centres. *(This includes drop-in sessions which take place in hubs, grounds, and Skye Centre*	90%	G	G	G	G	89%
4	Patients will undertake an annual physical health overview by the Practice Nurse.	100%	G	G	G	G	100%
5	Patients will undertake 150 minutes of moderate exercise each week.	70%	G	R	R	R	54.3%
6	Patients will have a healthier BMI.	25%	R	R	R	N/A	N/A
6a	Patients will gain less than 15%of their admission body weight during their staff at the State Hospital regardless of length of admission	60%	N/A	N/A	N/A	G	64.60%
7	Sickness absence rate.	5%	R	R	R	R	6.65%
8	Staff have an approved Personal Development & Planning Review.	80%	G	G	G	G	86.70%
9	Patients transferred / discharged using CPA.	100%	G	G	G	G	100%
10	Patients requiring primary care services will have access within 48 hours.	100%	G	G	G	G	100%
11	Patients will commence psychological therapies <18 weeks from referral date.	100%	G	G	G	G	100%
12	Patients have their clinical risk assessment reviewed annually.	100%	G	G	A	A	93%

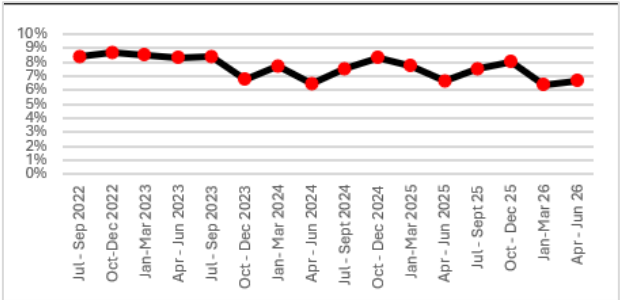
Definitions for Red, Amber, and Green zones:

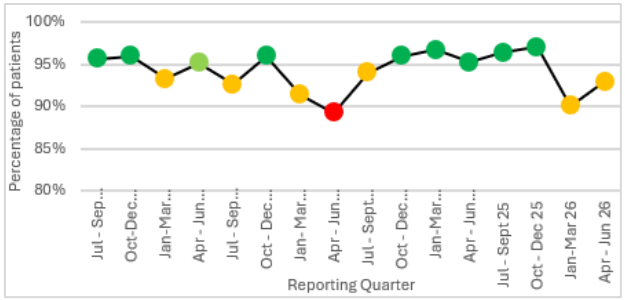
- For all but item seven, green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target.
- For seven (Sickness absence) green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over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



Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q1	Actions being taken	Improvement Opportunities	CRR
Patients have their care and treatment plans reviewed at six month intervals (Target 100% Actual 92.33%)	Moved from Rec to Amber		The indicator has improved since Quarter 4 2025/26, moving from a red to an amber RAG rating. Monthly analysis for Quarter 1 demonstrates improvement, with the proportion of records out of date reducing from 10% in April and May to 3% in June.	Monitoring will continue through the Corporate Planning, Performance. Clinical Administration will assume data ownership in Quarter 2 from Health Records to improve the accuracy and availability of data following the transition to electronic patient records for CPA documentation.	Clearer monitoring through the tableau dashboards.	No risk register identified.

Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q1	Actions being taken	Improvement Opportunities	CRR
Patients undertaken 150 minutes exercise each week (Target 70% Actual 54.30%	Red		Performance has improved since Quarter 4 2025/26; however, the indicator remains below target and continues to be reported as red. This marks a change from previous years, when performance at this stage typically achieved a green RAG rating. The Physical Health Steering Group continue to monitor to determine whether this is a short-term variation or an emerging sustained performance concern.	The Physical Health Steering Group is progressing actions to improve patient participation in physical activity and strengthen monitoring. This includes continued review of ward-level activity data, Admissions ward walking group participation and feedback on barriers such as patient numbers, daytime confinement, staffing pressures and annual leave. Work will continue with Admissions wards and AHP colleagues to increase access to structured walking groups and other activity opportunities, while reinforcing accurate recording and evidencing of patient activity.	Further development and promotion of ward-based physical activity programmes tailored to patient needs and levels of engagement Exploration of barriers to participation at ward level and engagement with ward leadership teams to identify targeted interventions that may improve uptake. Alignment of physical activity KPI reporting arrangements with other Board clinical quality indicators to improve consistency and monitoring.	No risk register identified

Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q1	Actions being taken	Improvement Opportunities	CRR
Sickness Absence rate (Target 5% Actual 6.65%)	Red		Year to date continues to underperform Significant increase in Nursing as enter the summer months.	Regular RAG Reviews for escalated areas. Continued partnership working with focus on providing a safe working environment. Recognition of departments with good attendance Encouragement and monitoring of consistent pathways usage & associated review of nursing reporting arrangements. Improved communication and awareness of impact of absence. Line Manager development scheduled for next quarter. Accountability and performance management for areas which require additional support.	OD strategy including culture assessment, bespoke wellbeing plans, line manager development and compassionate leadership will all have positive improvement on the working environment and staff experience which in turn should improve sickness absence rates. Consideration through Nursing Partnership Forum of ways of working to maximise staffing resource to avoid burn out.	HRD116

Summary position (where an Amber or Red RAG status has been identified)	RAG Scale	Previous Reporting Data	Analysis of Q1	Actions being taken	Improvement Opportunities	CRR
Patients have their clinical risk assessment reviewed annually. Target 100% Actual 93%)	Amber		Although the amber RAG remains in place for this indicator there has been a slightly improvement. When reviewing the data it was noted that some of the assessments were not reviewed within the timescales due to changes to the annual CPA date being changed, administration errors.	Health Records will use the data collected to provide the Consultant Clinical Psychologist with the information required to progress outstanding clinical risk assessments.		No risk register identified

2.1 Attendance at CPA Meetings

As documented within the Executive Summary during April to June 2026, MDT attendance was based on 36 meetings. Most professions met or exceeded targets, with strong Medical and Psychology attendance. However, Nursing fell to 86% against a 100% target, while Key Worker attendance improved to 28% but remained well below the 80% target. Occupational Therapy, Pharmacy and Dietetics also improved but remained below target. Continued focus is required across these areas.

A review undertaken by the Lead Nurse identified that low Key Worker attendance was likely linked to the significant and sustained resourcing pressures experienced during the reporting period. The weekly staffing position for June was generally reported as black, the review identified substantial staffing shortfalls throughout the month, with deficits exceeding 440 shifts per week.

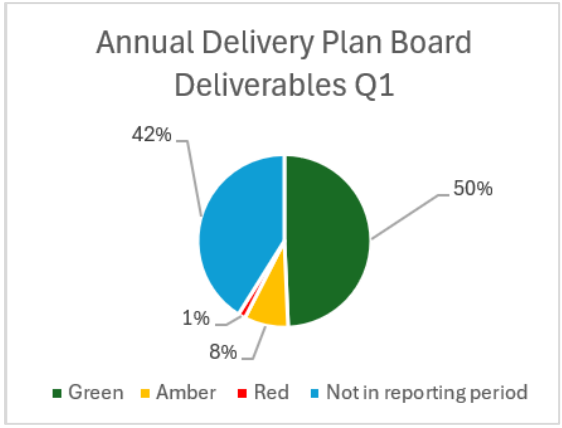
During periods of operation within the RAG framework, a key mitigation is to deploy nursing staff flexibly to maximise patient care across all shifts, including night duty. This often requires staff to move between shifts and clinical areas in response to organisational need. Initial review indicates that these staffing arrangements are likely to have had a significant impact on Key Worker attendance at CPA meetings, as Key Workers were redeployed to support patient care priorities.

The Corporate Planning, Performance and Quality Team will continue to monitor Key Worker attendance over the next two quarters to assess the impact of the interim plan during its implementation period and for three months following its conclusion. Any emerging trends or shifts in attendance will be reported through the 2026/27 Annual Corporate Report. It should also be noted that the CPA meeting attendance target is under review to reflect current practice.

Profession	Target	Overall attendance Jul-Sep 25 (n=44)	Overall attendance Oct-Dec 25 (n=39)	Overall attendance Jan-Mar 26 (n=50)	Overall attendance Apr-June 26 (n=36)
RMO (n=36)	90%	81%	90%	96%	97%
Medical (n=36)	100%	84%	100%	100%	100%
*Key Worker (n=36)	80%	55%	69%	16%	28%
Nursing (n=36)	100%	98%	100%	96%	86%
OT (n=36)	80%	66%	90%	44%	50%
Pharmacy (n=36)	60%	48%	74%	46%	53%
Clinical Psychologist (n=36)	80%	86%	90%	80%	92%
Psychology(n=36)	100%	89%	92%	84%	100%
Security (n=36)	60%	46%	74%	66%	64%
Social Work (n=36)	80%	91%	95%	84%	92%
Dietetics (Annual only)	60%	63%	64%	41%	47%

*Prior to Jan 26 – Key Worker/Associate worker was included in this from Jan 26 onwards Key worker only.

3 ANNUAL DELIVERY PLAN 2026/27 PERFORMANCE HIGHLIGHTS QUARTER ONE



Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
Mental Health & NHS Reform	**Deliverables - Four actions to be delivered, with one additional action carried forward from 2025/26:** (The State Hospital will engage with the emerging strategic direction for the development of a Forensic Mental Health Board for Scotland) All five actions identified in the ADP are rated green and remain on track. The action carried forward from 2025/26 also remains rated green, as the State Hospital awaits feedback from the Forensic Governance Advisory Group. At the time of reporting, no actions have been completed at this stage of the report period.
Women's Service	**Deliverables – Three actions to be delivered:** From the three actions identified in the ADP two are rated as green and remains on track. The Strategic Assessment was submitted for Scottish Government review and development of proposal for outreach service continued with significant stakeholder engagement noted, awaiting feedback from Scottish Government regarding funding for this service. One action has been identified as Amber. The identified amber is in relation to embedding the principles of trauma informed care.
Health inequalities	**Deliverable – One action to be delivered:** The one action within this critical success factor identified as RAG state green and remains on track for this reporting period.
Improving patient outcomes from their clinical care experience	**Deliverables - 27 actions to be delivered with three additional actions carried forward from 2025/26 Annual Delivery Plan:** Significant pressure has been noted this quarter with staff resource. As a result, one red action noted on DTC which is now at its highest level since recording started. An interim Clinical Operating Policy has been developed to support management of DTC and enable better planning and prediction for patients and address root causes. A further 2 amber actions noted on provision of and patients access to activity, with staff resource challenges and DTC having an impact on this. Quality improvement work continued this quarter with the successful delivery of TSH3030 QI sprint, with 11 project teams completing projects.
Continuous review of procedural, relational and physical security to reduce risk and harm and ensure resilience	**Deliverables - Eight actions to be delivered:** Eight actions have been identified in the ADP in relation to continuous review of procedural, relational and physical security to reduce risk and harm and ensure resilience however report on these commencing in Q2 of 2026/27.
Learning from views of patients, carers and stakeholders	**Deliverables – Three actions to be delivered:** All three actions identified for Quarter 1 review are rated green and remain on track. None have been completed at this stage.

Critical Success Factors & Key Themes	Annual Delivery Plan – Deliverables
Working in partnership to achieve organisational health well-being and an engaged well supported workforce	**Deliverables - 10 actions to be delivered:** Of the ten ADP actions identified under this theme, six were due for update in Quarter 1. Four actions are rated green and remain on track, while two are rated amber. The amber actions relate to the delayed roll-out of the Board Culture Assessment Tool, due to incident resource pressures, with the delivery timescale revised to Quarter 2; and the continued focus on maximising attendance through a proactive approach to sustaining the workforce. No actions are rated red and none have been completed at this stage.
Finance and eHealth/digital development	**Deliverables - 10 actions to be delivered:** Of the ten ADP actions identified under this theme, seven were due for update in Quarter 1. Six actions are rated green and remain on track, while one action is rated amber. The amber rating relates to the NIS audit preparations for the next scheduled audit, as the outcomes from a recent internal RSM audit carried out in Quarter 1 are still awaited.
Climate and Sustainability	**Deliverables – Two actions to be delivered:** Two actions have been identified in the ADP in relation to climate and sustainability reporting on these commencing in Q2 of 2026/27.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 11
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Director of Nursing and Operations
Title of Report:	Daytime Confinement (DTC): Interim Operating Protocol Report
Purpose of Report:	For Noting

1 SITUATION

An Interim Operating Protocol (Appendix 1) has been developed to provide a safe and sustainable operating model in response to ongoing nursing workforce pressures associated with the re-introduction of the Women's Service, implementation of the Reduced Working Week and sustained periods of increased patient acuity across a number of wards. The protocol has now been finalised and implemented, following formal approval from CMT on the 5 August 2026.

The purpose of this report is to provide an update regarding the levels of DTC, to inform the Board of the progress made regarding implementation of the Interim Operating Protocol.

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

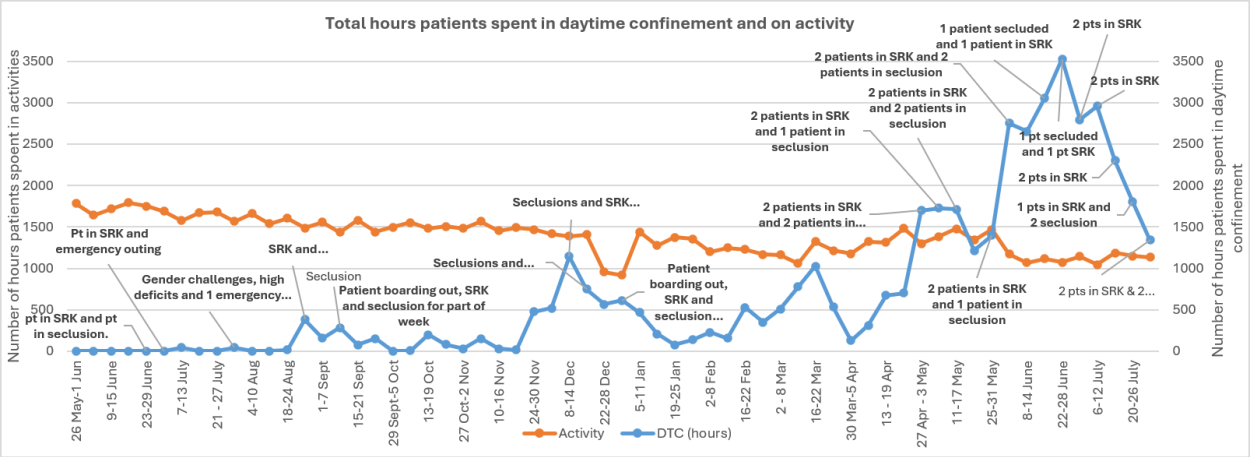
2 BACKGROUND

Achieving safe staffing levels and the elimination of DTC remain recognised corporate risks. Extensive engagement and improvement activity has been undertaken to understand the impact of current workforce pressures on patient care, staff wellbeing, operational resilience and working practices. This has included engagement with frontline nursing staff, senior nursing managers and Staff Side colleagues. Feedback consistently identified that the current position is not sustainable and that a more structured approach to service delivery is required whilst recruitment and onboarding activity continues. These engagement exercises directly informed the development of the Interim Operating Protocol.

The protocol has been developed collaboratively with contributions from Nursing, Medical, Security & Estates Directorates, operational management and Staff Side representatives and has undergone a formal draft and consultation process prior to finalisation.

3 ASSESSMENT

Chart 1



3.1 Hospital wide run chart (Chart 1)

June - has seen an increase in DTC from 6049 hours to 11,986.7 hours. The number of activities being provided to our patients decreased across the reporting month with these ranging from 1067.6 hours week beginning 1 June and 1175 hours week beginning 22 June. This is less than in May and June last year which were averaging 1750 hours (this is all planned and drop-in activity) but could be linked to the amount of time our patients experienced DTC throughout June. The weekly DTC median remained at 1455 hours, although this is heading towards another shift in the data with the last 4 data points all above the median.

July- has seen a decrease in DTC from 11,986.7 hours to 11188.5 hours. The number of activities being provided to our patients increased slightly across the reporting month with these ranging from 1045.7 hours week beginning 6 July and 1187.2 hours week beginning 13 July. This is less than in July last year which were averaging 1636 hours (this is all planned and drop-in activity) but could be linked to the amount of time our patients experienced DTC throughout the month. As anticipated, the weekly DTC median increased from 1455 hours to 2873.

3.2 Interim Operating Model (IOM)

The Interim Operating Protocol (Appendix 1) provides a structured and proportionate framework to support the continued delivery of safe, person-centred care during the recovery period. The approach is based on previously tested contingency arrangements and introduces clear operating models which can be applied according to staffing availability and clinical need. The protocol seeks to maintain patient care, therapeutic activity, psychological treatment, family contact, medication management and operational resilience while minimising additional restrictions on patients.

Robust governance arrangements have been built into the model, including daily site operational oversight, safe-to-start reviews. The Day Time Confinement Oversight group and CMOG will be replaced by a Clinical Operations Group (COG) which will meet fortnightly, co-chaired by the Director of Nursing and Operations and the Medical Director. This will report to the Corporate Management team (CMT) with clinical matters reporting to the Clinical Governance group. The protocol will remain under continual review throughout implementation to ensure any emerging issues are identified and addressed promptly.

Based on current recruitment trajectories, the protocol is anticipated to remain in place until late November 2026 or earlier should staffing levels permit a return to Business as Usual.

3.3 Recruitment

Recruitment Update: Recruitment to redress the variance from the establishment / actual continues.

- 18 WTE Registered Nurses commencing between the August and October inductions.
- Sickness Absence rates continue to be a challenge in terms of staff availability alongside less SSR and overtime hours (perhaps linked to summer and non-availability).

3.4 Patient Impact

The Patient Partnership Group (PPG) continues to meet monthly, with DTC feedback remaining a standing agenda item.

Feedback received highlighted the impact of DTC arrangements, particularly the challenges associated with prolonged periods spent in bedrooms, which patients reported as being especially difficult during recent periods of hot weather. Patients also raised concerns regarding restricted access to the grounds, limited opportunities to maintain contact with family via the telephone, video visits, during DTC, and delays in completing personal laundry. Concerns relating to takeaway meal containers and access to cold drinking water were also raised; however, these issues have since been addressed. Suggestions for improvement included exploring opportunities to maintain family contact during DTC, consideration of escorted walks where appropriate and permitting hot drinks in bedrooms. Overall, the feedback reflects the importance patients place on maintaining social connection, access to outdoor space, personal comfort, and meaningful activity during periods of restriction.

In relation to complaints, 20 were received during Q1 (1 April to 30 June 26) which related to nursing. The issues raised included frequent daytime confinement, which affected patients' ability to access placements, spend time in the grounds, use the day room, and access telephone or video calls. Some complaints also referred to meals being served in patients' bedrooms. All complaints were upheld.

The Director of Nursing and Operations has attended PPG to engage directly with patients representing each of the services and will continue to do so in order to provide regular updates and gather patient feedback.

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

APPENDIX 1

The State Hospitals Board for Scotland

Interim Operating Protocol

Lead Author	Director of Nursing and AHPs
Contributing Authors	Associate Director of Nursing Director of Security Associate Medical Director Lead Nurses Skye Centre Manager Lead AHP Staff Side Colleagues
Approval Group	CMT
Implementation Date	1st August 2026
Next Review Date	Protocol will remain under continual review
Responsible Officer (SMT)	Director of Nursing and AHPs

Version control

Version	Date	Change	Author
0.1	06.07.26	First draft - circulated for comment	KMcC
0.2	21.07.26	Second draft – circulated for comment	JC
0.3	30.07.26	Final Version – Transitions Service alternative included.	JC

Table of contents

1 BACKGROUND

This protocol has been drafted in response to ward-based nursing resource challenges following the re-introduction of the women's service at . These challenges have been further compounded by the simultaneous implementation of the Reduced Working Week (RWW) and the hospital experiencing a sustained period of increased acuity across a number of wards, resulting in those wards operating above their funded establishment on a daily basis.

Table 1 (below) outline the current funded establishment for each ward within .

Table 1: Funded Establishment Per Ward

	AM	PM	ND	Total Staff Required per Day
Arran 1	6	6	3	15
Arran 2	6	6	3	15
Arran 3	6	6	2	14
Iona 2	6	6	3	15
Iona 3	6	6	3	15
Lewis 1	6	6	3	15
Lewis 2	6	6	3	15
Lewis 3	6	6	2	14
Mull 1	4 (+1)	4(+1)	2	10
Mull 2	4(+1)	4 (+1)	2	8
Mull 3	5	5	3	13
Funded Establishment	**63**	**63**	**29**	**149**

Achieving safe staffing levels is a noted corporate risk and one which is under continual review by Senior Nursing Managers. In response to the above outlined resourcing challenges and feedback from frontline nursing staff, as well as staff-side colleagues, a range of engagement and improvement exercises have been undertaken to better understand the impact of current resourcing pressures on safe working practices, patient care, staff wellbeing and operational resilience. Feedback from these sessions has clearly illustrated that the current position is not sustainable and that an alternative, more structured, approach to the delivery of patient care is required whilst recruitment and onboarding continues. The State Hospital's Corporate Management Team (CMT) recognise the necessity to introduce changes to hospital's model of care delivery to ensure the health and wellbeing of our patients and staff remains paramount.

These exercises have resulted in the development of this Interim Operating Protocol.

Therefore, patient care during the recovery period will be modelled on previous, well-tested, contingency plans used during the Covid 19 pandemic, whereby patients were cared for in smaller cohorts within their wards.

The focus of this interim plan is to ensure safe care and working environments, provide a more planned approach to the use of daytime confinement and to maximise opportunities for therapeutic and recreational activity. Adherence to the practices outlined in the protocol will also ensure that additional restrictions on patients are minimised and proportionate. It should be noted that some patients may spend more time in their bedrooms than previously has been the case, but this is to ensure equity across the entire patient population. This practice will not be recorded as Level 1 seclusion but will be monitored and reported on through DTC tracking data.

The trajectory of onboarding new staff indicates that all grades will have reached funded establishment point (subject to leavers and/or reduction in hours) by end of October 2026. This protocol is therefore anticipated to be interim until 30th November 2026. Thereafter, a full return to Business as Usual is expected.

It is anticipated that this interim protocol will be in place until end of November 2026, when the last of the recovery onboarding will have concluded however a return to Business As Usual (BAU) will be actioned sooner, if possible. It should also be noted that every attempt will continue to be made to fill deficits required to manage clinical acuity.

2 AIM

The overall aim of the Interim Clinical Operating protocol is to support the continued delivery of safe, person-centred care while recognising the current challenges associated with clinical activity and available staffing resources.

It will specifically:

- Support the delivery of individualised care for patients, including the review of their physical and mental health.
- Maintain access to psychological treatment.
- Ensure clinical staff deployment and safe staffing, including the integrity of the responder model.
- Enable ongoing access to activity for patients.
- Ensure contact with family and carers is maintained.
- Ensuring nutritional care needs are met.
- Support safe medication administration.
- Ensure the maintenance of a safe, secure and clean environment.
- Improve service resilience.

The protocol outlines three operating models:

Operating Model A: Business as Usual (BAU) – Ward operating with funded establishment and no additional (skill and/or gender mix) requirements.

Operating Model B: Cohorting of Patients- Working with funded establishment however additional skill and/or gender mix requirements due to Enhanced Care Plan/Patient Safety Plan/My Personal Plan requirements.

Operating Model C: Care Teams - Working below funded establishment (skill and/or gender deficits)

2.1 Operating Model B – Cohorting Patients

The overarching focus of Operating Model B is to ensure that, while there may be limits on the number of patients who can access the day area at any one-time, robust planning should support the delivery of meaningful activity and minimise the amount of time patient's spend in daytime confinement. This approach allows identified groups of patients to be out of their rooms at scheduled times, reducing risk and enabling safe delivery of care within the available funded establishment.

The size of each cohorted group of patients and the duration of time spent in rooms will be determined by the Senior Charge Nurse and Charge Nurses, with oversight from the RMO/Clinical Lead and support from the clinical team. Decisions will take account of available staffing, clinical presentation, ward activity and individual patient risk.

Every effort will be made to ensure that any restrictions are proportionate, in place for the shortest possible time, and reviewed on a daily basis on a daily basis.

The underlying principle of Operating Model B is that activity should remain person-centred and needs-led, with care and therapeutic opportunities planned around the patient, wherever possible.

2.2 Operating Model C – Care Teams

It is anticipated Operating Model C, outlined above, will mitigate resourcing challenges. However, it is important to recognise that unforeseen and unplanned events may still result in periods of critical workforce shortage (for example an unscheduled boarding out, significant incident, or increased clinical acuity).

In such circumstances, support teams will be stepped-up to ensure care continues to be delivered safely across each hub.

Under this model:

- Each ward will maintain reduced staffing numbers in line with night duty working.
- Remaining available staff will be consolidated into four care teams, each aligned to a specific hub to facilitate meals, medication and other patient care needs.
- Care team deployment will prioritise areas where patients may struggle to tolerate being nursed in their rooms, with these areas having the most available staff within a care team.
- Any other available staff will be allocated flexibly to wards to maximise opportunities for patients to remain in day areas, reducing the need for room-based care and supporting therapeutic engagement.
- Responder model would remain intact as would DRN. If model was not able to be met, this would be escalated via existing processes.

Operating Model C ensures that, even during periods of extreme resource loss, patient care, safety, and activity remain the central focus.

Decision to move to Interim Plan C will be decided by Senior Clinical Cover (SCC) and discussed at the morning site safety meeting. Details of ward operating models will be recorded in the Site Safety briefing. Any unplanned changes to resourcing outwith core hours will be escalated to the On-Call Director.

2.3 Transitions Interim Model Of Working

The Transitions Service's current establishment is 5 nursing staff (minimum 2 males, 2 trained) across the AM and PM shifts on both wards. This moves to 2 nursing staff at night (minimum 1 trained) on both wards. We propose that we could sacrifice 2 staff to supplement other areas (as long as our minimums were maintained) and still maintain both Mull1 and Mull2 as fully operational and open; and allowing for the responder model. This would be the 4-4 model.

The above is consistent with the wider model, which states that wards should be working at their funded establishments.

2.3.1 Model

- Whereby one ward working with 4 staff members and one working with 3 staff members.
- This would allow one ward (with 4 staff) to be open and fully operational, and the other ward (with 3 staff).
- The ward with 4 staff would release one staff member to the other ward to allow the situation to reverse.

- Overall, this ensures that patients' experience of DTC is halved and equitable across the two wards.

2.3.2 Clinical Team Support

- When the Service is operating the 4-3 model the Transitions Service clinical team will be alerted to this by the SCN and/or nurse in charge of each ward.
- The clinical team will endeavour to identify staff who are able to be based on the ward with 3 nursing staff to ensure it can be fully operation – i.e. to bring us back to the 4-4 model.
- We recognise this will be impossible on Saturdays and Sundays and the 4-3 model will have to be in place.
- There is an acknowledgment that non-nursing staff who are coming down may be unable to perform their usual duties and so cover should be prioritised for essential times – for example, getting patients out of the ward to placements or lunchtimes. Iti is also important to recognise that nursing staff also have non-negotiable tasks that will need to be completed and may lead to DTC if staffing levels inadequate.

3 PATIENT CARE

Patient care must remain an organisational and clinical priority during this interim way of working. To that end, every patient within will have an individualised care plan developed and reviewed by the multidisciplinary team, which will specifically outline how their care needs will be met during this period. This care plan will also clearly outline their ability to tolerate periods of daytime confinement, or not. It is expected that care plans will be reviewed at each weekly clinical team meetings(CTM), with a summary of discussions noted in the weekly CTM documentation, in line with current practice.

To support patient care it is also expected that non-nursing staff who are PMVA Level 2 staff will contribute to maintaining the integrity of the responder model in place at the hospital.

4 THERAPUETIC AND RECREATIONAL ACTIVITY

4.1 Skye Centre Activity Timetable Adjustments

To support the proposed ward bubble model, the number of split sessions will be reduced across a number of activity areas.

The revised timetable will:

- Reduce split sessions within Crafts.
- Full sessions will be delivered within Gardens, Patient Learning Centre (PLC).
- Introduce one additional session within Gardens and two additional sessions within Crafts to maintain activity capacity.
- Crafts will deliver sessions to patients from two designated hubs at one time, aligning with the proposed 'ward bubble' arrangements.
- Condense PLC activities into five structured sessions.
- Retain flexibility within the timetable to respond to individual patient needs, recognising that some patients are unable to tolerate larger group activities or longer session durations.

The reduction of split sessions within Sports presents a greater challenge due to the impact on activity capacity. However, Sports can revise its delivery model by:

- Maintaining the range and variety of activities offered.
- Supporting Admissions and Women's Service induction sessions as currently provided.

- Delivering sessions to patients from two designated hubs at one time, aligning with the proposed ‘ward bubble’ arrangements.

Successful implementation of the revised timetable will require appropriate staffing levels are maintained across all activity areas, ensuring the required gender balance, skill mix and technical expertise are available to support safe and effective service delivery.

4.2 Learning and Vocational Programmes

To ensure staffing resources can be prioritised towards facilitating the core activities and to minimise disruption associated with revised timetables, it is proposed that SVQ related programmes are postponed until Quarter 4.

This would affect:

- Garden’s SVQ course.
- Crafts’ SVQ course.
- Sports Leadership programme.
- The 12-week themed learning group currently planned to commence in August 2026.

Maintaining these programmes alongside reduced split sessions is likely to result in inconsistent delivery and disruption to learning outcomes during the interim period.

4.3 Hub Staff Arrangements

The available Hub staffing resource available to support the interim operating arrangements is 5.8 WTE (6 staff).

Of the available resource, 1.8 WTE (2 staff) will be allocated to Mull 3 to support both ward-based and Skye Centre activities for the Women's Service. This effectively leaves the equivalent of four staff members to provide support across all remaining wards**,** alongside meeting the demands of the wider Skye Centre service.

A flexible weekly Hub timetable will be provided to meet the needs of patients requiring enhanced clinical support and assistance to engage in meaningful activity across the ward, Hub, and Skye Centre environments**.** This approach will support patient engagement, promote access to a range of therapeutic activities, and align with the proposed ward bubble model**,** enabling activity to be delivered in a way that supports both patient needs and operational requirements.

The Hub Team also maintains an existing caseload of patients who require ongoing assessment, intervention, and activity support. This demand will continue throughout the interim period and will need to be balanced alongside support for the revised service model.

Due to the complexity of this patient group, patients frequently require enhanced staffing levels, often at a 2:1 staff-to-patient ratio. Consequently, staffing resources will require careful planning and allocation to ensure activities can be delivered safely and effectively whilst continuing to meet the needs of the existing caseload.

It is also important to recognise that Hub staff work across a shift pattern and provide weekend cover. These commitments must be considered when planning the deployment of the available staffing resource throughout the interim period to ensure appropriate support is available across all service areas.

4.4 Shop Provision

The Patient shop timetable has also been reviewed, recognising the significant value patients place on this service.

To minimise disruption, it is proposed:

- All wards will continue to access the shop on a weekly basis.
- For the duration of the interim plan, Mull 1 and Mull 2 will each have one shop session per week, reducing access from three sessions to one.

This change will release Atrium staffing capacity on three mornings each week, enabling:

- Additional social activities to be provided.
- Patients attending activity departments the opportunity to remain in the Skye Centre for longer periods before returning to the ward.
- Greater support for 'ward bubble' arrangements without significantly reducing patient access to the shop.

4.5 Mental Health Tribunals/Court and Parole Hearings

No changes required. The Skye Centre will continue to prioritise staffing to support all hearings.

The above noted changes to Skye Centre functioning will:

- Support implementation of the ward bubble model.
- Reduce the operational challenges associated with split sessions.
- Maintain access to a broad range of therapeutic and recreational activities.
- Retain both the shop provision and visit timetable during the interim period, with only minimal adjustments required to support service delivery.
- Provide a clearer and more consistent process for carers and families.
- Reduce frustration for patients, carers and staff through improved predictability and communication.
- Allow the Skye Centre to continue delivering meaningful activity and social opportunities while supporting the wider interim service arrangements over the next few months.

4.6 Allied Health Professional Services (AHPs)

To support the Interim Operating Model, the AHP operating model has been revised within each clinical specialty and aims to respond to localised need. Group therapy will continue to be provided by Occupational Therapy and Music Therapy and individual work by all the AHP professions within all clinical specialties.

- Admissions service will continue to have Occupational group therapy and all AHP services providing individual work. A Priority focus will remain with those patients on enhanced care and patient safety plans. Dietetics will continue to provide assessment of all patients.
- Treatment and Recovery: two targeted Occupational Therapy groups per week will aim to be delivered for the service and be self- resourced by AHP staff.
- Intellectual Disabilities: AHP Support Worker group and individual input.
- Transitions: Four Occupational Therapy clinics weekly will deliver individual sessions on ward aiming to support ward functioning. Group therapy intervention will also be provided by Occupational Therapy and Music Therapy.
- Women's service: group and individual work will continue to be delivered.
- N2U charity shop will move to a mobile model across the hospital visiting all wards/hubs, increasing patient accessibility and reducing staff resource.

4.7 Psychological Services

As part of their planned care, patients require psychological treatment. This is delivered currently both on an individual basis and in groups (KPI states that 85% of patients will receive PT). Given this and the importance it plays in patients progress along with the Mental Health Act principle of reciprocity, it is essential that we strive to maintain this provision. Groups are delivered daily and most clinical work is through planned appointments. There are also however "drop in" sessions provided. These are more commonly used for newly admitted patients where the flexibility this provides means patients can be seen at times when they are most able to engage. To assist with the interim model planning we will, however, move towards planned appointments as much as possible.

The patient cohorts will be decided by nursing colleagues on a daily basis. To support their decision making about which patients are in which cohort and subject to DTC when, we will provide planned appointments and group information each week to the Lead Nurse. This can then be shared with the person making decisions about the cohorts. It is hoped that this will allow cohort planning to accommodate the patients planned therapeutic work, which will be monitored for the duration of the plan.

5 CLINICAL INTERVIEWS/SESSIONS

Clinical interviews and sessions for assessment and treatment of physical and mental health will continue but require close liaison with ward teams to ensure planned approach.

6 MEDICINES ADMINISTRATION

All medications will be administered in line with the State Hospital's safe use of medicines policy through clinical team meetings and any prescriptions occurring at 9pm will be reviewed and, where clinically appropriate, moved to an earlier time. This will be reviewed regularly at clinical team meetings.

7 GROUNDS ACCESS AND/OR ESCORTING PROCEDURES

Grounds access will be continued as normal but will be reviewed on a shift-by-shift basis dependent on staffing numbers

8 TELEPHONE ACCESS

Patients will be able to access the telephone in line with our established telephone access and supervision procedures.

Mobile telephones will also be available to wards as a contingency measure, if required.

9 FAMILY AND CARER VISITS

It is anticipated that the weekday visits timetable can continue with minimal disruption. However, recent experience has demonstrated that weekend visits have been increasingly affected by significant ward staffing deficits.

The current weekend model provides:

- Morning Skye Centre Atrium activity session.
- Afternoon visits.
- Reliance on registered ward nursing staff to support visit arrangements.

To improve reliability during the interim period, it is proposed that visit slots are redistributed across the morning and early afternoon. This approach would reduce the likelihood of later appointments being cancelled due to staffing pressures.

Proposed visit times:

- Saturday Morning: 10:30am–11:30am (with flexibility to commence at 11:00am where visitors are travelling by train transport).
- Saturday Afternoon: 1.00pm – 2.00pm.
- Sunday Morning: 10:30am–11:30am (no train transport available).
- Sunday Afternoon: 1.00pm. – 2.00pm.

Ward visit slots would be limited to 1.15pm – 2.15pm, although depending on the ward staffing deficits decision related to these going ahead will be taken by mid-day Friday to allow for communication to be provided to carers.

When planning weekend visits, consideration must continue to be given to overall site safety requirements and the responder model.

To support continuity of the visit programme:

- The Skye Centre and PCIT will seek to self-resource visits using their own registered staff wherever possible.
- This approach will result in additional overtime costs or TOIL requirements for the Skye Centre.

While this solution supports consistency of visits, there will be an impact on weekend activity provision, as staff will need to be deployed from the Skye Centre in the morning to support visits.

As a mitigation, during preparation of the weekly visit plan:

- Where no visits are booked into scheduled morning or afternoon slots, activity sessions can be planned and delivered instead.
- This ensures available staff time continues to be used for patient activity.

10 PROFESSIONAL VISITORS

No changes required. The Skye Centre will continue to prioritise staffing to support all hearings.

11 EXTERNAL CLINICAL APPOINTMENTS/PRE-TRANSFER VISITS/REHAB OUTINGS

During this interim period all essential outings will be prioritised. These are discussed and determined at the daily Site Safety meetings.

12 CATERING

Meal service, where possible will continue as per normal protocol with meals served in the ward dining room, in cohorts. Any changes to the meal service will be communicated to the patient group.

13 SEARCHING

Nursing staff will continue to be responsible for the planning, co-ordination and completion of patient rubdowns, property, room and ward searches.

Wider MDT members are trained in searching, including Clinical Security Liaison Managers, and can support search procedures, if required.

14 MANAGEMENT OF REFERRALS AND ADMISSIONS

Referrals to the hospital will continue to be managed through existing processes. Each referral will be assessed in the usual way, with the urgency of admission agreed following discussion with the referrer. During the interim operating arrangements, patients assessed as requiring urgent or emergency admission will be admitted as normal. Where admission is required but assessed as routine, the clinical team will identify the necessary resources and agree a planned admission date in line with policy and available staffing.

15 MAINTAINING OVERSIGHT AND COMMUNICATION

The revised site safety meeting will be held on MSTeams daily at 9 o'clock. This will be chaired by the Associate Director of Nursing and attended by the Associate Medical Director, Head of Psychology, Lead AHP, Head of Skye Centre, Lead Nurses, Head of Estates and Facilities and Clinical Liaison Security Manager. Any deputies in attendance will do so with the understanding they have been delegated the decision-making responsibility of those they represent. During this meeting confirmation of a Safe to Start position from all services will be determined, and this will be included in the briefing note issued following the meeting.

Normal communication and safety procedures will continue to apply when entering wards, (i.e. via the office and reporting to the Nurse in Charge). As patients will be managed in cohorts it is advised that all visiting professionals liaise with the ward prior to attendance to ensure they attend when their patients are available.

16 MONITORING AND REVIEW

16.1 Patient Review

As earlier outlined, every patient will have an individual plan of care that describe the care approach during this interim operating. This will be under continual review and discussed by clinical teams on a weekly basis as part of the Clinical Team meetings.

Clinical teams will need to pay close attention to any impact(s) of this operational protocol, and the tolerance of any patients to increased periods of isolation as a consequence of this interim measure.

16.2 Protocol Review

A fortnightly monitoring meeting will be held, jointly chaired by the Medical and Nursing Directors. This will involve the Clinical Leads from each Hub, and will also have senior representation from Nursing, AHP, Psychological Services, Security, Staff Side and the Patient Centred Improvement Lead. This will include a review of key DTC monitoring measures.

Data that is reviewed by the Clinical Quality Department will also be sent to clinical teams. Teams are expected to make use of this data to inform individual plans of care, identify and share best practice, and identify areas for improvement.

DTC monitoring will continue to be a standing agenda item for review by CMT, Clinical Governance and OMT.

The implementation of this interim protocol will be monitored on a regular basis, and adjustments made based on feedback from staff and patients.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	27 August 2026
Agenda Reference No:	Item No: 12
Sponsoring Director:	Director of Finance and E-Health
Author(s):	Deputy Director of Finance
Title of Report:	Finance Report to 31 July 2026
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on financial performance for Month 4 – July 2026, 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 has been submitted to SG and signed off to their satisfaction 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 3 August.

3 ASSESSMENT

3.1 Budget

The annual allocation of £57,047k has been received from the Scottish Government including:

- Baseline Recurring - £53,812k.
- Earmarked Recurring (women's services + realistic medicine) - £3,140k.
- Non Recurring - £96k.

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

- Further non-recurring allocations anticipated: £518k.
- Capital depreciation uplift: £1,706k.

This results in a total annual revenue budget of £59,272k reflected in the annual position.

At this stage, non-recurring budget allocations including additional agenda for change reform remain outstanding and will be incorporated into the budget once confirmed.

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

There is a £206k underspend year to date, primarily attributable to 48.88 WTE vacancies across the organisation, particularly within Nursing, Psychology, Allied Health Professionals (AHPs), Estates and Housekeeping. This figure excludes any additional establishment requirements associated with the development of the Women's Service – as this has not yet been incorporated into the funded staffing complement, the additional women's service workforce requirement is currently reflected as a WTE pressure, consequently, the reported vacancy level is masked by this.

The savings generated through vacant posts are being partially offset by a range of financial pressures, including nursing overtime costs, expenditure relating to the Enhanced Security Project, increased utility costs, and the implementation of Microsoft 365. The net impact of these movements are reflected in the year-to-date underspend position.

3.2.1 Directorate Summaries

Directorate	Annual Budget £'k	YTD Budget £'k	YTD Actuals £'k	YTD Variance £'k	Budget WTE	Actual WTE
Cap Charges	4,573	1,524	1,522	3	0.00	0.00
Central Reserves	2,853	0	0	(0)	0.00	0.00
Chief Exec	2,859	953	970	(17)	25.07	24.80
Finance	3,131	1,037	1,047	(10)	34.75	33.43
Human Resources Directorate	1,300	433	416	17	16.50	15.34
Medical	6,247	2,138	1,931	208	46.02	40.64
Nursing and AHPs	28,275	10,349	10,377	(28)	429.23	441.42
Security And Facilities	10,034	3,369	3,336	33	130.47	125.66
	59,272	**19,803**	**19,597**	**206**	**682.04**	**681.29**

3.2.2 Capital Charges – £3k underspent

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.

3.2.3 Central Reserves – nil variance

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.

3.2.4 Chief Executive – £17k overspend

The overspend within chief executive is a result of an unfunded post within the corporate services team and an emerging pressure within Social Work.

3.2.5 Finance – £10k overspend

Cost pressures have arisen from the stock write-off associated with the transition to the new Genesis system, increased legal counsel and audit fees, higher service contract costs within eHealth, and additional expenditure on essential software. Microsoft 365 also continues to place pressure on the eHealth budget, although this is currently being managed through the appropriate use of non-recurring reserves.

These pressures are being partially offset by pay underspends resulting from vacancies across a number of departments.

3.2.6 Human Resources – £17k underspend

Vacancies remain across Occupational Health, Human Resources, and Learning & Development. There is also currently an underspend against the corporate training budget.

3.2.7 Medical – £208k underspend

Clinical Psychology was previously reported within the Nursing Directorate and was transferred to Medical from Month 1. There is a £117k underspend within Clinical Psychology and a £74k underspend within Medical, both largely attributable to vacancies.

Drug expenditure and SLA costs for pharmacy have increased this year and are both currently presenting a small emerging pressure.

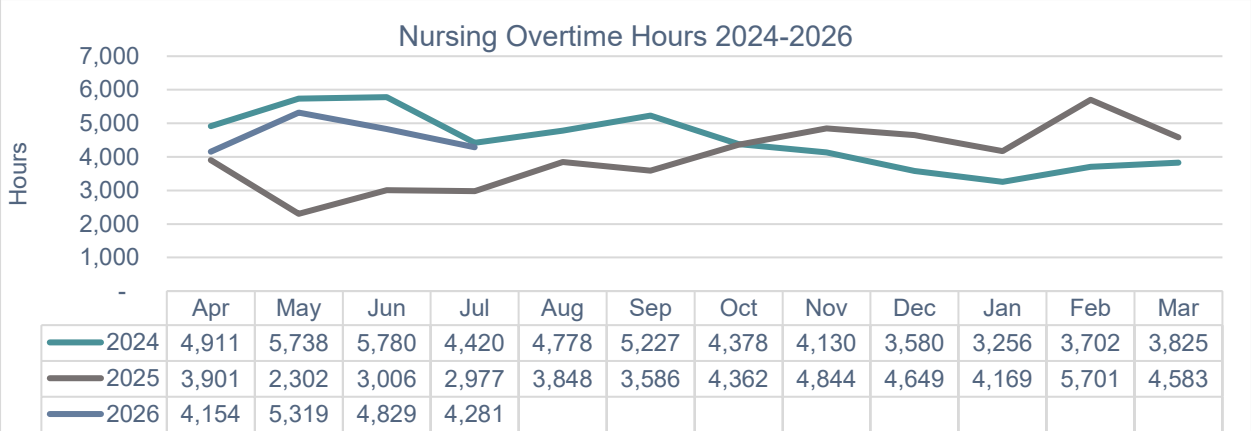
3.2.8 Nursing & AHP – £28k overspend

All costs associated with Women's Service are now fully funded. Funding of £3.1 million has been allocated to support delivery of the service, with a requirement to provide regular forecast updates to the Scottish Government reflecting the projected full-year cost. Year-to-date expenditure currently stands at £1.4 million and based on current patient numbers, staffing levels and expenditure trends, the estimated annual cost of the service is approximately £4.5 million. At the current rate of expenditure, it is anticipated that the allocated funding will be fully utilised by the end of Month 8 (November).

There are currently 16.62 WTE nursing vacancies across the wards, excluding posts associated with Women's Service. Recent recruitment activity has been successful, with a number of new starters expected to take up post over the next two months. In the interim, safe staffing levels have been maintained using overtime and supplementary staffing arrangements. Year-to-date expenditure on nursing overtime totals £1,094k, with a further £356k incurred through the supplementary staffing register.

The financial pressure within ward nursing is partially mitigated by vacancy-related underspends within the Skye Centre and Allied Health Professional (AHP) services.

Nursing overtime expenditure increased steadily following the opening of the Women's Service in July 2025. However, a significant reduction in overtime hours was observed in Month 4. The onboarding of additional nursing staff is now underway, supporting the planned over-recruitment model and helping to reduce reliance on temporary staffing arrangements over time.



	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	4,154	5,319	4,829	4,281								

3.2.9 Security - £33k underspend

A financial pressure of £84k has been identified in relation to the perimeter fencing project. Following the full capitalisation of the Enhanced Security Project, the remaining staffing and project management costs no longer met the criteria for capital expenditure and have therefore been charged to revenue. From Month 5 onwards, a proportion of the staffing costs will be recharged to Securitas, which will partially mitigate the revenue impact.

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.

Directorate	Annual Target £k	YTD Target £k	Savings Achieved £k	Surplus/ (Shortfall) £k
Chief Exec	44	15	8	(7)
Finance	48	16	16	0
Human Resources Directorate	38	13	14	1
Medical	127	42	42	0
Nursing and AHPs	799	266	265	(1)
Security And Facilities	564	188	195	7
	1,620	**540**	**540**	**0**

3.4 Capital Resource Limit

Capital resource remains at £282k. Capital expenditure bids have been reviewed, with the following projects identified as current priorities to be taken forward:

- Upgrade to plexus water monitoring system (£24k).
- Refurbish main turnstiles to extend lifecycle (£25k).

Additional capital bids are being prioritised as part of the ongoing capital planning process and will be allocated appropriate timeframes.

Confirmation is awaited that SG will provide the additional capital funding to support fully the repairs required as a result of the April incident in Arran – this was notified verbally post-incident by SG, and written confirmation requested from on 3 August as the scope of work and provider are now being finalised.

4 RECOMMENDATION

The Board is invited to note the content of the report and the current financial position, including the key points below.

4.1 Revenue

The year-to-date financial position is an underspend of £206k, with the forecast outturn remaining breakeven, subject to full funding being received for the Women's Service and the continued management of financial pressures.

The principal risks and pressures to achieving this position are:

- Receipt of the remaining funding required to support the Women's Service in Quarter 4, as previously indicated.
- Continued nursing overtime expenditure required to maintain safe staffing levels, although overtime levels have reduced following recent recruitment activity.
- Rising utility costs and ongoing inflationary pressures.
- Revenue costs associated with the Enhanced Security Project – to be confirmed – partially offset by planned cost recharges to Securitas from 1 August 2026.
- Workforce pressures across a number of clinical and support services and the associated impact on service delivery and resilience.
- The recurring savings target remains on track, with year-to-date savings being achieved in line with plan.

4.2 Capital

- Capital projects and investment plans will continue to be progressed through the Capital Planning Group and remain under active review.
- Discussions continue with the Scottish Government regarding additional capital funding to support repairs identified following the Arran 2 incident.

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	Better Value • Meet the key finance targets set for the organisation and in line with Standard Financial Instructions. • Deliver all Scottish Government financial budget and resource reporting and monitoring requirements for NHS Scotland 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 Finance, eHealth and Audit Group
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).	There are no privacy implications (1).

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 13
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning, Performance and Quality Head of Clinical Quality Corporate Planning, Performance & Quality Project Support Manager Clinical Quality Facilitators
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

This report updates the Board on developments in quality assurance and improvement since the last Board meeting. It demonstrates their alignment with the hospitals strategic planning and organisational learning processes, supporting the commitment to embedding quality in care and service delivery

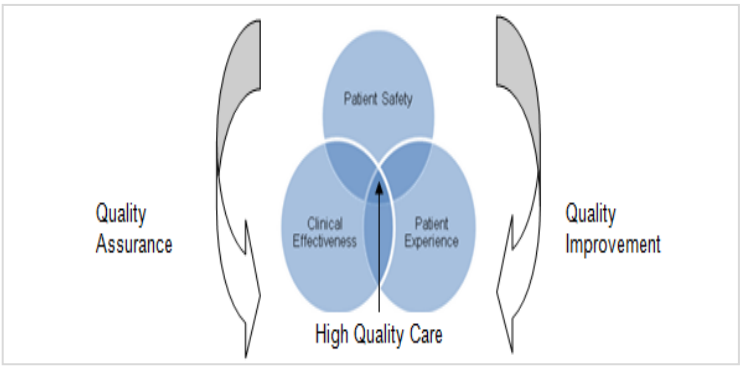
2 BACKGROUND

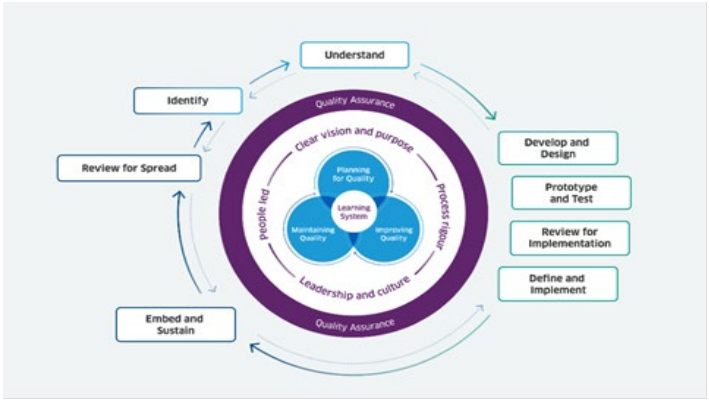
Quality assurance and improvement at the State Hospital align with the Clinical Quality Strategy 2024–2029, approved by the Board in August 2024. This strategy outlines the direction and goals for enhancing clinical care, aiming to improve patient experiences through person-centred, safe, high-quality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

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

The State Hospital quality vision is to deliver and continuously improve the quality of care through the provision of safe, effective and person-centred care for patients.

Figure 1





3 ASSESSMENT

The paper outlines key areas of quality improvement and assurance activity over the reporting period, these include:

- The monthly CPA oversight monitoring report.
- 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 State Hospital Clinical Quality Strategy 2024 - 29
Corporate Objectives Please note which objective is linked to this paper	**1. Better Value** Safe delivery of care within the context of least restrictive practice resilience and the ability to identify and respond to risk. Deliver a programme of Infection Control related activity in line with all national policy objectives. 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. Embed the principles of Realistic Medicine, through the Realistic Action Plan for 2026/27. **2. Better Health** Ensure the delivery of tailored mental health and treatment plans individualised to the specific needs of each patient. 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).	There are no privacy implications (1).

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL

1 Assurance of Quality

1.1 Clinical Audit

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

Within this reporting period, there have been three local audits supported by the Clinical Quality Department and actioned through the Commissioning Groups. The RMO contact with patients audit gave significant assurance as did the unvalidated progress note audit and the progress note on each shift audit.

A number of other audits have been completed but have not been tabled at their commissioning group for approval due to meetings being rescheduled.

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											
Nurse progress note on each shift											
Controlled Drugs Audit											
RMO contact with patients											
Observations of Care											
PMVA Seclusion Audit						n/a	n/a	n/a	n/a		
Oxygen cyclinder checklist											
Epilepsy Audit		n/a			n/a	n/a	n/a		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		
Lithium Audit	n/a		n/a			n/a	n/a	n/a	n/a		

Service Leadership Teams are advised of the master audit adherence to enable overview of audit adherence within their wards. A report on the master audit adherence was provided to the Clinical Governance Group in February 2026 and will be included in Clinical Quality annual reports going forward.

1.2 CPA oversight monitoring report

The June 2026 CPA flash report showed that the majority of interventions continued to demonstrate random variation throughout the reporting period, with two notable exceptions.

- RMO attendance showed a sustained improvement, with an upward shift in the median from 87% to 95%, indicating a positive change in performance over time.

- Psychology – discussion of reports with patients prior to the CPA meeting showed a decrease, with a downward shift in the median from 100% to 71%, suggesting reduced consistency in meeting this requirement.

RMO, Psychologist, Security and Social Work met or exceeded their KPI attendance target. The CPA monitoring dashboards will go live in July 2026, with Heads of Services having access to their own professional data vi

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

2.1.1 Current Portfolio

Twelve active QI projects are underway, led by multidisciplinary teams across clinical, operational, and patient groups. These initiatives are designed to deliver measurable improvements in care quality and patient experience.

2.1.2 TSH3030

The State Hospital's QI sprint, TSH3030, ran throughout May. Seventeen teams registered to take part, most with patient involvement. Compared with the 2025 sprint, there was an increase in ward-based projects led by ward staff. Each team was allocated a QI Mentor to support the use of quality improvement methodology.

This year's QI sprint focused on three main themes: Patients' Health and Wellbeing, Therapeutic Improvements, and the State Hospital Processes. This represents a slight shift from previous years, when Staff Health and Wellbeing was a key theme, and may reflect the ongoing work of the Staff Health and Wellbeing Team.

Each week, teams submitted a "word of the week" and a mid-point poster. At the end of the 30-day sprint, 11 teams submitted final posters, which were assessed across six domains:

- Clarity of Aim – the poster presents a clear, specific aim and explains what the project intends to achieve.
- Use of QI Methods – the poster demonstrates appropriate use of the Model for Improvement, QI tools or PDSA cycles to support the project aim.
- Measurement and Evidence of Improvement – the team uses data, feedback or other measures to assess whether the change resulted in improvement.
- Learning, Reflection and Next Steps – the poster outlines what the team learned, how the work developed and the proposed next steps.
- Teamwork, Collaboration and Involvement – the poster evidences teamwork and meaningful involvement of relevant staff, patients or stakeholders.
- Creativity, Innovation and Communication – the project shows fresh thinking or imaginative solutions, and the poster communicates the improvement story clearly and effectively.

A Staff Choice Award was also included, giving State Hospital staff the opportunity to vote for their preferred project. Forty-three votes were received from across professional groups.

Two Oscars-style celebration events were held on 26 June 2026, one for staff and one for patients. Both were well attended by participating teams. The winning and highly commended projects are displayed on the QI Notice Board in reception. A casebook has also been produced and will be shared across the wards, Staff Wellbeing Centre, Reception and Carers Centre; this is included as Appendix 1. Some projects are expected to continue, and the TSH3030 Project Team is considering how best to provide ongoing support.

2.2 Scottish Approach to Change

The Scottish Approach to Change is continuing to be embedded nationally, with State Hospital leads supporting this work through participation in networking meetings. While the national approach remains at an early stage, the State Hospital is promoting local awareness and engagement through regular updates and feedback at the QI Forum, inclusion within QI Essential in-house training, and access to information through the Project Management Resource Hub on the intranet.

2.3 QI Capacity Building

2.3.1 – Scottish Improvement Leaders Programme (ScIL)

Cohort 53 – Three staff commenced the programme in November 2025. The theory component has now been completed, and participants are identifying suitable quality improvement projects to undertake as part of the programme. Recruitment ongoing for cohort 54.

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 scheduled to commence in September 2026. To date, ten staff from clinical and non-clinical backgrounds have expressed an interest in participating. Earlier promotion of the programme, aligned with the TSH3030 communication period, has contributed to increased levels of interest compared with previous cohorts.

2.4 Realistic Medicine

Three members of staff attended the Realistic Medicine Conference in June 2026. A State Hospital poster was accepted for display and was positively received by conference attendees.

The Realistic Medicine Team continues to progress delivery of the approved 2026/27 action plan. Current activity includes a pilot within the referral pathway, using DUNDRUM-1 and DUNDRUM-2 to support structured professional judgement. This work aims to strengthen shared decision-making within the PPM process by providing a common and transparent assessment of security need and urgency, and by supporting the organisation to evidence why special security is required in individual cases.

Work has also commenced to review the use of enhanced observations within the State Hospital. This SEIPS-based review is at an early planning stage and will consider how decisions about enhanced observation are made at three key points across the care pathway.

3. EVIDENCE FOR QUALITY

3.1 National and local evidence-based guidelines and standards

The State Hospital has a robust process for reviewing all incoming guidance to determine its relevance to the State Hospital. Pertinent documents are evaluated by multidisciplinary teams using an evaluation matrix to ensure compliance. During the period 1 April to 31 July 2026, 75 guidance documents have been reviewed: 57 documents were considered either not relevant or were overridden by Scottish guidance and 7 were shared for information. There are currently 11 documents awaiting action or decision of relevancy to The State Hospital: 5 MWC documents to be tabled at 3 meetings (Clinical Governance, MHPSG and the Medicines Committee) and 1 recent publication from NHS Scotland and 5 NICE guidelines currently with the Practice Nurse and GP. The 3 completed gap analyses are in relation to Migraine, Anaphylaxis and Food, Fluid and Nutrition (FF & N). The FF & N standards review achieved 76% compliance with 10 recommendations requiring further action, the remaining 2 gap analyses are table for the next scheduled steering group meetings for agreement and sign off.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required
SIGN	1	0	1
MWC	8	3	(5 pending)
HIS	3	1	1
NHS Scotland	1	0	(1 pending)
National Institute for Health & Care Excellence (NICE)	62	3	1 (5 pending)

There are currently two additional guidelines currently sitting with the Practice Nurse and GP for review regarding relevancy to the State Hospital which have been outstanding for a prolonged period. Meetings are set up monthly with the Clinical Quality Facilitator and Practice Nurse to review any physical health guidelines outstanding. Recent meetings have been cancelled due to training, annual leave and clinical demand however progress is prioritised against clinical workload.

Table 3: Evaluation Matrix Summary

Body	Title	Steering Group	Current Situation	Publication Date	Projected Completion Date
NICE	Pneumonia: Diagnosis and management QS	PHSG	Previously circulated for information only as our patients would be transferred to UHW if pneumonia was evident. Practice Nurse and GP to review update to see if previous decision still stands or if a full gap analysis is required.	Sept 2025	Aug 2026

Body	Title	Steering Group	Current Situation	Publication Date	Projected Completion Date
NICE	Pneumonia: Diagnosis and management Guidelines	PHSG	Previously circulated for information only as our patients would be transferred to UHW if pneumonia was evident. Practice Nurse and GP to review update to see if previous decision still stands or if a full gap analysis is required.	Sept 2025	Aug 2026

APPENDIX 1

Contents

TSH3030

TSH3030 is a quality improvement challenge within The State Hospital that provides an opportunity to get involved in Qi and make changes/improvements within a department, ward or through service leadership teams.

Throughout **May 2026**, 11 teams completed the TSH3030 challenge, producing posters that celebrated their achievements and showcased the dedication, creativity, and innovation they brought to the quality improvement challenge.

The key themes of the improvement projects were; patient health and wellbeing and the State Hospital processes.

Word of the Week

These are the words that fueled momentum week by week

TSH3030
Make your ideas matter

NHS SCOTLAND

Better Decisions Together

Improving Shared Decision-Making in TheStateHospital

QualityImprovementProject | Arran&LewisHubs

Aim

To improve shared decision-making (**measuredby increasing the mean CollaboRATE* scoreto ≥8.0forallthreedomains by 31 May 2026**) in pre-CPA medical reviews in Arran and Lewis Hubs.

QI Methods

- AdvocacyledbaselineCollaboRATE data collected(April 2026)
- Gaps identified particularly in patient involvement in CPA planning
- **Co-produced workshop with patients, advocacy, and doctors to improve pre-CPA reviews**
- **Semi-structured questions developed and implemented for pre-CPA medical reviews**
- Post-intervention collaboRATE scores and qualitative feedback from resident doctors (May–June 2026)

What we learned?

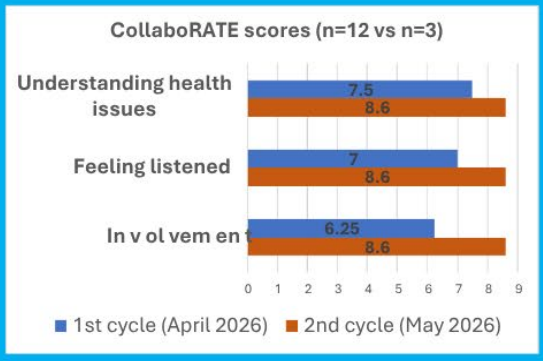
- Patients felt listened to and understood, but less involved in CPA planning, especially at first CPA
- Lived-experience feedback highlighted need for:
  - Clear explanation of CPA process
  - Honest, transparent communication
  - Review of previous CPA goals
  - Asking what patients want raised at CPA

What we achieved?

- Co-produced improvement approach through collaboration between patients, advocacy, and c li nic i ans
- Introduced a simple, feasible structure for pre-CPA reviews
- -Improved patient-reported shared decision making
- Addressed key gap in patient involvement in CPA planning

**CollaboRATE is a validated tool to measure shared decision making*

Results/ Impact



- **Preliminary results (n = 3) show increase in all**
- **domains compared to baseline**

Resident doctor feedback:

- Easy to use questions and fits naturally in consultations
- Helps structure discussions and clarify priorities
- Supports more patient-centred conversations
- Minor refinements suggested

Next Steps

- Continue datacollection(June)to strengthen findings
- Refine semi-structured questions
- Improve consistency of use across teams
- Introduce shared decision-making workshop in resident doctor's induction

Consider CollaboRATE roll out tomonitor and supportimprovementinshareddecisionmakingat

KIND CREATIVE PEACEFUL CARING

CALM HELPFUL SUPPORTIVE CREATIVE CREATIVE CALM SUPPORTIVE PEACEFUL

MINDFUL MAKERS

By All Staff + Patients in Iona 3

AIM

A structured artsandcrafts group was created with all patients on the ward, where each person selected a word that described how they see the ward and then used that word to create a personal piece of artwork; this was especially meaningful because the walls within Iona 3 were completely bare and hospital policy prevented patients from displaying anything with their names, so the project offered a way to bring colour, identity, and expression into the space while also supporting tangible skill development, refining fine motor skills, building confidence encouraging ownership, and enhancing emotional well-being through a shared creative experience.

PLAN

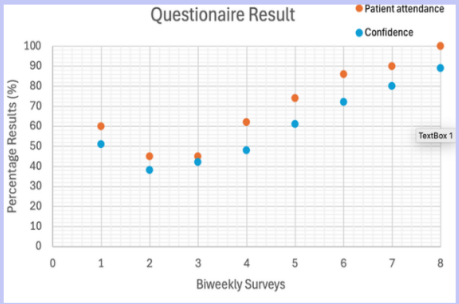
- Speak to staff and management of the ward for their support on this project.
- Talk to patients and see if they would participate
- Discuss with A Campbell and J Smith from OT dept to find out if could borrow art supplies
- Liaise with I Dickson for any additional supplies required.
- Questionnaires were used to measure attendance and assess patients' confidence in completing the tasks. The questionnaire also included a section where patients could provide feedback on how the sessions could be improved. All questionnaires were presented in an easy-read format to support better understanding for individuals with intellectual disabilities.

DO

- The project commenced on 1 May, with sessions scheduled to run every evening throughout the month at 7pm.
- Patients selected a personal word that they felt best described Iona 3, and these words are displayed around the edge of the poster.

Study	Change	Results
The rigid once-daily schedule meant patients often couldn't attend due to their presentation, and sessions were frequently cancelled because of staffing pressures or other clinical activity on the ward.	The sessions were adjusted to 30 minute blocks that could take place at any time of day, creating greater flexibility for the project.	Every patient was able to take part, which led to a clear increase in session attendance.
The ward sometimes had inconsistent staffing, meaning the regular staff who had agreed to take part were not always on shift.	With support from ward management, regular staff on duty were motivated and encouraged to take part in the project. Management also led by example by participating in the sessions themselves.	All Iona 3 staff worked together and consistently went above and beyond to support and motivate patients in their artwork.
Patients felt the sessions were becoming repetitive and asked for a wider range of materials to keep them more engaging.	Liaised with OT dept and I Dickson senior charge nurse for more materials.	After additional materials were provided, all patients were eager to try the new items and incorporated them into their work.

QUESTIONAIRE RESULTS



Changes in patient attendance and reported confidence across the eight biweekly surveys. Attendance initially decreased from 60% to 45%, enabling the team to identify and address barrier to participation. Following adaptations to the project attendance increased steadily to 100%. These findings suggest that the continued participation in the project was associated with improved engagement and confidence among patients over time.

CONCLUSION

- The plain walls on Iona 3 havebeen transformed by the creative, personal pieces patients produced.
- Attendance continued to riseasthe sessions progressed, particularly after feedbackwasacted on and changes were introduced.
- Social interaction withinthepatient group has also increased, with patients connecting overashared interest.
- As the sessions continued,patients became increasingly confident in their creative abilities.

NEXT STEPS

- Patients are keen to continue the art sessions on the ward, with different themes planned for different walls. A World Cup theme was suggested for the next project.
- Sessions will be kept flexible so as many patients as possible could take part.
- The team also worked with the OT department to access any support or materials they could offer.

CALM CARING KIND HELPFUL

NHS SCOTLAND

TSH3030

Make your ideas matter

Team Name: Mull Transitions Team

Project Aim: Primaryaimis toimprove patient safety and communication by integrating the documentinto theCPAprocess

Team Members:

QI Methods

Baseline data was gathered through a staff survey exploring awareness, understanding, current usage, and confidence in using the Past Medical History document

What we learned:

Key finding 1
Staff understand its purpose, but awareness is inconsistent.

Key finding 2
Document is not routinely used or embedded in CPA practice.

Result/Impact

As part of the ~~TSH3030~~ project, we have also engaged with Julie McGee from the Clinical Quality team, as parallel work is underway with the Medical department to improve the recording of patients' Background History and updates during their hospital stay. Within the RiO form, there is a section dedicated to past medical history, and we will work collaboratively to ensure consistency and alignment across both forms.

Caldicot Guardian, Dr Alcock offered support with Rio implementation.

Over half of respondents reporting that access to an updated document would improve confidence when caring for unfamiliar patients

What we achieved:

Key patient information such as allergies, vulnerabilities and physical health conditions is consistently accessible to support safe and effective care

Next steps:

Next steps include embedding the document into CPA reviews, clarifying roles and responsibilities, and promoting routine use across clinical pathways. To use source ofmedical information for patients who are boarding out.

Dungeons & Dragons

The Whispering Vale

To introduce a structure co-produced Dungeons & Dragons (D&D) group intervention on an admission ward to enhance patient engagement, social interaction, emotional regulation, and recovery-oriented practice.

What we achieved

Established a sustainable D&Dgroup within a forensic admission

Successfully engaged patients who previously declined other therapeutic activities

Developed a replicable model for creative, recovery-focused group work

What we learned

- Co-production significant improves engagement and ownership.
- Flexability is essential (simplifying rules, pacing sessions)
- Staff confidence of facilitating non-traditional interventions improves over time.
- Narrative based approach supports emotional expression and perspective taking.
- Consistency in scheduling supports attendance and routine.

QI methods

- Co-productive approach with patients involved in campaign design.
- Plan - Do - Study - Act to refine session format and accessability.
- Weekly facilitated D&D group sessions
- Adaptation of materials to match cognitive and communication needs.
- Collection of qualitative feedback from patients and staff.
- Observational data on sattendance, engagement, and behaviour

What we learned

- Increased patient engagement in ward activities.
- Improved peer interaction and cooperative behaviours.
- Improvement in mood and motivation reported by partricipants.
- Enhanced therapeutic relationships between patients and staff.
- Increased sense of autonomy and creativity through co-production.

Next steps

Expand group to include additional ward. Develop facilitator guidance to support wider implementation. Introduce outcome measures (e.g. wellbeing, engagement scales). Explore links with psychological therapies (e.g. CBT, MBT-informed approaches). Continue iterative improvement through ongoing PDSA cycles. Share learning across the hospital.

WINNER

People Choice Award

NHS SCOTLAND

TSH3030
Make your ideas matter

Giving Patients a Voice

through meaningful ward meetings

Team: Meetings Matter — Lewis 2 patients, PPG representatives and nursing staff

PROJECT AIM Reliably deliver structured weekly ward meetings, reaching 80% consistency within 30 days to improve communication and patient engagement.

QUALITY IMPROVEMENT APPROACH: PDSA CYCLES

Plan → Do → Study → Act

PLAN	DO	STUDY	ACT
Co-designstructure	Trial Friday meetings	Review data +	Adjust timing+format

Cycle 1 tested a fixed structure; Cycle 2 embedded action logging and patient feedback loops.

MEETING PATTERN

Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026
Weekly	0 No mtgs	1	1	1	0 No Mgts	Restarted QI project

RESULTS AND IMPACT

67% Patient participation increased after structured meeting restarted

BEFORE	AFTER
Inconsistent meetings Long gaps Actions not visible	Meetings restarted All staff attended Actions displayed

Fortnightly format agreed
Actions shared via PPG reps and notice board.

QI METHODS: FISHBONE

Cause-and-effect map targeting PDSA tests

People Pressure
Process Routine
Comms Actions
Timing Gaps
Inconsistent meetings

Tests: structure + action log + feedback loop

WHAT WE LEARNED

- Purposeful structure helps patients participate
- Consistent timing improves engagement
- Visible actions build trust and accountability
- Staff and PPG involvement strengthen communication

Next focus: embed meetings into routine ward practice.

NEXTSTEPS

1. Fortnightly Friday meetings
2. Monthly attendance review
3. Visible notice-board updates
4. Re-audit in 3 months

Quality improvement through patient voice • Lewis 2 ward meetings

NHS SCOTLAND

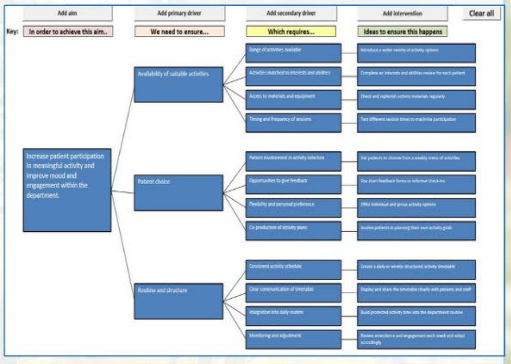
TSH3030
Make your ideas matter

Better Days Project

Team members:

PROJECT AIM Increase patient participation in meaningful activity and improve mood and engagement within the Gardens department

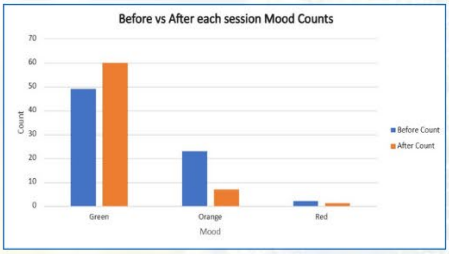
QI METHOD
Plan → Do → Study → Act



WHAT WE LEARNED

- Clear explanations built confidence.
- Mood reflection opened discussion.
- Group sessions helped patients connect.

RESULTS / IMPACT



More green responses after sessions; orange reduced.

WHAT WE ACHIEVED

- Engagement improved during activities.
- Patients shared more confidently.
- Mood board supported self-expression.
- Discussion built peer support.

PATIENT QUOTE

> ***"I'm feeling great because my mental health isgetting better."***

—Patient

NEXT STEPS

Use peer support and patient volunteers.

Keep the mood board visible and evolving.

Meet monthly to celebrate, learn and plan.

TSH3030 | Make your ideas matter

Best Use of QI Methods

TSH3030
Make your ideas matter

IONA Releaf

AIMS

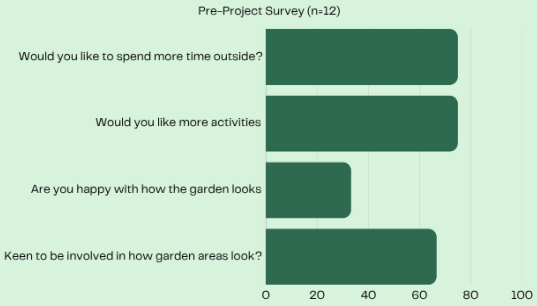
Toimprove therapeutic engagement, activity levels, and the ID patients' sense of ownership of the hub environment by establishing a structured, MDT-supported indoor and outdoor gardening project over a 6-month period.

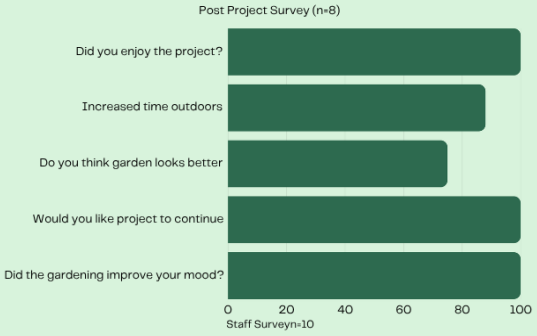
PLAN

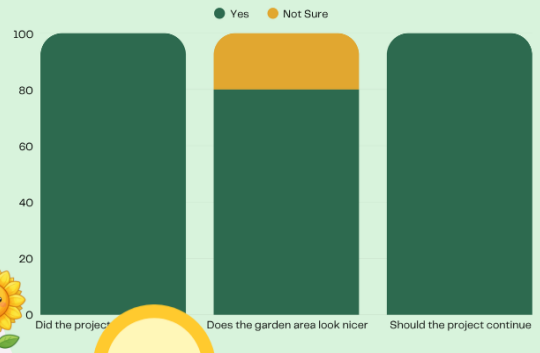
Tostart a patient led, weekly gardening group supported by MDT. This is based on research evidence of the therapeutic benefits of gardening for mental and physical health

STUDY

First, a driver diagram was developed to map the main drivers of change and guide our improvement strategy. Then we produced easy-read surveys and collected responses from our patients. We received easy read survey responses from 12/15 (80%) of ID service patients prior to project starting.
After the project we surveyed patients who had taken part in the groups. We also surveyed staff in Iona to get their views on the imapct of the project and for suggestions of future improvements







DO

We surveyed all patients in the ID service on their desire for increased activity, time outdoors as well as their thoughts on the garden areas in the hub.

We procured basic gardening supplies.

We ran 5 gardening sessions for patients in the ID service at weekly intervals through the 3030 period. This involved planting and nurturing indoor and outdoor plants in MFR and hub garden as well as painting planters.

ACT

We learnt that patients enjoyed being part of this group and found it therapeutic. Clinical staff also noted benefits to patients

The physical appearance of the hub garden improved, with both staff and noting that the area looked better.

Plans going forward with the project:

Adopt- We will continue running this group at a scheduled time as patients enjoyed it and benefitted from the reliable timing and structure

Adapt- Free text options in the surveys made suggestions such as including other outdoor areas, encouraging patients with grounds access to use and maintain the garden outwith session times and allocating gardening slots for harder to reach patients. Participants were keen that the project continue beyond TSH3030.

Abandon- We abandoned the idea of using gardening tools due to security concerns and to avoid limiting the number of patients who could join the group

Before

After

WINNER

Most Creative and Innovative Project

NHS SCOTLAND

TSH3030

Make your ideas matter

"Start Well" - Early structured weekly CTM Review to improve patient progression to grounds access and to prevent weight gain in the State Hospital

Project Aim

To increase the proportion of newly admitted patients reviewed for grounds access progression and weight management at CTM from 0% to 100% by 31st May 2026, using a structured, sustainable MDT prompt.

Background

Patients are not considered for grounds access until Admission CPA at around 12 weeks. Delays in this contribute to:

- Reduced rehabilitation momentum
- Missed early intervention opportunities
- Early, preventable weight gain

Baseline

- No structured early ground access review at CTM
- Pharmacological Weight Management discussions in CTMs inconsistent

What We Did (Change Idea)

We proposed a 5-minute structured CTM prompt at the start of each CTM covering

G Grounds access status
B Barriers to progression to grounds access
E Early pharmacological consideration (Metformin/GLP-1)
P Preventative physical health planning

Circulated staff questionnaire (n=4 responses)
Gathered feedback to inform refinement

What we learned

1. Structured prompts improve reliability of decision-making
2. Embedding within workflow (Rio CTM template) is essential for sustainability
3. Early CTM intervention enables anticipatory care rather than reactive decisions
4. Flexibility is critical in forensic pathways

PDSA 1

Plan: Introduce 5-min CTM prompt at start
Study: Disrupted flow; duplication
Act: Integrate into individual patient-level discussion

PDSA 2

Plan: Embed prompts within each patient review
Study: Improved usability and engagement
Act: Refine criteria (exclude pre-admission CPA patients) – Eligible patients were post-admission CPA

Results

Implementation:
• 12 patients reviewed using structured CTM prompt

Outcomes:
• 6/12 patients have already had admission CPA → 5 progressed to ground access during the project

- 3 additional patients progressed to next level of ground access

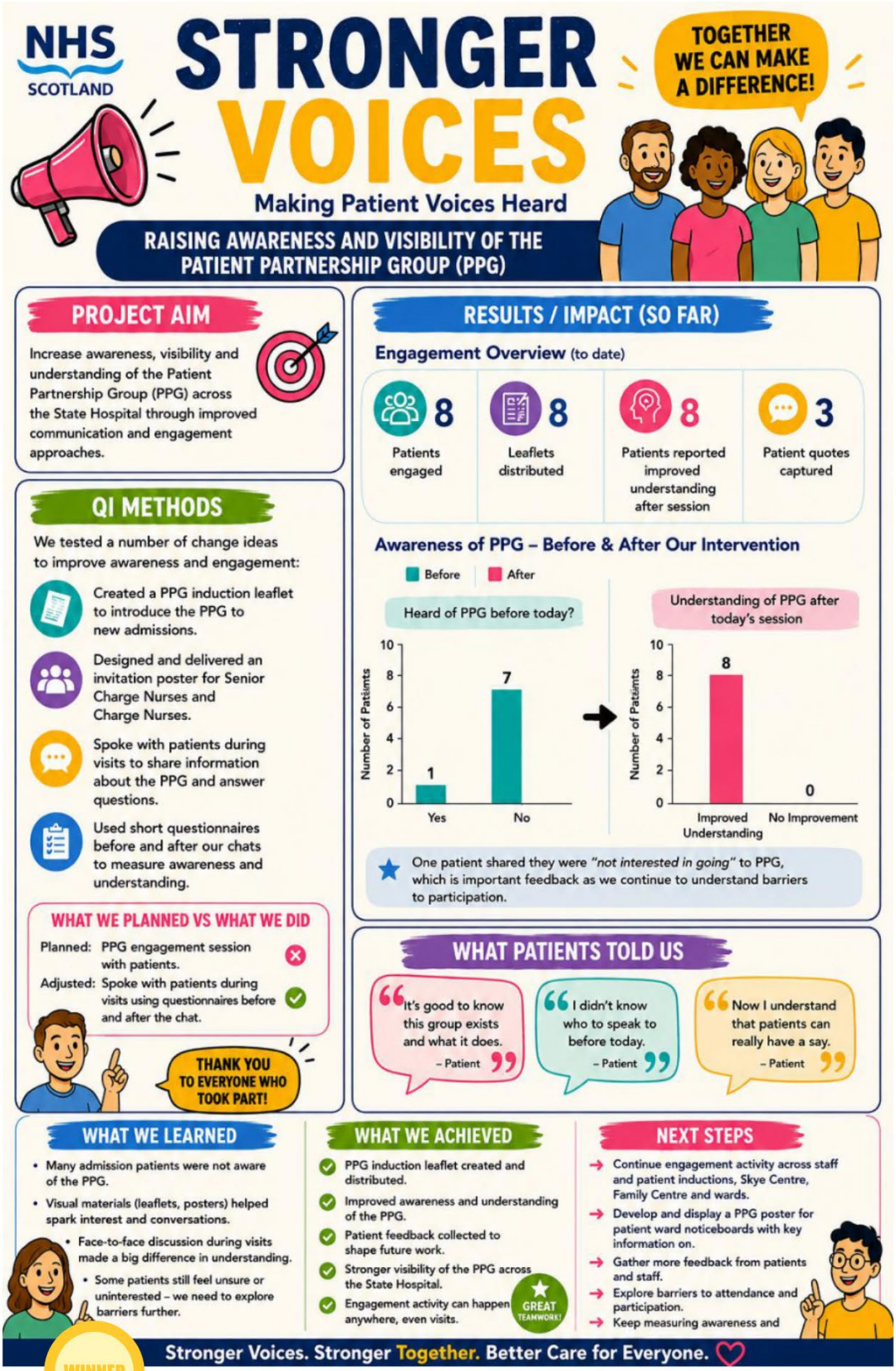
• 12/12 patients were considered for Metformin - 4/12 new patients were prescribed. 1/12 patient had a dose increase

- Increased GLP-1 consideration – none was prescribed

Next Steps

1. Embed review using existing RiO data and dashboards
2. Refine format to improve usability and relevance

NB – the project concentrated on the introduction of the structured tool which was achieved for all patients – further monitoring is required on the impact of this in time to gain grounds access and time to consider pharmalogical interventions



WINNER

Best Patient Involvement

The GASS Project: Overcoming Barriers to Psychotropic Side-Effect Monitoring

TEAM GASS Team Members:

TSH3030
Make your ideas matter

PROJECT AIM

To reduce unrecognized and unaddressed psychotropic side-effects by improving the routine use of GASS from admission, supporting safer, patient-centredprescribing.

QI METHODS

Baseline audit of GASS completion on admission wards.

↓

Intervention: brief ward-based teaching on GASS and side-effect informed prescribing
Emphasis on:

✓ Early completion
✓ Interpretation of scores
✓ Documentation of action

↓

Repeat data collection following teaching intervention.

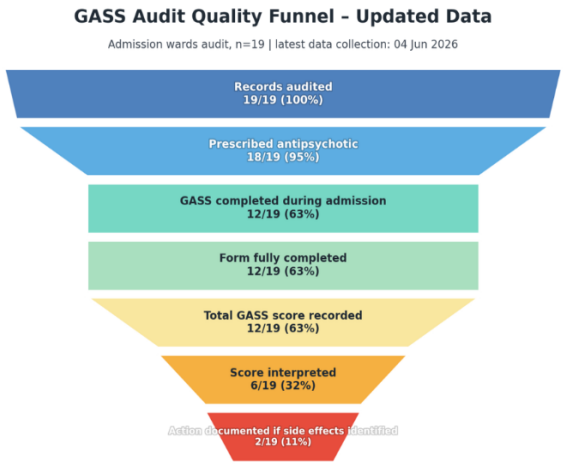
↓

Comparison of completion rates pre and post intervention

RESULTS/IMPACT

Baseline: 11/19 patients on antipsychotic medication (58%) had a GASS completed at any point during their admission

Post-teaching: 12/19 patients (63%)



KEY FINDINGS

- Completion remains inconsistent
- Full adherence to TSH GASS protocols was not achieved in any patient within the sample
- Limited documentation of score interpretation and subsequent clinical action following GASS completion
- Limited evidence of GASS influencing prescribing decisions

KEY FINDINGS

- Teaching alone resulted in minimal behaviour change
- Gap identified between knowledge and implementation
- Further investigation into barriers for GASS completion is necessary. Are these system-based barriers rather than knowledge-based barriers? Is the antipsychotic monitoring protocol realistic in the frequency of GASS completion?

WHAT WE ACHIEVED

- Established baseline and repeat measurement
- Identified the need for investigation into barriers to GASS use
- Demonstrated that education alone is insufficient to drive change
- Highlighted potential need for workflow integration and system support
- Generated data to inform future improvement cycles

NEXT STEPS

Further investigation is needed to better understand barriers to GASS completion, including whether these are primarily system-level rather than knowledge-based, and whether current protocol requirements for frequency of completion are achievable in practice.

Potential improvements include embedding GASS into routine clinical documentation, introducing prompts at CTMs, and assigning clear responsibility for completion. Ongoing education may also reinforce the clinical importance of side-effect monitoring, interpretation of scores, documentation of subsequent actions, and the role of GASS in informing prescribing decisions.

Project with Greatest Potential

What Went Well ?

TEAMWORK MAKES THE DREAM WORK!

Innovation & Impact

Overall, the experience was favourable. The team took pleasure in implementing something innovative at The State Hospital that benefited both patients and staff. A significant amount of preparatory work was required to price all the items initially, but over the course of 4 weeks, it became evident that the price adjustments were manageable, and patients largely supported the shift in practice.

Support & Struture

We were well supported by our mentor and having weekly meetings was helpful to guide the project and organise our thoughts. Input in relation to QI methods from or mentor was vital to structure how we worked across the 30-challenge and the offer of support to continue the work of the project after is invaluable.

Fun & Team Building

Found it good fun and good team building with healthy competition.

Team Plan & Motivation

It was a positive experience to implement a small project. There was a lot of work and development, which will require continuing however, overall a positive experience to better support our patients. Having a deadline was helpful to keep us motivated to continue the work. Implementing a whole team plan and regular check in's ensured we kept ourselves on track and things didn't fade away and get forgotten about.

Positive Collaboration

Overall, the experience was positive, and the project team appreciated collaborating on a project aimed at enhancing the health and wellbeing of the staff.

Project Impact

The use of the mood board developed relationships and supported self-expression. Engagement in activity increased and patients appeared keen to complete questionnaires and sessions improved.

I found the support I received during this project to be invaluable, from OT dept, to ward management and Corporate Planning, Performance and Quality team.
Everyone on the ward seemed to really enjoy taking part in the project and has led to further art projects to take place on ward.

The team learned the importance of listening to patient feedback, using data to guide improvements and testing changes on a small scale before embedding them into practice. The project reinforced that collaborative working, flexibility and creativity can lead to sustainable improvements that benefit both patients and staff.

The project successfully increased awareness and understanding of the Patient Partnership Group (PPG) amongst participating patients.

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE **CGC(M)26/02**

Minutes of the meeting of the Clinical Governance Committee held on Thursday 14 May 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
Non-Executive Director	Shalinay Raghavan
In Attendance:	
Corporate Business Manager	Anne Donnelly [Minute]
Head of Learning	Sandra Dunlop [Item 11]
Higher Trainee in Forensic Psychiatry	Dr Owen Gribbell
Consultant Forensic Psychiatrist	Dr Sheila Howitt [Item 6]
Chief Executive	Gary Jenkins
Risk and Resilience Support Officer	Kris Lawson [Item 13, 16 & 17]
Infection, Prevention and Control Lead	Jonathan Lee [Item 12]
Director of Nursing and Operations	Karen McCaffrey
Head of Corporate Planning, Performance and Quality	Monica Merson
Board Chair	Brian Moore
Consultant Forensic Psychiatrist	Dr Jon Patrick [Item 5]
Consultant Forensic Psychiatrist	Dr Gordon Skilling
Head of Corporate Governance	Margaret Smith
Medical Director	Professor Lindsay Thomson
Lead Dietitian	Frances Waddell [Item 9]
Lead Pharmacist	Nicola Watkins [Item 8]

1 APOLOGIES AND INTRODUCTORY REMARKS

Ms Fallon welcomed everyone to the meeting and noted apologies from Mr Robin McNaught, Director of Finance and eHealth, Mr Allan Hardy, Acting Director of Security, Estates and Resilience, Dr Liz Flynn, Head of Psychology and Sheila Smith Head of Clinical Quality. Ms Fallon also welcomed Dr Owen Gribbell who joined the meeting as an observer.

2 CONFLICTS OF INTEREST

No conflicts of interest were noted.

3 TO APPROVE THE MINUTES OF PREVIOUS MEETING

The Committee approved the minute of the previous meeting held on 19 February 2026.

The Committee:

1. Approved the minute of the meeting held on 19 February 2026.

4 MATTERS ARISING / ROLLING ACTIONS LIST

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

Ms Fallon also noted that the previous discussion within the Committee in respect of reflecting consequential risk as part of the Corporate Risk Register. It was noted that this would be an action to be taken forward.

Action: Mr Hardy

In relation to the rolling action list the Committee received the following updates; Mr Jenkins added in respect of Action No 1: Closed Circuit Television Policy [SPO4] had been out for consultation and was now with the Policy Approval Group. The remaining actions were either closed or would be picked up as part of the agenda items.

The Committee:

1. Noted the updates from the Rolling Action List.
2. Requested an update on the job planning reported within Psychological Therapies Service.
3. Requested that consequential risk be included within the Corporate Risk Register.

5 DISCUSSION ITEM: STRUCTURED CLINICAL CARE

Dr Patrick informed the Committee that Structured Clinical Care was a phased, whole-system approach for the State Hospital that would create a more psychologically informed environment, improve consistency in staff responses and strengthen risk management. He advised that current care had often been fragmented across teams and shifts, and that a shared psychological framework, embedded formulation and consistent day-to-day interactions would improve patient care, staff wellbeing and governance. He explained that every interaction should have been treated as a therapeutic opportunity and that structured clinical care would have linked individual and group treatment to a wider multidisciplinary approach across the whole service. He referred to evidence from various Royal College of Psychiatry services, where whole-system interventions had been shown to improve outcomes, and emphasised the importance of staff training, reflective practice, clinical supervision and a common language across disciplines. He proposed workforce-wide training, stronger use of formulation in daily care, and a pilot implemented across a whole hub rather than a single ward, with review points at six and 12 months. He acknowledged risks around staff buy-in, resistance to change and the need for follow-up after training but considered that the hospital was well placed to test the model and that likely benefits included fewer incidents, better engagement, improved staff retention and clearer assurance through governance metrics.

Ms Fallon thanked Dr Patrick for his presentation and opened for questions. In response to a question from Mr McConnell about formulations for every patient, Dr Patrick advised that these were already in place but could be written in technical language. He referred to the need to strengthen the link between existing formulations and everyday clinical practice, so that staff responses and care planning would be more consistent.

Mr Currie commented that, although this appeared sensible, whether it could be delivered in practice. He asked how consistency could be achieved across staff, in practical terms and how a pilot would be evaluated and kept focused. He also asked whether there was evidence that a similar approach had improved outcomes, particularly in relation to staff absence and wellbeing. Dr Patrick noted that there could be a lack of shared language and a consistent way of working across teams and that structured clinical care could help to address that. He referred to the evidence base available which demonstrated the benefits but accepted that implementation would be a significant undertaking.

Ms McCaffrey added that the approach supported nursing and multidisciplinary practice by providing a clearer framework and greater consistency, particularly for less experienced staff. Dr

Patrick underlined the importance of nursing input and that much good interpersonal practice was already taking place and that this could be built upon. Dr Skilling acknowledged that aspects of structured clinical care were already being used in isolated cases and had helped some highly complex patients to make progress when this had not previously been expected. He noted the model appeared to work in practice, but that the main challenge would be embedding it consistently across the whole system and securing organisation-wide buy-in.

Professor Thomson added that structured clinical care had been under discussion within the hospital for some time and highlighted the benefits of this approach. She thought that structured clinical care could incorporate a range of psychological approaches within one consistent framework and said that the next step would be to consider how it could be taken forward in practical stages. Mr Jenkins noted the proposal as positive, but stressed that timing, staff confidence, and service stability were crucial to a pilot being agreed in the future. He noted that baseline measures and a clear evaluation framework were needed in this regard, and to allow time for appropriate planning.

The Committee:

1. Discussed and noted the content of the presentation.
2. Requested the presentation slides to be circulated.

Action: Secretariat

6 WOMEN'S SERVICE UPDATE

The Committee received an update on the Women's Service presented by Dr Howitt who advised that the service had been open for around eight months and was caring for patients with significant and complex needs who had required prolonged enhanced care. Although the service had experienced a high number of incidents to date, it did appear to be experiencing a more stable period, although recognised that periods of instability might recur. She outlined work under way to increase physical activity for patients on enhanced care plans considering the associated health risks and that the Mental Welfare Commission visit in January had provided very positive feedback with no recommendations.

She acknowledged that the service remained under pressure as it was operating significantly above its initial nursing complement but explained that work was under way to optimise staffing resources and that a proposal was being developed for unescorted grounds access in consultation with colleagues. Finally, she noted that an application for dialectical behavioural therapy training: useful for patients with a personality disorder, was being progressed as an important part of service development.

Ms Fallon thanked Dr Howitt for the update and opened for questions. In response to a question from Mr McConnell about funding for the service, Mr Jenkins clarified that he had formally gone back to the Scottish Government to request review of this and that their response was awaited. If additional funding was not confirmed, the way in which the service was being delivered would require review within the available resources. Mr Currie noted that the key issue was whether the progress reported depended on additional resources and that, if the current level of care required funding above the existing allocation, this would need to be made clear. He also noted concern about whether it could be sustained and about the wider impact on the rest of the hospital. Dr Howitt noted that from a clinical perspective, the progress being made had been due to the additional resources in place and that, within the baseline funding allocation, the women would not have received the level of care needed to support recovery.

Mr Jenkins commended the progress made in the Women's Service and described the improvement as remarkable. He added that the challenge for the Board was balancing that progress against the impact on the other patients as the service was demonstrating what good care looked like but required staffing levels above those supported by the current funding. He

noted that while this strengthened the case to the Scottish Government for additional support, he remained concerned about the effect on the male service and the need to consider the wider overall position. Professor Thomson added that while progress for some of the women was positive, it was important not to characterise the issue as one of gender, as the impact on male patients, including through daytime confinement, was substantial.

Ms Fallon thanked everyone for their comments and requested an update on the service going forward.

The Committee:

1. Noted the Update.
2. Requested a further update on the Women's service (as per workplan).

7 CLNICAL GOVENANCE COMMITTEE ANNUAL REPORT / TERMS OF REFERENCE

The Committee received the Clinical Governance Committee Annual Report for 2025/26, and Committee Terms of Reference. Professor Thomson presented the report and highlighted that it demonstrated the breadth of the Committee's work and its focus on keeping the patient at the centre of governance activity and noted that the report identified a number of areas of good practice. She also confirmed that a plan was already in place to take on board the newly published Clinical Governance Standards in the future work of the Committee. She asked members whether the Committee was meeting their needs in providing assurance and in identifying and addressing key clinical governance issues.

Ms Fallon thanked Professor Thomson for the overview and opened for questions. Mr McConnell queried the lack of inclusion of formally noted areas of concern. Professor Thomson agreed to check this but was confident that there were no areas of particular concern noted. Mr Moore added that this was an issue the Committee should remain alert to in future annual reports and noted that concerns were regularly raised and discussed at standing committee meetings. He suggested that further consideration should be given to how such concerns were captured both in the minute and in annual reporting.

Action: Ms S Smith

Ms Fallon suggested that it would be helpful for future annual reports to follow a standard format to better reflect the Committee's discussions and work. She added that, in her view, the Committee had fulfilled its remit, had operated in accordance with its terms of reference, and that the governance arrangements remained fit for purpose. There was agreement around the table.

The Committee:

1. Approved the Clinical Governance Committee Annual Report 2025/26 subject to the noted checks and amendments.

8 MEDICINES COMMITTEE 12 MONTH REPORT

The Committee received the Medicine Committee 12 Month Report presented by Ms Watkins who highlighted progress in obesity management prescribing, including implementation of the pharmacological management of obesity guidelines and the weight management referral group. She noted that HEPMA reporting had improved operational efficiency and would support further analysis of prescribing patterns. She reported that local medicines audit work had continued, with a focus on high-risk medicines, and that medicines incidents had reduced during 2025–26. She also advised that medicines supply issues had lessened and had not adversely affected patient care. Ms Watkins noted that medicines expenditure had increased, partly due to obesity management treatment and higher nicotine replacement therapy use. She advised that work was

under way to standardise nicotine replacement prescribing and outlined priorities for the coming year, including further work on obesity management, psychotropic and clozapine monitoring, oxygen processes and updates to the safe use of medicines policy.

Ms Fallon thanked Ms Watkins for the update and opened for questions. Mr Moore asked if the hospital was optimising the features on HEPMA or if there were further opportunities to do so, and how this benchmarked with other organisations as any incident remained a potential concern. Ms Watkins advised that HEPMA reporting was close to being fully optimised and noted that further system developments were expected later in the year, including additional functionality to support medicines management. She also advised that benchmarking of medicines incidents against comparable services was being developed through wider system discussions and would inform future reporting.

Mr Jenkins noted that the service level agreement with NHS Lothian had been signed off and highlighted that it now incorporated the requirement to appoint a Director of Pharmacy Services. He advised that this arrangement ensured compliance with the national requirements issued to Boards.

Professor Thomson clarified that, of the 11 medicines administration incidents reported during the year, most had been of relatively low severity, with only one involving administration of the wrong medication with no serious harm arising. She also advised that, following withdrawal from the Prescribing Observatory for Mental Health, the hospital had implemented a local audit programme which she considered more relevant to its needs, and which had performed to a high standard.

Ms Fallon thanked Ms Watkins for the assurance provided and commended the breadth of activity undertaken, including the involvement of nurses in the Medicines Committee, and that the outlined audit plan had been particularly helpful.

The Committee:

1. Noted the Medicines Committee 12 Month Report.

9 SUPPORTING HEALTHY CHOICES 6 MONTH REPORT

The Committee received the Supporting Healthy Choices six-month report presented by Ms Waddell who advised that work remained aligned to the clinical model and continued to progress across a wide-ranging action plan. Over the reporting period, activity had focused on admission support, pharmacological weight management, changes to the hospital shop and revision of the BMI performance measure. Progress had been made in each area, including implementation of referral guidance and the introduction of a revised KPI focused on limiting significant weight gain during admission. Remaining actions would continue to be progressed on a phased basis.

Ms Fallon thanked Ms Waddell for the report and opened for questions. Mr Jenkins welcomed the positive progress reported and noted encouragement that the combined effect of pharmacological weight management and the targeted programme of work was beginning to show early signs of improvement. He acknowledged that, while a number of different approaches had previously been considered, the current combination of actions appeared to be creating a sense of momentum and positive change, which he hoped would continue.

Mr Moore also welcomed the progress following previous difficulties in evidencing improvement in this area and asked whether the position on grounds access for admission patients presented an opportunity for further improvement. He also asked about progress in discussions with Central Legal Office (CLO) regarding limits on shop stock items, given the importance of product availability in supporting positive patient outcomes. Ms Waddell replied that grounds access for admission patients remained challenging, as practice was to wait until the 12-week admission CPA, although being reviewed this still depended on the individual patient. Interim measures had included admission walking groups, increased access to fresh air, and earlier access to the Skye

Centre and sports facilities to support activity during the admission period. Ms Waddell advised that Dr Khan would provide an update on the point about the hospital shop.

Action – Dr Khan

Dr Skilling clarified that unescorted grounds access was not ordinarily available until after the admission CPA at around three months, when a full structured clinical judgement risk assessment had been completed. However, some admission patients were remaining on admission wards for longer than originally anticipated and that there was variation across wards in the timing of access being granted, but this variation was being reviewed as a potential area for improvement.

Professor Thomson added that escorted walks had been a positive development and provided a practical means of supporting patients' access to activity and fresh air while recognising the significant clinical considerations involved in decisions about unescorted grounds access. She emphasised that, although the revised overarching KPI on limiting weight gain was important, equal importance should be attached to the supporting intervention measures, including pharmacological treatment, psychological interventions and physical activity, to ensure that preventative and treatment actions were being implemented consistently and effectively.

Ms Fallon also welcomed the progress made, particularly in relation to improvements to the shop and the development of digital patient spending plans. She noted some disappointment regarding the position reported under the Test Admission Kickstart Collaborative Programme and asked that future reporting included detail on stakeholder experience to support the Committee's ongoing consideration of this area.

Action: Dr Khan

The Committee:

1. Noted the Supporting Healthy Choices 6 Month Report.
2. Asked for a further update on the hospital shop stock items.
3. Requested that future reporting on stakeholders included patient experience.

10 DAYTIME CONFINEMENT (DTC) REPORT

The Committee received the DTC Report, which covered the period from the end of December to end of March 2026. Ms McCaffrey highlighted significant levels of DTC had continued during the period and that while efforts had remained focused on reducing incidences, particular attention had also been given to minimising its impact on patients where it could not be avoided. She reported that work had continued to strengthen the audit trail, support safe decision-making at ward level, maintain recruitment activity and review the management of acuity across the hospital. She further noted that ongoing pressures relating to the Women's Service and wider clinical acuity continued to affect progress in reducing DTC. Finally, she advised that current work was focused on identifying practical measures to lessen the impact of DTC on patients' daily experience, while balancing the support provided by other professional groups against their core responsibilities.

Ms Fallon thanked Ms McCaffrey for the update and opened for comments or questions. Ms Raghavan asked about the cumulative impacts on staff morale and wellbeing if this was linked to occupational therapy staff leaving, and whether exit interview feedback had identified DTC as a contributory factor. Ms McCaffrey advised that the impact of redeploying staff to support DTC was recognised and continued to be monitored across professional groups. She confirmed that while requests to undertake additional duties had featured in some exit interview feedback, this had not generally been identified as the main reason for turnover. However, efforts continue to balance operational demands with the wellbeing of staff.

Mr McConnell asked how decisions were made in practice when balancing the different measures used to manage DTC, including overtime, staff redeployment, support from other professional

groups and the use of Allied Health Professionals (AHPs). Ms McCaffrey replied that an agreed escalation process was in place and that decisions were informed by regular multidisciplinary discussions to ensure essential activity was prioritised and operational demands were balanced as safely as possible. She further advised that, while staff continued to work hard to maintain services, there was a need to remain realistic about what could be delivered effectively in the current circumstances.

Mr Moore noted that the Clinical Forum had written to him, as Board Chair, to express concerns regarding staff redeployment, particularly in relation to AHPs, and that a response was being prepared and would be made as soon as possible.

Ms Fallon acknowledged the significant operational pressures associated with DTC and noted concern regarding its impact on both staff morale and patients, including the potential effect on length of stay and completion of risk assessments. She asked that future reports provided detail of the impact on patients, as well as staff, within the stakeholder analysis.

Action: Ms McCaffrey

The Committee:

1. Noted the Daytime Confinement Report.
2. Requested future reporting on stakeholders included detail on the impact on patients.

11 PATIENT LEARNING 12 MONTH REPORT

The Committee received the Patient Learning 12 Month Report presented by Ms Dunlop who highlighted that the patient learning team had delivered a positive year, with increased patient participation in accredited learning and a rise in qualification achievements across a broad range of subjects. She said that core skills screening had continued, with progress made in recording results more accessibly so that clinical teams could consider targeted interventions. She also noted that a small number of patients with literacy and numeracy deficits had engaged in support, although this remained a challenging group to involve. While staff pressures had limited progress on some planned new qualifications, she advised that work on digital inclusion had moved forward. She further highlighted consistently positive patient feedback and strong external quality assurance results, including recognition as one of the best centres

Ms Fallon thanked Ms Dunlop for the update and opened for questions. Mr Currie said that the external recognition had provided reassurance that the service had been following the right approach and asked about the hospital's relationship with Qualifications Scotland. Ms Dunlop confirmed that they had acknowledged good practice within the hospital and also supported ongoing improvement through feedback, suggestions and shared learning.

Ms Raghavan commented that the report was excellent, and that some of the comments had shown how transformative it had been for patients. She expressed thanks to the team for their commitment to sustaining the programme despite the challenges of working with a complex patient cohort. Mr Moore commented that many of the successes outlined had been recognised at the Celebration of Achievement Awards in March, which was very positive and had been attended by patients and their families. He welcomed the progress on digital inclusion and noted the contribution of the Patient Learning Centre which had delivered a tremendous return and deserved recognition.

Ms Fallon noted that this was Ms Dunlop's last Committee attendance and expressed her gratitude for her positive contribution over the years and detailed reporting which reflected breadth of work and standard of qualifications provided by the team. She also noted the patients' appreciation for the service was evident through comments at the Patient Partnership Group. Members wished Ms Dunlop a happy retirement and Ms Fallon also acknowledged the meaningful and lasting difference she had made to many people.

The Committee also noted the length of reporting and thought that consideration could be given to shortening this moving forward.

The Committee:

1. Noted the Patient Learning 12 Month Report.
2. Requested reporting be reviewed moving forward.

12 INFECTION, PREVENTION AND CONTROL 6 MONTH REPORT

The Committee received the Infection Prevention and Control (IPC) 6-Month report presented by Mr Lee. He advised that Operation Pegasus had not resulted in any immediate change for the hospital, as there remained no new national guidance on pandemic planning, although plans had been updated to remove specific reference to influenza. He reported that there had been no IPC incidents during the period, including over the winter months, and that vaccination uptake among staff and patients had been encouraging. He also advised that the inspection and audit programme continued to progress well, with inspections aligned to national standards, no significant concerns identified and a positive overall direction of travel.

Ms Fallon thanked Mr Lee for the report and update and opened for questions. Mr Currie welcomed the positive position on IPC incidents and noted that national guidance was often broad and required to be tailored to the hospital's specific circumstances. He also expressed concern about low vaccination uptake and questioned how this could be improved. Mr Lee acknowledged vaccination uptake remained low generally post-pandemic and that this was a widespread issue across the NHS. Whilst some Boards had used incentives to increase uptake, services continued to face difficulties. He added that vaccination fatigue appeared to be a significant factor.

In response to Ms Fallon's question about how IPC was communicated to patients, Mr Lee advised that a new facility had been built into the current audit structure which would allow staff to display ward audit findings in the wards. He noted that this reflected national standards and had only been possible once sufficient data was available. He added that some engagement had taken place with the Patient Partnership Group and acknowledged that more could be done to involve patients in this area.

Ms Fallon thanked Mr Lee for the clear and helpful report, welcomed the positive audit findings and requested an update on the outstanding soap dispenser delay issue as soon as possible and also asked for an update on the decision regarding future IPC mandatory training requirements.

Action: Mr Lee

The Committee:

1. Noted the IPC 6 Month Report.
2. Requested an update on the soap dispenser delay before the next meeting.
3. Requested an update on the decision regarding IPC mandatory training requirements.

13 INCIDENTS AND PATIENT RESTRICTIONS REPORT

a) Male Service

The Committee received the Incidents and Patient Restrictions Report for Q3 presented by Mr Lawson who reported that incidents within the male service had increased overall, although most key incident categories had reduced, including health and safety incidents, behavioural incidents, attempted assaults, assaults, patient care incidents and self-harm, which had significantly reduced.

The Committee discussed reporting and noted that it did not reflect changes previously requested,

including that the female service be removed from this report. This was noted as an action to be taken forward within reporting going forward. The Committee also noted the suggestion reporting could be developed further in respect of assault and self-harm incidents to provide earlier identification and oversight.

Action – Mr Hardy

b) Women's Service

Mr Lawson provided a summary overview of reporting in relation to the Women's Service. He reported that incidents had increased in the quarter, particularly in relation to health and safety, direct patient care, self-harm, attempted assaults and assaults.

Ms Fallon thanked Mr Lawson for the report and opened for questions. Ms Raghavan asked for further clarity around the increase in incidents triggering RIDDOR reporting, and the likely impacts of this. Mr Jenkins referred to the defined criteria in this respect, and reporting requirements. He advised that no concerns had been raised to date, and this was likely to reflect the nature and categorisation of incidents within a high secure mental health setting.

Mr Currie asked whether the increase in incidents following admission reflected a pattern of initial instability before patients became more settled, or whether such spikes were likely to continue, placing this in the context of the wider patient cohort and staff. Professor Thomson advised that, whilst newly admitted male patients often showed an initial increase in incidents before settling, the pattern in the Women's Service was more complex and was not expected to follow the same trajectory. She noted that improvement was likely to be gradual and would continue to require significant support and a consistent therapeutic approach.

The Committee:

1. Noted the content of reporting.
2. Requested reporting be split into male/female distinct reporting groups as previously outlined.

14 LEARNING FROM COMPLAINTS & FEEDBACK

Members received the Learning from Complaints and Feedback Report Q4 presented by Ms Smith who provided a summary of the key points noting that complaint volumes had shown an overall upward trend, with many complaints reflecting the impact of staffing pressures, clinical acuity and DTC. She advised that performance remained strong, with 94% of complaints resolved at stage 1. She noted that only two complaints had escalated during the quarter and that, in comparison with wider pressures across NHS Scotland, the organisation continued to provide a timely and effective complaints service.

Ms Fallon thanked Ms Smith and opened for questions. Mr Currie commended the strong complaints performance and noted that a responsive complaints process helped to build confidence among patients and carers. He expressed continuing concern about complaints relating to behaviours and attitudes, welcomed the focus on carer involvement, and highlighted the wider impact of resource pressures and consequential risk on complaint themes.

Ms Fallon sought clarification on the categorisation of the 25 complaints recorded under clinical treatment, and how these aligned with the details within the appendix. Ms Donnelly advised that the current coding framework grouped a range of issues under clinical treatment for the hospital and explained that the team were planning on reviewing the coding categories to make this easier to identify.

The Committee:

1. Noted the Learning from Complaints and Feedback Report.

15 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 March 2026. She advised that pressure on capacity had continued, particularly within the Women's and Intellectual Disability services, and confirmed that the contingency plan was now in use. She also reported that all admissions during the period had taken place within six weeks of referral.

Ms Fallon thanked Professor Thomson for the report and opened for questions. Mr McConnell suggested that future bed capacity reporting should distinguish between actual and effective capacity, particularly in the Women's Service, where operational capacity was reduced by patient acuity despite available beds. Professor Thomson agreed that a footnote could be added to future reports to explain that.

Action: Professor Thomson

Mr Moore asked whether further joint working with other medium secure units was planned, noting the importance of patient flow across the system. He also sought clarification on any current obstacles affecting flow at either whole-system or service level. Professor Thomson advised that patient flow continued to be constrained in parts of the medium secure system and that no straightforward solution had yet been identified. Dr Skilling added that flow through the Intellectual Disability pathway remained particularly constrained due to limited capacity at Rowanbank, which contributed to over-capacity pressures in Iona Hub.

Mr Jenkins added that networking across services continued to develop positively e.g. Foxgrove and that the hospital remained open to further visits and joint working opportunities.

Ms Fallon summarised the discussion and also asked for an update in future reporting on the impact that the contingency plan had had across services.

Action: Professor Thomson

The Committee:

1. The Committee noted the Bed Capacity Report.
2. Requested a foot note to be added to the report to distinguish between actual and effective capacity.
3. Requested reporting on the impact of contingency plan.

16 CORPORATE RISK REGISTER - CLINICAL RISKS

The Committee received the Corporate Risk Register - Clinical Risks report presented by Mr Lawson who advised that no risk assessments were due for review. MD30 - failure to prevent or mitigate obesity, was progressing and there was no update at that time on risk ND70 - failure to utilise resources to optimise patient care and experience.

Ms Fallon thanked Mr Lawson for the update.

The Committee:

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

17 LEARNING POINTS FROM SERIOUS ADVERSE EVENTS (SAER) REPORT

The Committee received the Learning Points from SAERs Report presented by Mr Lawson who summarised the position in terms of ongoing investigations as outlined in reporting.

Ms Fallon thanked Mr Lawson for the update and opened for questions. Mr Currie emphasised the importance of timely action in response to serious incidents. He noted that learning appeared to be taken forward appropriately and highlighted the need to ensure that actions were sustained over time to prevent similar issues recurring. Mr Jenkins welcomed the more streamlined arrangements for progressing adverse event reviews through the dedicated SAER Group which supported more effective oversight and reporting and added that it remained important to ensure that learning was shared appropriately.

Professor Thomson clarified that the duty of candour case had arisen from a national medication stock shortage rather than refusal by the patient, failure to offer treatment, or local pharmacy issue. Recommendations had been identified to improve early awareness of such shortages and national drug supply problems were being seen more frequently, including in relation to medications relevant to the hospital.

The Committee:

1. Noted the Learning Points from SAER Report.

18 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted improvement in the patient shop and the good practice of sharing literacy and numeracy deficits with the clinical teams.

19 COMMITTEE WORKPLAN 2026

The Committee noted the Workplan for the remainder of 2026.

20 ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

Ms Fallon noted that she would raise the increase in staff-related RIDDOR incidents associated with the use of soft restraint kits with the Staff Governance Committee

12 AGREEMENT OF ITEM FOR DISCUSSION AT NEXT MEETING

Ms Fallon noted the topic for discussion at the next meeting was the Clinical Care Policy.

13 ANY OTHER BUSINESS

Ms Fallon suggested that feedback from Non-Executive Directors attending the PPG should be captured more formally for the Committee. This was agreed, on the basis that patients should be asked for their views. Ms McCaffrey suggested that this information could be included within the Person Centered Improvement Steering Group who could capture any attendance as part of the report that comes to the Committee.

Action: Ms McCaffrey

14 DATE OF NEXT MEETING

The next meeting would be held on **Thursday 13 August 2026** at 09:30 hours via Microsoft Teams.

The meeting concluded at 1245 hours.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 27 August 2026

Agenda Reference No: Item No: 14

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 13 August 2026.

	Item	Summary
1	Clinical Care Policy	The Committee received a presentation on the Clinical Care Policy, which aimed to support a whole-team therapeutic approach to monitoring and responding to deterioration, with a focus on progression of care. The one-year review identified variable adoption, and the Committee acknowledged the work ongoing to address this.
2	Daytime Confinement / Nursing Operation Model	Reporting provided an overview and noted that daytime confinement remained significant which reflected ongoing clinical and operational pressures. The Committee acknowledged the Interim Operating Protocol plan to provide stability and improve planning.
3	Incident Reporting and Patient Restrictions Q1 2026/27: • Male Service. • Women's Service.	Reporting provided the position on the types and numbers of incidents 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.
4	Learning from Complaints and Feedback Report Quarter 1 2026/27	Reporting highlighted an increase in complaint volumes, reflecting wider staffing and clinical pressures, but received assurance that complaint handling performance remained strong, with most complaints resolved at stage 1 and only limited escalation during the quarter.
5	Corporate Risk Register: Clinical Risks	The Committee reviewed the clinical risks and agreed that reporting represented an accurate statement of risk.
6	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.
7	Chief Pharmacist Standards: NHS Lothian Assurance Report	The Committee received appropriate assurance through the NHS Lothian pharmacy Service Level Agreement.

	Item	Summary
8	Bed Capacity Report	Reporting highlighted continued pressure on bed occupancy, with patient flow being managed within limited capacity and contingency arrangements available if required. Assurance was provided that despite ongoing pressures, admissions, transfers and patient flow continued to be actively managed, with contingency arrangements in place to support safe capacity management.
9	Duty of Candour Annual Report 2025/26	The Committee noted that no Duty of Candour incidents had been agreed in 2025/26, training compliance remained high, and revised screening arrangements had significantly reduced the number of incidents considered by the Duty of Candour Group.
10	Specified Persons Annual Report 2025/26	The Committee noted Annual Reporting was no longer required by Scottish Government. However, the data contained within the report will continue to be reported via the Incidents and Patient Restrictions quarterly report.
11	Research Committee Annual Report 2025/26	Reporting highlighted patient involvement, increased publication activity, and structured dissemination of research as supporting the use of evidence to inform practice. Members noted topics referenced in the report could be considered for future Committee presentations or a Board Development Session.
12	12 Month Reports: • Patient Safety Programme. • Rehabilitation Service. • Mental Health Practice Steering Group.	The Committee received assurance reporting from a range of areas, including the Patient Safety Programme, the Rehabilitation Service and the Menal Health Practice Steering Group. The Committee welcomed and acknowledged the scope and breadth of work across these areas.
13	Areas of good practice/concerns	The Committee noted the following areas of good practice: • Patient Safety debriefing guidance document template. • Duty of Candour Group's review of associated .investigation reports provided additional assurance and supported consolidated learning. • Patient involvement in research projects and structured dissemination of research across the organisation. • SAER Group's ability to meet required timescales.

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)26/02**

Minutes of the meeting of the Clinical Forum held at 10am on 10 June 25, 2026. by way of MS Teams.

Chair:	
Consultant Clinical Psychologist	Dr Joe Judge
Present:	
Consultant Psychiatrist	Dr Stuart Doig
Dietitian	Diane Mullen
In Attendance:	
Board Chair	Brian Moore
Director of Nursing and Operations	Karen McCaffrey
Head of Corporate Governance	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Joe Judge opened the meeting and welcomed everyone, noting apologies from Ashleigh Wallace.

2 MINUTES OF THE PREVIOUS MEETING

Members approved the minutes of the previous meeting.

3 MATTERS ARISING AND ROLLING ACTION LIST

Members noted that the position on the action list, and there were no other matters arising.

4 NURSE RESOURCING: DAYTIME CONFINEMENT AND IMPACT ON CPAs

Joe Judge opened discussion noting the background for this item and thanking colleagues for their contributions in preparing the letter sent to the Board Chair, and noting the response received. He confirmed that Brian Moore and Karen McCaffrey would be joining the meeting for this item. There was discussion around this, and the key areas for focus for today's discussion, and the role of the Clinical Forum in supporting the Board's understanding of the range of impacts that daytime confinement (DTC) had on the delivery of services and on patients as well as on staff in terms of their professional roles.

Joe Judge then welcomed Brian Moore and Karen McCaffrey to the meeting and offered thanks for the response received. He invited Brian Moore to offer some opening thoughts.

Brian Moore apologised for the delay in providing his response but noted that DTC remained an evolving issue. He confirmed that the Clinical Forum's correspondence had contributed helpfully to the wider discussion. He stated that, from both a Board and governance perspective, this had been a key area of focus over the preceding six months, with detailed consideration at Board level and through the Clinical Governance Committee. He noted that the impact on patients, as well as on staff and said that this been recognised and had been informed by relevant analysis and data. He

emphasised that the discussion now needed to move beyond analysis and understanding towards identifying and implementing solutions. He acknowledged that the Women's Service had been central to current staffing and resourcing pressures and had contributed to increased levels of DTC daytime. He also indicated that the discussion had highlighted the need to revisit aspects of the operating model and the approach to the clinical care policy, particularly where inconsistencies had been identified and where improved outcomes and more effective use of resources were required.

Mr Moore advised that additional resources from Scottish Government had been confirmed verbally and this would provide a stronger foundation for the Women's Service. At the same time, he cautioned that the position would not be resolved immediately and represented only one aspect of the wider challenges.

He noted in particular the comments made in relation to the concept of DTC being a never event, recognising that such an approach could present challenges while agreeing with the underlying principle. He further advised that Non-Executive Directors regularly attended the Patient Partnership Group and had received patient feedback directly in this way. He reflected that patient views could vary and that the issue was complex and multi-layered. He also observed that the wider clinical model continued to be reviewed and developed, noting that there may be on going refinement. He invited Karen McCaffrey to provide an update on more recent initiatives.

Karen McCaffrey acknowledged the complexity of the issue and stated that the contributing factors were understood. She recognised the frustrations expressed, noting that a significant amount of work had already been undertaken, not only to understand the problem but also to identify potential solutions to DTC. She advised that progress had been affected by a range of factors, including the introduction of the Women's Service and the reduction in the working week, but confirmed that the organisation remained committed to addressing the matter. She further noted that the impacts on patients, staff and professional groups had been recognised and was being reflected within reports to the Clinical Governance Committee.

She advised that, from a Board perspective, it had been necessary to quantify the level of DTC and to understand the reasons for its use, particularly where the practice could not be fully justified. She noted that some staff had initially viewed DTC as a safe practice because of its origins during the Covid-19 pandemic, but emphasised the longer-term harm to patients, particularly where confinement affected engagement with clinical teams. She confirmed that the hospital was committed to ensuring that any time patients spent in their rooms was proportionate, carefully monitored and clinically justified.

Karen McCaffrey outlined that work had also been undertaken to create greater stability within the staffing position, including through approval to over-recruit. She highlighted the need to understand the factors underlying current practice, including compliance with the clinical care policy, the balance of experienced and less experienced staff, and requests for additional staffing support linked to clinical acuity. She stated that the Clinical Forum could provide a helpful contribution to that work by supporting discussion and understanding of these issues. She further noted that, although available data indicated that acuity had not changed significantly compared with historical levels, the organisation was requesting more staff than previously to manage it, and that this required further examination, including consideration of staff confidence, capability and support.

Stuart Doig picked up on these points, and emphasised the harm caused by DTC and the way in which this had increased in recent months as a result of a system under strain. As a consequence, it was difficult to assess patients, and for them to progress on from Enhanced Care Plans (ECPs). In this way DTC was contributing to delays in treatment. This in turn may impact on bed availability within the Admissions Service i.e. if patients were delayed in moving on through the services. He considered that the risk was of these impacts increasing citing recent pressures in patients not being able to attend their CPAs due to operational pressures.

Joe Judge concurred and reflected further on how this impacted on professional practice at the front line referring to the inability to arrange formulation meetings to assess patients due to lack of

availability of nursing colleagues, the overall impact this would have on the patient. There had been a marked increase recently in psychologist colleagues reporting going to assess patients on wards and being unable to do so as patients were confined to their rooms.

Karen McCaffrey acknowledged these pressures and the importance of these incidents and experiences being reported through the Service Leadership Teams (SLTs), and to the DTC Oversight Group. Stuart Doig thought that it was important for the SLTs to establish a strengthened position within the governance structure and referred to current proposals for a change within the clinical model and structure of services which should help in this respect, especially in escalating identified risks or concerns quickly. In response, Karen McCaffrey underlined the importance of ownership on the part of SLTs, to provide meaningful data led reporting. This was something she would help to lead on working alongside Clinical Leads for each service.

The discussion moved on to consideration of secure care being at the core of the aims of the State Hospital, and the key dimensions of this this being physical, procedural and relational security. Stuart Doig said that it may be more straightforward to assess physical security but that there may be wider challenges in procedural and relational security. All three aspects required to be functioning well in order to deliver safe, high-quality care. He cited examples of inconsistency in procedural practice e.g. Room4 U with lack of concrete definition and guidance causing additional confusion. Further, taking relational security as being staff understanding of patients and their environment, then the operational pressures causing staff moves meant that the ability of staff have this type of knowledge was undermined. He referred to the recent serious incident that occurred and the Serious Adverse Event Review (SAER) underway in this regard.

Karen McCaffrey provided assurance that she had recently led a development session with nursing colleagues to focus on operational pressures, and that an Interim Operating Model was under development for implementation. She was in agreement on the importance of all three aspects of security working in alignment and the need for change in operational delivery to support procedural and relational security. She said it was essential that care delivery enabled professional colleagues to utilise their clinical judgement and expertise.

Brian Moore added that he found this discussion helpful and also referred to the security review commissioned by the Chief Executive, and that there would be further opportunities to consider all three aspects of secure care. He also noted that whilst the hospital was in a positive position in terms of nursing recruitment, it was important the newer nursing cohorts were supported as they developed their practice within the hospital. Overall, there was a key need to address DTC and thus improve patents outcomes as well as staff experience in their day to day working lives.

Joe Judge spoke to the discussions within the Clinical Forum this year, with colleagues voicing concern about safety and how this may impact on a perceived need for increased staffing levels being the solution. He thought that there a need to consider this in a more nuanced way, to help understand staff views. Stuart Doig agreed with this especially in the context of the incident which had occurred in April and highlighted the reflective practice work being delivered to help support staff, and the proposal under development for structured care.

Karen McCaffrey welcomed this and noted that this approach should anchor operational delivery. Reflective practice was essential especially in terms of the undoubted impact of either being involved in or being aware of a serious incident within the hospital as a secure environment. This would affect responses and practice in the future and colleagues required safe spaces in which to reflect on this. Joe Judge noted the difficulty for nursing colleagues in particular to attend these sessions due to operational pressures. Stuart Doig added that this really tied into the previous discussion about relational security, noting the need for staff to understand patients and the environment and that this had to be a key part of handovers. It had to be part of day-to-day business. Karen McCaffrey added her agreement to this, and the need to further support staff throughout their careers. This meant that in addition to the induction package, there also had to be a more comprehensive three-year plan which included mentoring by more experienced colleagues so as to harness those skills.

Diane Mullen thought that this was helpful and spoke to the particular pressures experienced within Allied Health Professionals (AHPs) who supported services within the wards. She was concerned in particular about the impact on students and their experience of the hospital. It was difficult to provide students with the full experience they should have included e.g. observational practice due to operational pressures and DTC. There had been clear impact of staff morale within the AHP Service over the recent period and colleagues reported feeling that they were unable to deliver their key aspects of their professional practice. There had been loss of Occupational Therapy (OT) staff who had chosen to move on to other roles.

Brian Moore acknowledged that the turnover of OT staff was disappointing and should be taken on board and noted that overall turnover of staff across services was in a more positive position.

Joe Judge emphasised the length of time that DTC had been experienced at the hospital, with an aim of eliminating this practice. However, this had not been achieved, and the impact and risks were increasing over time without a solution being found. This was the essence of the concerns being raised by professional colleagues as part of the Clinical Forum. Ms McCaffrey fully acknowledged this and said that she understood these concerns. She reflected on the need to tackle each of the component factors that were contributing to DTC. Whilst nursing recruitment efforts were proving successful, this was only one part of the overall solution. She went on to say that the introduction of the Women's Service had been a key component in the challenges being faced. However, there needed to be greater change in practice in order make the progress required and the discussions today were helpful in understanding staff experience and views. She would welcome returning in future following implementation of the Interim Operational Model.

Brian Moore underlined the importance of the Clinical Forum as part of overall Board governance and said that he very much welcomed the re-establishment of the group. He provided assurance that the views expressed would be fed into ongoing consideration of this issue by the Board.

Brian Moore and Karen McCaffrey left the meeting at this point.

Members further discussed the helpfulness of this discussion and that the hope was that this did help to inform the Board's understanding and views of what was a complex and challenging situation.

5 REVIEW /UPDATES FROM EACH GROUP/PROFESSION

(a) Medical Advisory Committee

Forum members received and noted the Medical Advisory Committee (MAC) Meeting minutes from 9 March 2026.

Stuart Doig advised that the latest meeting had taken place on 8 June and that there had been a focus on the difficulties on patients being able to attend their CPAs, and how this related to the definition of a "locked area" and staffing levels. Specifically, that case conference rooms where CPAs were held were defined as such. However, in a practical basis this did not necessarily point to a higher staffing level being required on a case-by-case basis. He advised he was taking forward further consideration of the interplay between ECPs and DTC and challenges arising from that and writing to the Medical Director on behalf of the MAC. He would share this with the Clinical Forum.

Action – Stuart Doig

(b) Psychology Professional Practice Group

Members received and noted the Psychology Professional Practice Group Meeting minutes from 9 April 2026.

Joe Judge also highlighted a visit by the Chair of the Clinical Psychology Division of the British Psychology Society. Further, that there had been discussion of the proposed changes in the hospital in the context of DTC and the current operational challenges.

(c) Allied Health Professionals Advisory Group

Members received and noted the minutes of the meeting of the AHP Advisory Group which had taken place in May.

Diane Mullen Aso advised that discussion had included DTC and staffing pressures and how to adapt delivery of services within this context. She provided an update on recruitment within the service. Finally, she noted that this would be her last attendance at the Clinical Forum, as she was moving on to a new role herself. Colleagues expressed their thanks for her work and helpful contributions in setting up an AHP group and working with the Clinical Forum.

(d) Pharmacy

Members received and noted the Pharmacy Group Updates from May 2026 as well as the most recent Medicines Incidents Flash Report for information.

(c) Nursing

The Clinical Forum highlighted concern about the lack of progress in setting up a nursing advisory group. Margaret Smith advised that she had met with the Associate Nursing Director to help bring focus on this and to seek support in taking this forward. This had included perceived difficulty in taking this forward presently given the resourcing position. Margaret Smith noted that she had been able to outline the ways in which the Senior Nurses Forum could not fulfil the role of an advisory forum, and this led to discussion of how to make this an inclusive group through nomination and election of nursing members from each service across the hospital and to include both registered and non-registered nursing colleagues. She also noted that it had been helpful to discuss the positioning of the Clinical Forum as part of Board governance, as had been highlighted by Brian Moore at this meeting today.

Josie Clark had confirmed that she would meet with Karen McCaffrey to review the draft terms previously drafted and the proposed way forward, and an update would come back to the Clinical Forum. The aim was to be in a position to launch this following the summer period.

Members noted the position, and also that although Hamish Fulford had been very helpful in supporting the re-establishment Clinical Forum, it was accepted that he had withdrawn as understandably he could not represent nursing colleagues without an agree structure in place.

6 BOARD STRUCTURE

Margaret Smith confirmed that this had been included in the papers to help to support the discussion of the position of the Clinical Forum and related professional advisory groups within the Board.

7 ANY OTHER BUSINESS

There was no other business raised at this meeting.

8 NEXT MEETING DATE

The next meeting to be held on 10 September 2026 at 10:00am via Microsoft Teams.

The meeting ended at 12noon.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 16
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 July 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.

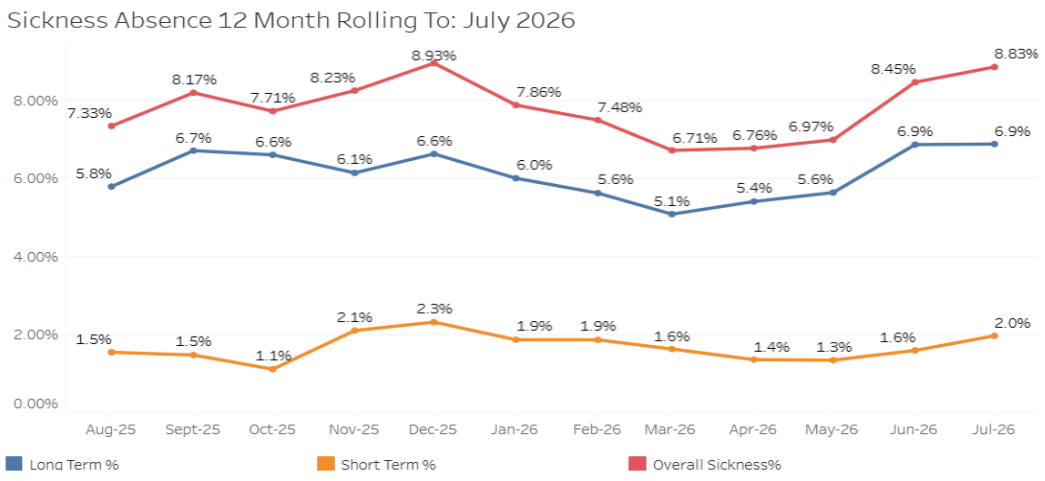
3 ASSESSMENT

3.1 Attendance Management

3.1.1 TSH Sickness Absence current position

The positive and sustained improvements in absence over the early part of the year have been replaced with significant increase over the months of June and July. The July position is 8.83%, 2.12% higher than March 26, which was 6.71%. This is illustrated in graph 1 below.

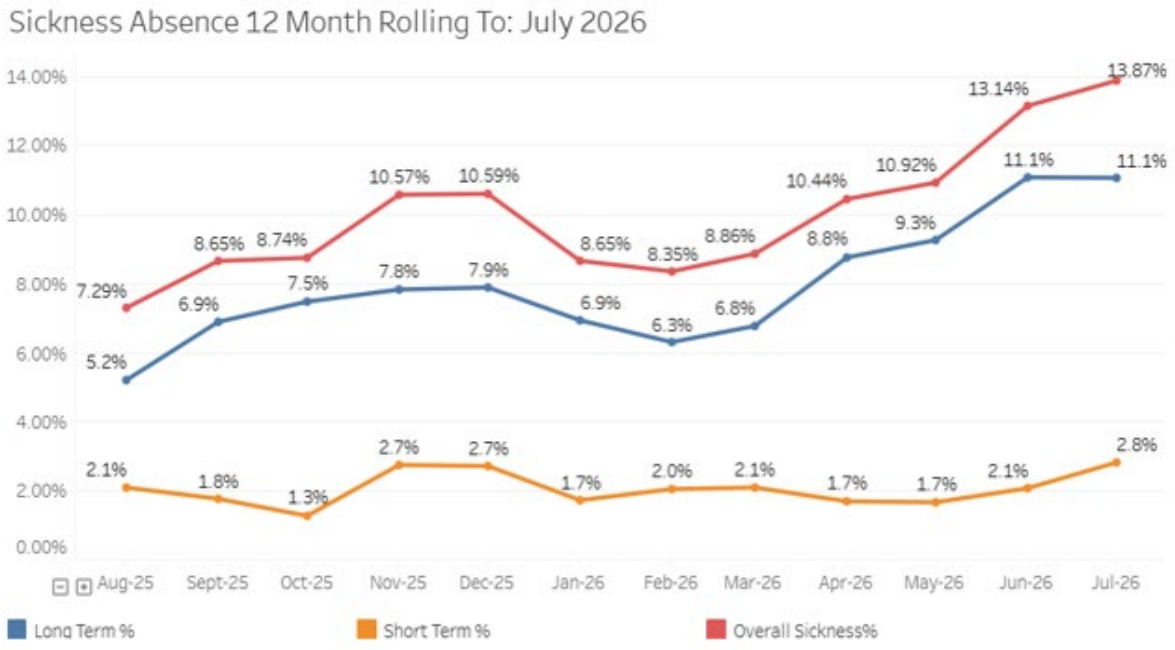
Graph 1 – All Staff



3.1.2 Nursing Sickness Absence

There has been a significant increase absence within Nursing as outlined below (from 8.35% in Feb 26 to 13.87% in July 26). The total absence spike is almost identically mirrored by long term absence, although this looks to have plateaued in July. The scale of this spike is demonstrated by the absence rate in Nursing in August 2025 which was 7.29% and our July 26 figure is almost double at 13.67%. There is a correlation between our working environment and overall wellbeing, to the ongoing challenging resourcing position with a significant increase in long term absence, anxiety and stress as the highest type of absence, and a workforce which needs greater capacity or new ways of working to support our current model. Proactive and mitigating actions will be covered later in the paper.

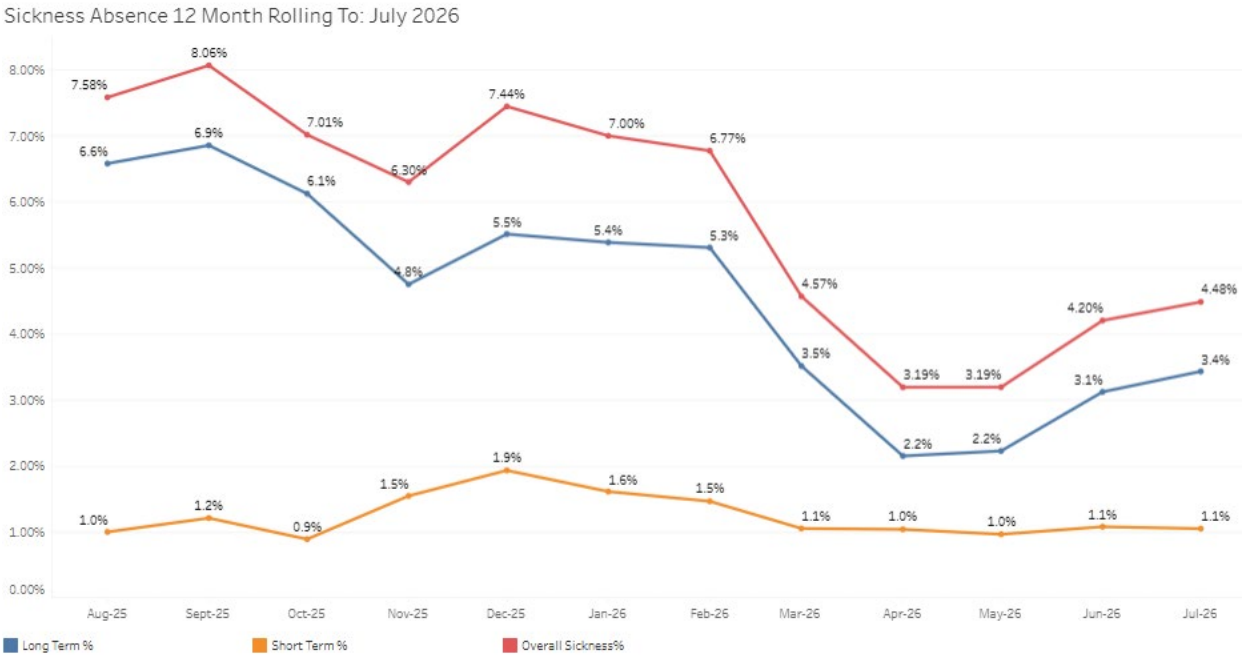
GRAPH 2 – Nursing Hubs



3.1.3 Departments out with Nursing

Non-Nursing ward areas have demonstrated an overall improvement across the rolling year, decreasing from 7.58% in August 2025 to 4.48% in July 2026, albeit there was a slight increase in absence during June (from 4.2% to 4.48%). The data therefore indicates that the current organisational absence position is being driven primarily by sustained and increasing absence levels within Nursing Wards.

Graph 3 – Non-Nursing Staff



3.1.4 Attendance Management Observations

Short-term absence: 2% (an increase of 0.4% since June).

Long-term absence: 6.91% (remains the same since June).

The principal causes of long-term absence during July 2026 were:

- Anxiety, stress, depression and other psychiatric illnesses (2,414 hours lost).
- Injury/fracture (1,401 hours lost).
- Other known causes not otherwise classified (903 hours lost).

The principal causes of short-term absence during July 2026 were:

- Unknown cause/not specified (303 hours lost).
- Injury/fracture (302 hours lost).
- Anxiety, stress, depression and other psychiatric illnesses (207 hours lost).

All absences with ‘unknown cause’ reason are explored with the manager to ensure appropriate use of sickness absence and accurate reporting.

At the time of reporting, six employees had been invited to a Stage 1 Attendance Management meeting during July. There were no Stage 2 or Stage 3 meetings held.

In the past 12 months, 161 employees have been placed on formal monitoring. For employees currently on monitoring:

- 44% are monitored for between three and five months.
- 35% are monitored for six months.
- 16% are monitored for between seven and nine months.
- 5% are monitored for 12 months.

3.1.5 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 screenshot below reflects the June 2026 position.

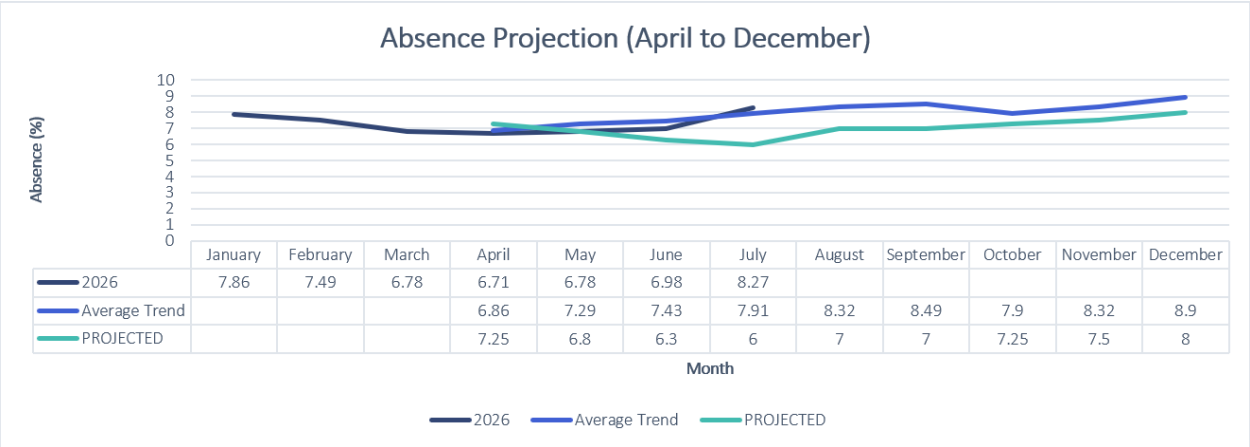
Sickness Absence Statistics by NHS Board

1st June 2026 - 30th June 2026

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**6.19**	**4.19**	**2.00**	**34,574**	**11,145**	**23,429**	**31,757**	**2,817**
NHS Ayrshire & Arran	6.21	4.44	1.77	1,926	677	1,249	1,797	129
NHS Borders	6.04	4.04	2.00	604	191	413	542	62
Public Services Delivery Scotland [4]	3.32	2.40	0.92	682	225	457	627	55
NHS 24	9.13	6.08	3.05	607	186	421	591	16
Healthcare Improvement Scotland	6.19	4.97	1.22	81	36	45	76	5
Public Health Scotland	2.81	1.89	0.92	133	32	101	125	8
Scottish Ambulance Service	9.19	6.66	2.53	1,282	506	776	1,221	61
The State Hospital	7.41	5.56	1.85	122	56	66	113	9
National Waiting Times Centre	5.90	3.92	1.97	498	161	337	455	43
NHS Fife	6.45	4.77	1.68	1,647	662	985	1,584	63
NHS Greater Glasgow & Clyde	6.31	4.45	1.86	8,020	2,971	5,049	7,502	518
NHS Highland	6.16	3.99	2.17	2,236	628	1,608	1,822	414
NHS Lanarkshire	7.08	5.25	1.83	2,602	1,080	1,522	2,348	254
NHS Grampian	5.24	2.93	2.31	3,355	709	2,646	2,936	419
NHS Orkney	6.33	4.34	1.99	143	42	101	136	7
NHS Lothian	5.79	3.59	2.20	5,270	1,382	3,888	4,795	475
NHS Tayside	6.35	4.16	2.19	2,727	812	1,915	2,525	202
NHS Forth Valley	6.89	4.77	2.12	1,350	463	887	1,301	49
NHS Western Isles	6.56	4.21	2.35	227	55	172	224	3
NHS Dumfries & Galloway	6.43	3.94	2.49	923	243	680	909	14
NHS Shetland	4.33	2.33	2.00	139	28	111	128	11

3.1.6 Projected Position

The current spike in absence has taken absence out with the level of tolerance (between average trend and projection) and will require sustained and focus improvement over the next two months to lower this position, in advance of the challenges of Winter. The anticipated onboarding of staff in August and October, along with ongoing recruitment and the introduction of the Interim Model will be key.



3.2 RECRUITMENT

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

3.2.1 Time to Hire

The average Time to Hire in July was 81 days, (the KPI being 75 days). Areas where we are successfully below the national KPI are:

- Job Approval to Live by one day.
- Closing date to shortlisting complete by four days and from Conditional Offer to Contract issued by five days.
- The average time from job approval to advert going live was one day, exceeding the KPI target of two days, demonstrating timely progression at the initial stage of the recruitment process.

However, stages of the process which are out with the KPI are:

- The average time from advert live to closing date was 16 days, compared with the KPI target of 10 days.
- The average time from interview invitation to interview date was 13 days, against a target of seven days, indicating delays between shortlisting and interview.
- The average time from interview completion to conditional offer was six days, compared with the KPI target of two days.
- The most significant delay within the recruitment process continued to be the period from conditional offer to completion of pre-employment checks, which averaged 48 days against a KPI target of 20 days.

3.2.2 Vacancies Advertised

During July 2026, there were five advertisements, comprising four Support Services positions and the Registered Nurse role.

3.2.3 Ward-Based Nursing Recruitment

The following nursing staff are due to commence employment:

- August induction: Nine (five female / four male, eight starting as Band 3 initially).
- October induction: Nine (eight females / one male, one already SN, eight potentially starting as Band 3 initially).

Further interviews for Registered Nurses will take place on 27 August 2026.

3.3 EMPLOYEE RELATIONS - LIVE CASES

There are 11 formal cases to report.

3.3.1 Eight Formal Conduct

Six are connected to one event and the investigation is expected to conclude by mid-September.

The other two conduct cases (one commenced in March and one in June), have both progressed however, have experienced complicating factors such as new allegations being raised during the process. For the case that was raised in March, the investigation is predicted to conclude by mid-October due to the requirement for further investigation interviews associated with new allegations and the notice periods associated with the Once for Scotland policy for notes being approved and meeting arrangements.

3.3.2 One Formal Grievance

During the reporting period, the grievance which was raised in February has progressed to stage 2 with dates being arranged for this to take place.

3.3.3 Others

During July there was one appeal against absence management stage 2 decision and 1 one flexible working appeal. Both of which were dealt with and outcomes given within the month of July.

3.4 LEAVERS

Eighteen employees have left the organisation year to date (April to July 2026). Ten within Nursing and AHP, six within Medical, one in Workforce and one in Security Division.

There were six leavers during July 2026, across the Nursing & AHP and Medical Directorates.

Year-to-date turnover currently stands at 2.63%.

Based on 18 leavers year to date (2026/27), the current exit interview completion rate is 27.8%. For comparison, the completion rate for the full year 25/26 was 50%. Work is ongoing to encourage all staff to complete their exit interview prior to leaving the Board.

3.5 JOB EVALUATION

3.5.1 Progress & Status

Two new job descriptions were submitted in July with panels scheduled in August.

3.5.2 Band 5 Reviews

Two reviews are submitted which are awaiting Lead Nurse approval.

3.5.3 Job Evaluation Steering Group

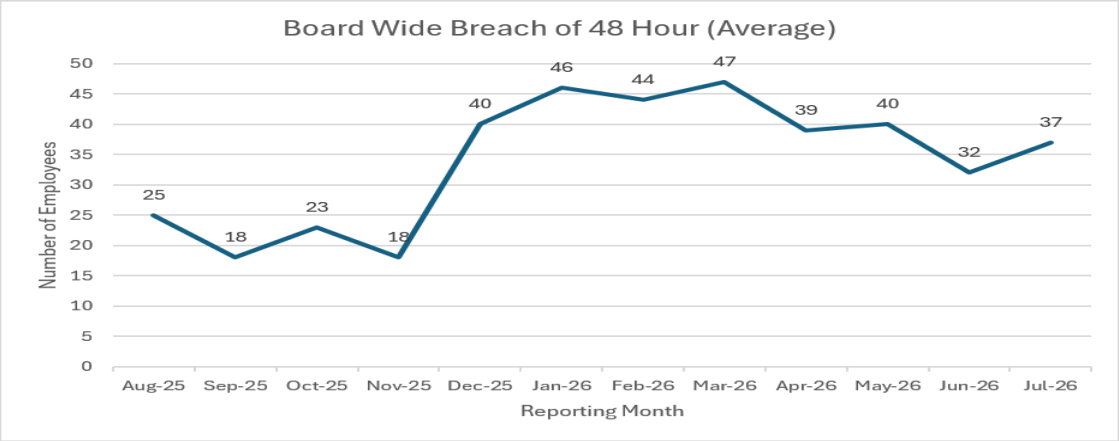
The group is scheduled to meet in August to review national actions, plans for any approved Band 5 reviews and appraise progress / scheduling of panel arrangements.

3.6 WORKING TIME REGULATIONS OVERVIEW - BOARD WIDE BREACH OF 48-HOUR (AVERAGE)

Board wide, there were 37 staff who breached the average 48-hour working week as defined by WTD as highlighted above. This number has increased by five from the 32 staff who breached in June 2026.

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

Currently 62% of those employees who have breached the average have completed a waiver, Work will continue to address compliance in terms of those working with a waiver, and to reinforce that staff should not work beyond these hours without the waiver.

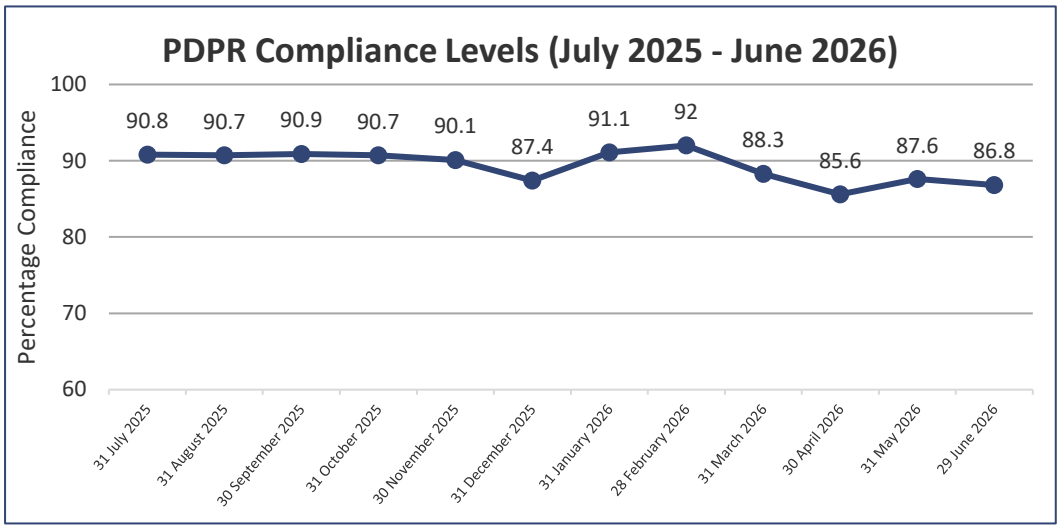


The most significant concentrations are within Arran and Iona Hubs, which together account for over half of all identified breaches. The number of breaches, and compliance with waivers, will continue to be monitored through the Nursing Partnership Forum.

3.7 PDPR COMPLIANCE

The chart below provides details of PDPR compliance for the period from July 2025 to June 2026, indicating that a high level of compliance is being effectively maintained.

Key challenges in maintaining above 90% have been resourcing, in allowing time for PDPR to be completed: this position and those areas under performing have been reviewed and action plans in place to raise 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 Workforce - Support the Independent National Whistleblowing Standards and support this workstream locally including promoting awareness for staff.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	WGG & SGC
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 17
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Update – Quarter 1
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

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

3 ASSESSMENT

The Quarter 1 update is from 1 April 2026 to 30 June 2026.

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

Two anonymous concerns were raised direct to the TSH during this quarter, and they were advised that anonymous concerns do not meet the criteria for the Whistleblowing Standards.

Both concerns were escalated and have been managed through Business-as-Usual processes.

In the performance year 2026/27 to date, the State Hospitals Board for Scotland had no cases raised under Whistleblowing.

4 RECOMMENDATION

The Board is invited to note the content of the Quarter 1 Whistleblowing Position.

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 Workforce - Support the Independent National Whistleblowing Standards and support this workstream locally including promoting awareness for staff.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	N/a
Risk Assessment (Outline any significant risks and associated mitigation)	N/a
Assessment of Impact on Stakeholder Experience	Na
Equality Impact Assessment	N/a
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	
Data Protection Impact Assessment (DPIA) See IG 16. 1. There are no privacy implications. 2. There are privacy implications, but full DPIA not needed 3. There are privacy implications, full DPIA included Please state which option above applies (i.e. 1, 2 or 3).	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE SGC(M)26/02

Minutes of the meeting of the Staff Governance Committee held on Thursday 21 May 2026.

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

Chair:	
Non-Executive Director	Ms Radage
Present:	
Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Non-Executive Director	Shalinay Raghavan
In attendance:	
Joint Head of Organisational Development and Learning	Graeme Anderson
POA Representative	Alan Blackwood
Associate Director of Nursing	Josie Clark
Personal Assistant	Jen Davies **[Minutes]**
Chief Executive	Gary Jenkins
RCN Representative	Joanne Logan
Unison Representative	Anthony Mcfarlane
Head of Corporate Planning, Performance & Quality	Monica Merson
Head of Human Resources	Laura Nisbet
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 meeting and no apologies were noted.

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 12 February 2026.

The Committee:

1 Approved the minute of the meeting held on 12 February 2026.

4 MATTERS ARISING AND ROLLING ACTIONS LIST

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

The Committee:

1 Noted the updates from the Rolling Actions List.

5.1 OD LEARNING & WELLBEING UPDATE (INCLUDING OD STRATEGY)

The Committee received the OD Learning and Wellbeing Update (including OD Strategy) and Mr Anderson reported on PDPR, statutory and mandatory training, and induction compliance. He stated that PDPR compliance had reduced to 88.3% by end March, reflecting staffing pressures, and that actions to support improvement were under way, including manager training and escalation of non-compliance through management routes. Mr Anderson advised that statutory and mandatory training compliance was around 88% at end March, reflecting a slight decrease from February influenced by changes to national Once for Scotland modules. He reported that role-specific training remained broadly stable, induction compliance remained strong, and work continued with managers and staff to address a small number of overdue cases.

Turning to organisational development and wellbeing, Mr Anderson reported continued progress across the OD strategy, including service and team development, learning from the Excellence Awards, wellbeing support through the Wellbeing Centre, appointment of a new Staff Care and Wellbeing Officer, activity through the peer support network, preparations for the iMatter survey, and ongoing development of the integrated leadership management framework.

Mr Connor raised concern regarding overdue induction checklist completion, including a small number of cases dating back to January 2025 and others more than six months overdue, and sought assurance on action to address the backlog. Mr Anderson advised that the overdue items reflected individual circumstances in some cases and had been escalated to staff and line managers for follow-up. Ms Clark added that overall compliance had improved and confirmed that the remaining outstanding cases would be prioritised within nursing.

Ms Fallon highlighted the impact of vacancies and wider workforce pressures, particularly in Estates and Psychology, and noted the need to remain mindful of organisational responsibilities where induction had not been completed. She suggested that a future presentation at the Committee from a Peer Supporter, and in due course the Staff Care and Wellbeing Officer, may be helpful. Mr Wallace advised that these concerns had been raised through the Workforce Governance Group and were being followed up and clarified that the induction issue related primarily to sign-off rather than completion, with associated governance and legal risk implications. He also noted that the reduction in compliance reflected national changes to module expiry dates. Mr Jenkins added that the Estates position appeared cyclical and had previously improved following management intervention, and that the Psychology compliance issue would be followed up with the relevant service lead.

Ms Raghavan emphasised the need for robust training compliance to support assurance in the event of an incident or inquiry and sought clarification on whether the new staff wellbeing role would contribute to building a psychologically safe environment and support work on staff speaking up. Mr Anderson advised that the new Staff Care and Wellbeing Officer role had been expanded and would contribute not only to reactive staff support but also to preventative work, including support for speaking up, psychological safety and wider culture change.

Mr Currie welcomed the report and the breadth of activity under way, while emphasising the need for clarity in mandatory training requirements, early staff conversations, and a sustainable approach to measuring the impact of wellbeing activity. Mr Anderson acknowledged these points and advised that wellbeing provision was being strengthened to support a more preventative approach, and that reporting would return to the Committee in this respect.

There was discussion on rates of PMVA refresher training, with confirmation that this was under close review. Ms Radage also noted that inclusion of qualitative context alongside the quantitative data would support fuller understanding and assurance in reporting. She also asked about whether the introduction of the Women's Service had brought any need to consider the programme content. Mr Wallace confirmed that he was not aware that there had been any need for specific change, but clarification would be sought on this point.

Action: Mr Anderson

The Committee:

1 Noted the OD, Learning & Wellbeing Update (including OD Strategy).
2 Requested additional information on PMVA training as noted.

5.2 HEALTH DASHBOARDS (OD STRATEGY)

Committee members received the Health Dashboards (OD Strategy) report and Mr Anderson advised that the health dashboards formed part of a wider, evidence-led approach to culture change, initially focused on speaking up and psychological safety, with longer-term work under way to support organisational culture development through team development, the employee lifecycle and leadership frameworks. He added that the health dashboards would bring together existing workforce measures to provide a broader picture of team health and support earlier, more targeted intervention, and were intended as a support tool rather than a performance management measure.

Ms Fallon welcomed the dashboards and sought assurance that the dashboards would be understood as a support tool rather than a performance management measure. Mr Anderson advised that early feedback from initial ward and team testing had been positive, and that careful attention would be given to language, reporting arrangements and visibility to support sensitive implementation. Mr Anderson outlined that the dashboard process would involve quarterly reporting, threshold-based follow-up and review with team managers to agree targeted improvement actions, with the approach intended to strengthen local accountability and support timely intervention where required. To help demonstrate how the dashboard would work in practice, he also shared an example on screen and talked through how it would apply in a team setting.

Ms Nisbet added that the process considered not only the quantitative data within the dashboard but also the qualitative picture within each team, with key directorate staff reviewing the wider context, including any wellbeing, HR or other relevant factors, in order to provide the most appropriate and targeted support to that team.

Mr Jenkins noted that the dashboards formed part of a wider framework to support devolved local management, and that this would support ongoing work to define and support local team within wider environmental factors across the organisation. Mr Wallace added that the dashboard would provide a bespoke and practical means of directing workforce support to teams and services according to need, enabling the organisation to commission the right interventions, target resources more effectively, and measure whether improvement had been achieved.

There was further discussion on how to consider the impacts of this workstream which would benefit from further exploration at a future Board Development Session, and this was agreed.

Action: Ms Smith/Mr Anderson/ Mr Wallace

Ms Merson said that the organisation was using a whole-system approach to review performance and workforce health data, applying a structured framework to understand what the information showed, why issues had arisen, what action had been taken and what learning could be applied.

She added that this work was being supported through the development of wider dashboards bringing together a range of metrics to improve visibility and help the organisation support staff to deliver their roles effectively within a culture that promoted wellbeing.

The Committee:

1 Noted the Health Dashboards (OD Strategy).
2 Requested further review at a Board Development Session.

5.3 SUCCESSION PLANNING

Mr Anderson presented a draft succession planning framework intended to establish a consistent organisational approach aligned to workforce strategy, organisational priorities and the development of internal talent and capability. He advised that, given the Board's specialist roles and national remit, succession planning was a key strategic requirement to support continuity in critical posts. He outlined the proposed six-stage framework and confirmed that engagement on the draft would take place over the summer, with a final version to be presented to the Staff Governance Committee in August. Mr Wallace added that the draft framework had drawn on national development programmes and supporting tools, but required further engagement to ensure it reflected a broader range of roles and career aspirations before a final version was brought back to the Committee.

Mr Currie emphasised that succession planning should be realistic, support individual career aspirations, and avoid moving staff into roles beyond their capabilities or interests. He added that the organisation should identify and retain internal talent, support development openly and credibly, and demonstrate confidence in its own staff as future leaders.

Ms Raghavan welcomed the framework but emphasised the need for clear and reassuring communication to staff. Mr Anderson advised that succession planning would be supported through PDPR and aligned to the wider leadership and management framework.

Ms Fallon emphasised the need to use inclusive language when engaging with staff, so that roles were not presented in a way that could disengage employees and added that succession planning should support fresh thinking as well as continuity.

Ms Radage noted that succession planning should be a dynamic, employee-centred process that created opportunities for all staff rather than a static exercise, with further development to be brought back to the Committee after summer engagement.

Action – Mr Anderson

The Committee:

1 Noted Succession Planning.
2 Agreed that the finalised draft Framework should return to the August meeting.

6.1 WORKFORCE REPORT

The Committee received the Workforce Report to 30 April 2026 presented by Ms Nisbet who provided a summary of the key aspects. She highlighted continued recruitment activity, particularly within nursing, with vacancies largely at Band 5 and a continuing pipeline of new starts. She also provided updates on employability activity, low levels of employee relations and job evaluation cases, strengthened exit interview arrangements, and ongoing monitoring of working time regulation breaches in the context of staffing pressures and clinical acuity.

Ms Raghavan sought clarification on the recent in-person nursing recruitment event and whether it represented a new approach. Ms Nisbet confirmed that it had been introduced to improve efficiency and access by enabling same-day interview and offer, had resulted in 12 offers, and was intended to be repeated. Ms Clark added that the organisation intended to repeat the in-person recruitment approach with third-year nursing students over the summer, including invitations to visit the hospital and interview at that stage.

Ms Fallon sought assurance on the location and impact of remaining non-nursing vacancies and the risk associated with Working Time Directive breaches. Ms Nisbet advised that further analysis was being developed through a detailed establishment workbook and that, outwith nursing, the most significant proportionate vacancies were within Security, with other vacancies limited and dispersed. Mr Wallace added that vacancy risks were overseen through the Workforce Governance Group and that the current position did not present any greater risk at that time.

Ms Radage noted the positive recruitment approach and the early potential of modern apprenticeships and highlighted the need for continued monitoring of Working Time Directive breaches. Mr Wallace advised that breach levels remained above the desired position due to staffing pressures and should be reduced as far as possible in the interests of staff health and work-life balance.

Mr Jenkins agreed that while the report provided a broad range of workforce metrics, further work was required to present vacancy information more explicitly at a high level, particularly outwith nursing, and to strengthen governance oversight of Working Time Directive (WTD) compliance through more detailed review and exception reporting. Ms Radage summed up for the Committee, agreeing that whilst detailed operational information was not required, it would be helpful for reporting to be extended to present the wider challenges being experienced within specific areas.

Action – Ms Nisbet

The Committee:

1 Noted the Workforce Report.
2 Requested exception reporting as required on areas of challenge in respect of the WTD.

6.2 MAXIMISING ATTENDANCE UPDATE

The Committee received the report, presented by Mr Wallace who reported that sickness absence had reduced to 6.78% at end March 2026, with overall absence for 2025/26 at 6.69%, reflecting improvement on the previous year and particularly in long-term absence. He advised that projected trend data had been introduced to provide a more realistic baseline for scrutiny, and highlighted continued local action in higher absence areas, signs of improvement across those teams, a stable occupational health position, and the need for ongoing management of some recent increase in long-term cases.

Mr Currie welcomed the inclusion of projected absence trends, noting that these would support more realistic scrutiny, better understanding of the causes of absence, and more targeted action to support staff wellbeing, attendance and use of resources.

Ms Fallon highlighted the significance of carer responsibilities as a contributory factor in absence related to anxiety, stress and depression, and suggested that this be explored further to inform targeted wellbeing support. Mr Wallace agreed and noted the need for earlier, more joined-up support to help prevent avoidable sickness absence.

Mr Blackwood welcomed the development of the team health dashboards and looked forward to seeing how they would provide greater insight into sickness absence and support improvements in attendance over time.

Ms Radage welcomed the report, noted signs of improvement in the management of absence and its associated costs, and said that the organisation should continue this approach while monitoring progress through future reports.

The Committee:

1 Noted the Maximising Attendance Update.

6.3 MANAGEMENT OF EMPLOYMENT RELATION (ER) CASES: IMPROVEMENT PLAN

The Committee received the Management of ER Cases: Improvement Plan, and Ms Nisbet provided an update on work arising from previous case learning and engagement with staff-side representatives. She advised that Appendix A set out the agreed themes and actions for oversight, with 11 actions completed and seven in progress, including changes to ways of working, additional training and further guidance where gaps had been identified in policy, local processes or the commissioning manager role.

Ms Fallon welcomed the report as clear and improved, and noted that meeting staff off site where appropriate represented helpful progress in supporting those absent through sickness to re-engage more easily. Ms Raghavan noted the person-centred approach in the report and sought assurance on whether KPI monitoring had been considered for the timely appointment of commissioning and investigating managers. Ms Nisbet advised that the key learning related to delays at the start and conclusion of investigations, and that these remained a focus in oversight of employee relations cases, with local KPI measures used where appropriate.

Mr Currie noted that the report demonstrated meaningful organisational learning and a mature approach to employee relations and emphasised the importance of progressing cases as quickly as possible in the interests of fairness, avoiding unnecessary delay and cost, and maintaining constructive staff-side engagement. Mr Connor echoed these comments and welcomed the report, noting that, from a staff-side perspective, it reflected the actions previously discussed and agreed and represented positive progress.

Ms Radage welcomed the report and noted that progress was being made in strengthening the quality and consistency of case management and emphasised the importance of respectful arrangements and wellbeing support for individuals involved, particularly where cases were difficult or potentially traumatic.

The Committee:

1 Noted the Management of ER Cases: Improvement Plan.

7.1 WORKFORCE EQUALITIES GROUP: ACTION PLAN

Mr Wallace provided an update on the work of the Workforce Equalities Group, advising that a draft annual equalities plan, incorporating anti-racism priorities, was in development. He outlined progress in relation to senior engagement and visibility, education and awareness, zero tolerance, monitoring and recording, and cultural development, aligned to wider work on speaking up and psychological safety, while noting that capacity remained a challenge. He added that the draft plan aimed to support visible culture change through targeted campaigns, accreditation and training opportunities, including work linked to White Ribbon and Equally Safe at Work, informed by findings from the lived experience survey. He advised that the paper was intended as a high-level progress update, with a final version to follow after the summer alongside implementation of the agreed actions.

Ms Fallon sought clarification on the relationship between training and inequalities, progress on dashboard reporting, and how allyship would be taken forward.

Mr Wallace advised that relevant iMatter indicators could be incorporated into future reporting, although the work remained at an early stage, and that a more formal approach to allyship would be developed, informed by learning from other Boards.

Ms Raghavan thanked Mr Wallace for the work undertaken and noted the value of learning from other Boards with more developed programmes. She added that allyship and network development would take time but could be progressed gradually through collaboration and increased awareness. Mr Jenkins agreed with the proposed approach and reiterated that anti-racism should remain an explicit but integrated part of the wider equalities work. He added that concepts such as allyship would require clearer promotion and explanation across the organisation.

Mr Moore noted that he remained concerned by some of the findings of the lived experience survey but recognised the work presented as representing significant progress and thanked those involved for their contribution.

Ms Radage agreed that the survey findings had been stark but welcomed the swift development of the action plan, noted the early progress made, and confirmed the Committee's support for the proposed way forward.

Action – Mr Wallace

The Committee:

1 Noted the Workforce Equalities Group: Draft Action Plan.
2 Agreed that a finalised plan would return to the next meeting.

7.2 FITNESS TO PRACTICE ANNUAL REPORT

The Committee received the Fitness to Practice Annual Report, which outlined the process for monitoring professional registration status at the State Hospital for all staff for whom professional registration is a statutory requirement. Ms Nisbet presented the report and provided assurance that all staff requiring professional registration held current registration, supported by established pre-employment and ongoing checking processes. She added that there had been no lapses or expiries affecting patient care or service delivery during the reporting period, although one routine extension to revalidation had been granted.

Mr Blackwood asked whether future reports should also identify cases where staff had been referred to their professional regulatory body through internal disciplinary processes, particularly to support oversight of longer-running cases and staff wellbeing. Ms Nisbet noted that the issue could be considered further through workforce governance arrangements, but that its relevance for Committee reporting would require review.

Ms Radage welcomed the comprehensive report and the assurance it provided, recognising the work undertaken to achieve that position.

The Committee:

1 Noted the Fitness to Practice Annual Report.

7.3 INTERNAL AUDIT – NURSING ROSTERING IMPROVEMENT PLAN

Ms Clark provided a verbal update on progress following the previous audit of rostering practice, advising that a local audit process had been introduced and that work had been undertaken to improve audit returns.

She added that concerns raised at the February meeting had prompted further engagement with staff-side representatives, which had helped to clarify the areas of concern and inform the next phase of the work.

She explained that, following discussions with the Lead Nurse for Workforce Planning, a revised audit process had been developed under which independent monthly audits would now be undertaken and reported to relevant managers. She added that the findings would be reviewed to identify any required action, improvement activity or performance management response. In answer to a query from Mr Connor about the process, Ms Clark confirmed that she would liaise with him directly as this continued to be developed.

It was agreed that a fully detailed report be brought back to the Committee in August to provide assurance and set out any further areas for improvement.

Action – Josie Clark

The Committee:

1 Noted the verbal update of the Internal Audit – Nursing Rostering Improvement Plan.
2 Agreed that fully detained reporting would be presented to the next meeting.

7.4 E-ROSTERING UPDATE

The Committee received the e-Rostering Update and Mr Wallace provided a summary overview of this, advising that implementation of the 36-hour working week had been completed and full updated rosters were now in place across all areas. He reported good progress with SafeCare and Loop, including strong staff uptake of self-service functionality, but noted that full benefit realisation remained constrained by the lack of integration between Optima, SSTS and payroll, requiring ongoing double keying and limiting efficiency gains pending national system developments.

Ms Fallon commended the work undertaken to complete the Optima exercise in support of the 36-hour week. Ms Raghavan echoed the Ms Fallon's comment and recognised the scale of the work involved. She asked whether the longer-term intention was to simplify and better integrate the different systems, given concern that the current arrangements appeared more complex than originally intended.

Mr Jenkins reassured the Committee that the wider national business systems work remained under active discussion at Chief Executive level and that the associated risks were well understood. He added that, while the Board was well advanced, further reflection would be needed on system design, procurement and future requirements, including the potential role of AI.

Ms Radage welcomed the update and noted the helpful wider context provided and acknowledged that further work would be required to achieve an optimal long-term solution.

The Committee:

1 Noted the e-Rostering Update.

8.1 WORKFORCE GOVERNANCE GROUP OVERVIEW

The Committee received the Workforce Governance Group Overview and Mr Wallace summarised the most recent meeting. He advised that the Group had reviewed key workforce performance issues and risks, including sickness absence, vacancies, PDPR and mandatory training compliance, with recovery planning in place and no new workforce risks identified.

He added that the Group had also considered health dashboards, organisational development and culture change, attendance and employee relations, training plans, early work on recruitment and retention, national iMatter findings, and routine workforce change and vacancy oversight.

Ms Radage welcomed the update and noted that the summary had been clear, concise and helpful.

The Committee:

1 Noted the Workforce Governance Group Overview.

8.2 PARTNERSHIP FORUM APPROVED MINUTES

The Committee received the approved Partnership Forum Meeting minutes from 10 February 2026. Ms Radage noted that it was helpful to have sight of the minutes for openness and transparency.

Ms Fallon asked whether the issue noted in the minutes in relation to sickness payments for staff on SSR contracts, and its potential equality implications, would be reported back to the Committee, and welcomed the positive use of the Wellbeing Centre by staff. Mr Wallace noted the delay had been due to a Special Meeting of the Partnership Forum and advised that a response on the sickness payments issue for staff on Supplementary Staffing Register (SSR) contracts would be brought to the next Partnership Forum.

The Committee:

1 Noted the Partnership Forum Minutes.

9.1 STAFF GOVERNANCE COMMITTEE ANNUAL REPORT

The Committee received a draft annual report, outlining its activities for 2025/26 as well as presenting its terms of reference for review. Ms Radage opened discussion by noting the content of the annual report and inviting Ms Smith to comment on this within the governance framework. Ms Smith noted that this was part of annual reporting to the Bard, and the greater consistency in reporting across the standing committees. She added that reporting helped to demonstrate the way in which the Committee fulfilled its remit and considered its own effectiveness.

Mr Wallace agreed with Ms Smith's comments and added that the report had followed the established format and was intended primarily to provide assurance that the Committee had fulfilled its responsibilities over the year through attendance, regular reporting, annual compliance returns and oversight of key workforce, wellbeing, learning, fitness to practise and risk matters. He further added that it had also provided an opportunity to reflect on and recognise areas of good practice and improvement arising from the Committee's work.

Ms Raghavan noted that recent engagement with the National Whistleblowing Office had been helpful in recognising the challenges for staff confidence and confidentiality within a small Board and had provided positive feedback on work to strengthen psychological safety. She added that further consideration would be given to external and confidential routes for raising concerns. Mr Jenkins suggested that, drawing on a point previously raised by Mr Connor, there might be value in considering an approach similar to the counter fraud process, whereby concerns could be raised through an external route and notified back to the organisation through an agreed and transparent process, in order to support confidence.

Ms Radage commended the improved quality and focus of papers in supporting effective Committee discussion throughout the year.

There was agreement from members of the Committee that reporting reflected the work conducted and demonstrated that the Committee had fulfilled its remit. Ms Radage also noted the Committee's agreement to approve its terms of reference with no amendments made.

The Committee:

1 Endorsed the Staff Governance Committee Annual Report, and that it should proceed as part of annual reporting.
2 Approved its terms of reference, with no amendments required.

9.2 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 active risks within the register led by the Workforce Directorate as detailed within reporting.

Mr Wallace reported that sickness absence remained the only high workforce risk, while reduction in hours, backfill and recruitment, and PMVA compliance remained medium risks, with job evaluation and PVG now reduced in status. He added that a separate high nursing risk in relation to resourcing remained live and asked the Committee to endorse the report as an accurate statement of risk.

Ms Radage welcomed the dynamic management of workforce risks, noted the potential for the induction hours risk to reduce over time, and supported endorsement of the report.

The Committee:

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

9.3 AREAS OF GOOD PRACTICE / AREAS OF IMPROVEMENT

The Committee commended the use of projected trend graphs, noting that they supported more forward-looking scrutiny and a more constructive discussion about performance and improvement in respect of workforce metrics. The Committee also recognised the work of the Workforce Directorate in updating the systems and supporting implementation of the reduced working week.

The Committee commended the strength of partnership working and the consistent involvement of partners across the themes as demonstrated in the today's meeting papers.

9.4 ANY ISSUES ARISING TO BE SHARED WITH BOARD GOVERNANCE COMMITTEES

It was noted that a separate briefing session would be held with the Non-executive Directors on the issues around a recent hospital incident.

10 ANY OTHER BUSINESS

The Committee noted the retirement of Ms Sandra Dunlop, Head of OD and Learning at the end of June, recorded its thanks for her contribution, and noted Mr Anderson's appointment as Head of OD and Learning from 1 June, with a short handover period to support continuity.

11 DATE OF NEXT MEETING

The next meeting would be held on 20 August 2026 at 9.30am. *The meeting concluded at 12.17pm*

Paper No: 26/65

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 27 August 2026

Agenda Reference No: Item No: 18b

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 20 August 2026.

No	Item	Summary
1	Organisational Development and Wellbeing, including OD Strategy Update	The Committee noted progress in OD, learning, leadership and wellbeing, including PDPR, mandatory training and OD Strategy implementation. Evaluation, engagement and sustainable improvement during change were emphasised.
2	Succession Planning Framework	The Committee endorsed the Succession Planning Framework, noting its role in supporting critical roles, talent pipelines and long-term organisational capability.
3	Workforce Report	The Committee reviewed workforce metrics, noting continuing recruitment activity and workforce challenges. Positive developments included funding secured for an Employability Officer post and ongoing recruitment initiatives.
4	Quarterly Health and Care Staffing Report	The Committee noted assurance on the annual staffing report and updates on the Women's Service, reduced working week, leadership development and workforce planning. Discussion focused on aligning establishment, recruitment and staffing resources with service demand.
5	Annual Report – Exit Interviews	The Committee noted the annual exit interview themes, including staffing pressures, communication, culture, psychological safety and flexible working, alongside positive feedback on colleagues and meaningful work.
6	Maximising Attendance	The Committee noted increased sickness absence, particularly in nursing, and ongoing support to improve attendance and resilience.
7	Management of Employee Relations Cases: Improvement Plan	Progress was noted against the Employee Relations Improvement Plan, with all planned actions either completed or progressing to implementation.

No	Item	Summary
8	Workforce Equalities Group	The Committee approved the Workforce Equalities Action Plan. The plan was recognised as an important step in strengthening equality, diversity and inclusion arrangements within the organisation, with actions aligned to national priorities and anti-racism commitments.
9	Occupational Health Report	The Committee received the annual Occupational Health report, noting increased service engagement and self-referrals. Mental health remained the main referral reason, with musculoskeletal conditions also rising.
10	Nurse Practice Development Update	The Committee received an update noting ongoing support for recruitment campaigns, induction programmes, leadership development and workforce training initiatives.
11	E-Rostering Update and Nursing Rostering Improvement Plan	The Committee noted progress on e-rostering and audit actions, as well as Optima and payroll integration developments.
12	Corporate Risk Register: Staff Governance Risks	The Corporate Risk Register was reviewed and endorsed. Key workforce risks remained centred on sickness absence, mandatory training compliance and workforce capacity. The Committee noted progress in managing these risks while recognising the continued operational challenges facing services.
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	Members noted the positive outcome of a recent employment tribunal, increased use of Occupational Health self-referral by staff, and the continued progress being made across staff governance and workforce activity.

RECOMMENDATION

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

Paper No: 26/66

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 19
Sponsoring Director:	Chief Executive Officer
Author(s):	Head of Corporate Governance
Title of Report:	Feedback and Complaints Annual Report 2025/26
Purpose of Report:	For Decision

1 SITUATION

NHS Boards are required to produce annual reporting relating for both complaints and feedback, to comply with the Patient Rights (Scotland) Act 2011 and associated regulations and directions.

2 BACKGROUND

Scottish Government issues guidance each year, which sets out the required areas of reporting to be included. The guidance covers both feedback and complaints, and the key performance indicators which must be reported on. The guidance is prepared based upon the Good Practice Guide for NHS Complaints Handing led by the Scottish Public Services Ombudsman.

Responsibility for publication of reporting of all feedback and complaints across NHS Scotland is managed by Public Health Scotland, in line with other NHS Statistical publications. The State Hospital's Annual Report is required to be published on the Board's website.

3 ASSESSMENT

The report provides a summary of activity for period 1 April 2025 to 31 March 2026, in line with national guidance. At the same time, it has been developed in an accessible and inviting format to help to encourage uptake of it by stakeholders. The report has been shared with the Corporate Management Team, who endorsed the content and presentation of the report.

The report outlines the steps undertaken to encourage and gather feedback, and places this within the context of the challenges of doing so within the State Hospital given its unique patient cohort. The report also highlights the central importance of engagement with key stakeholders, particularly the Patient Partnership Group, as well as through the Carers' Strategy. As part of ongoing engagement, the report (as well as an easy read version) will be shared with the PPG to continue to support open and transparent discussion of patient experience in this area.

Reporting provides a range of metrics including numbers received and the time taken to resolve at each stage of the complaints process. A key highlight is the increase in the numbers of complaints received. The areas in which the biggest increases are Communication, Shortage/Availability, Patient Property and Expenses, Failure to Follow Agreed Policy. There is some impact from patient experience of daytime confinement, but the reporting time period predates the biggest increases in this respect which have been seen in Quarter 1 of the current year.

The general increase in complaints received aligns with the experience throughout NHS Scotland as a whole, and reflects the changes made in management of complaints within the State Hospital to increase the visibility of the service, and to build trust with patients and carers. This year has seen the vast majority of complaints resolved quickly at the early resolution stage.

There is further background relating to the outcomes of complaints on how to take learning, linking this to quality improvement in the delivery of services. This is further developed thematically and with some examples of changes made as a result of complaints.

The report also acknowledges the involvement of the Patients' Advocacy Service, who work closely alongside the Complaints Team to support patients through the process to resolution.

Finally, the report summarises the governance and accountability arrangements in place to ensure that patients and carers can share their views and influence the delivery of care within the State Hospital.

4 RECOMMENDATION

The Board is invited to endorse the Feedback and Complaints Report 2025/26 for onward submission to Scottish Government, and publication on the website.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	The Model Complaints Handling Policy (MCHP) introduced a standard approach to managing complaints across NHS Scotland which complies with the Scottish Public Services Ombudsman (SPSO) and meets all the requirements of the Patient Rights (Scotland) Act 2011. Reporting measures performance and delivery in line with national guidance, as well as local priorities.
Corporate Objectives Please note which objective is linked to this paper	**Better Care:** Be accessible to patients, their family and visitors ensuring their views and experiences are reflected in service improvements Work with stakeholders and Scottish Government representatives to enhance the reputation and healthcare 'profile' of the State Hospital **Better Value:** 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	There are no associated workforce implications, and training and support for staff is reported on within the report.
Financial Implications	There are no associated financial implications.
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	Requested by Board through workplan as part of annual reporting requirements. CMT have endorsed this report, and it is in addition to detailed, quarterly reporting submitted to the Clinical Governance Committee.
Risk Assessment (Outline any significant risks and associated mitigation)	There are reputational risks associated with not meeting the MCHP target response times, as well as the risk of systemic failure to respond to concerns raised.
Assessment of Impact on Stakeholder Experience	Reporting captures engagement with stakeholders and how their views help to inform service delivery and to make improvements.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not applicable

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 (1).

ANNUAL REPORT
COMPLAINTS & FEEDBACK
2025/26

THE STATE HOSPITALS BOARD FOR SCOTLAND

Contents

Introduction

The State Hospitals Board for Scotland is one of NHS Scotland's National Health Boards and is a high secure forensic mental health facility, providing care and treatment for up to 140 male patients during 2025/26. In July 2025, the hospital opened an interim service for women.

This report provides details of feedback and complaints received during the period 1 April 2025 to 31 March 2026, aligned to the NHS Model Complaints Handling Procedure (CHP), and focused on supporting service improvement based on lived experience.

Section 1 – Feedback

Encouraging and Gathering Feedback

Patients, carers, and wider stakeholders are encouraged and supported to provide feedback to improve services. The Person-Centred Improvement Team (PCIT) plays a key role in facilitating engagement through a range of methods, including the Patient Partnership Group (PPG) and the bespoke Carers' Strategy.

Throughout 2025/26, our patients contributed to service development, quality improvement initiatives, and policy consultations. Stakeholder presentations to the Board highlighted positive patient involvement opportunities, including the "Pass It On" quality improvement initiative, Patients' Rights Day, and volunteering experiences.

The "Safely Recovering: Your Experiences in The State Hospital" questionnaire identified that most patients reported feeling safe.

Additional feedback raised concerns regarding outdoor access during visits, visiting times and the increased use of Day Time Confinement.

Positive feedback and compliments were received from patients and carers in relation to festive activities, the work of the PPG and patient involvement in the Digital Inclusion pilot project within the Transition Service.

Recording Feedback

Feedback is shared with service providers which enables learning and the potential for improvement. Feedback is reported quarterly through Feedback and Complaints Reporting and this is reported through the governance structure to ensure that there is awareness across the organisation. Stakeholders sharing feedback are advised of this and asked if they wish to be kept advised of progress.

Section 2 – Complaints

Encouraging and Handling Complaints

The model CHP introduced a standard approach to managing complaints across NHS Scotland, which complies with the Scottish Public Services Ombudsman (SPSO) and meets the requirements of the Patient Rights (Scotland) Act 2011. The two-stage model enables complaints to be handled:

- Locally, allowing for **Early Resolution (Stage 1)** within 5 working days.
- Or, for more complex issues, by **Investigation (Stage 2)** within 20 working days.

Complaints Received

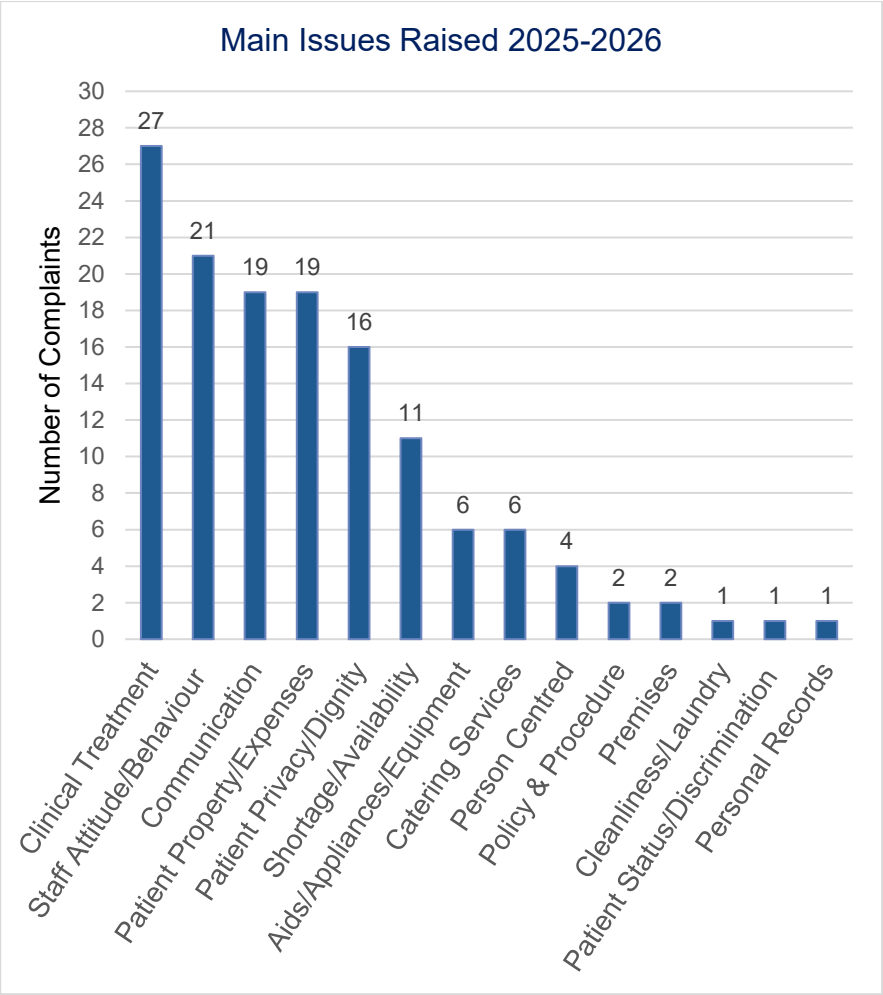
The hospital received **136** new complaints this year showing a substantial increase on the previous year. The table below shows the number of complaints received, the average number of patients, and the number of complainants over the last three years.

Complaints Received	2023/24	2024/25	2025/26
Total Number Received	95	83	136
Average Patient Number	103	101	106
Number of Complainants	40	44	54

Due to the nature of the environment as a long-term healthcare setting, it is expected that patients will make more than one complaint during their time with us. As a result, 29 stakeholders made more than one complaint, compared to 17 in 2024/25 and 16 in 2023/24.

The areas that have shown the greatest increase are Communication, Shortage/Availability, Patient Property and Expenses, and Failure to Follow Agreed Policy.

The chart below shows the main issue raised in each complaint.



Supporting Early Resolution

The 5-day early resolution stage has continued to enable the majority of complaints (85%) to be resolved locally with local services leading on the resolution.

The independent Patients' Advocacy Service (PAS) provides a valuable service in supporting patients who wish to make a complaint and may require support, or do not wish to do so directly.

Being based on site enables PAS to support patients to resolve issues through early resolution in particular. This helps to identify opportunities for learning emerging from complaints and feedback. This year **90** patient complaints were supported by PAS, which represents **66%** of all complaints received.

In a forensic mental health setting, it can be challenging for patients to make complaints. Patients are encouraged and supported to do so in a variety of ways.

This includes meeting with staff locally supported by PAS or the Complaints Officer, or to receive a response directly from the Complaints Officer or through PAS. This can be verbal or written, depending on patient preference. Patients can also contact the Complaints Officer directly by telephone or meet face to face.

These arrangements are growing in strength, as shown by greater uptake from patients this year.

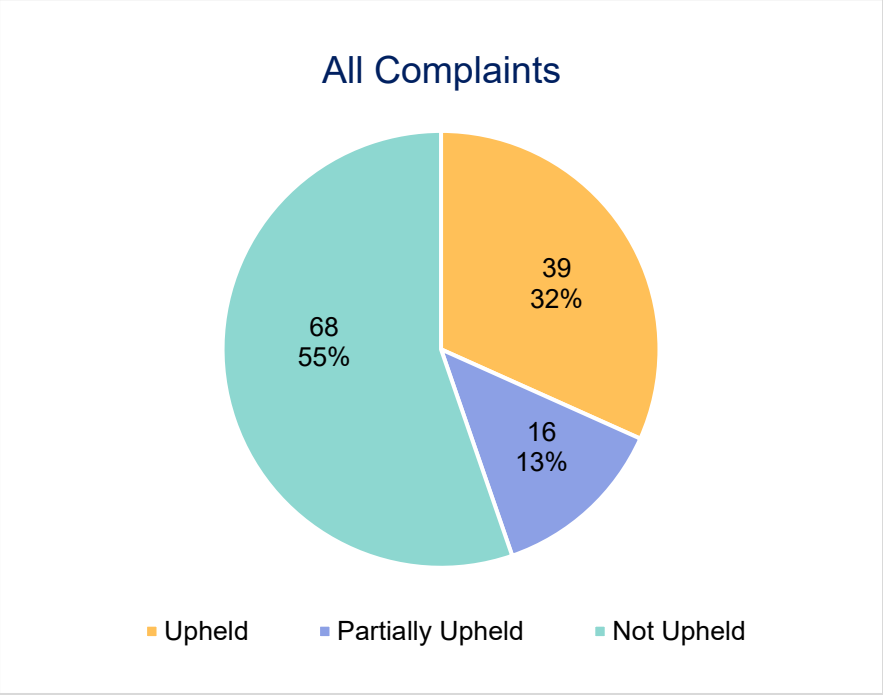
Complaints Closed

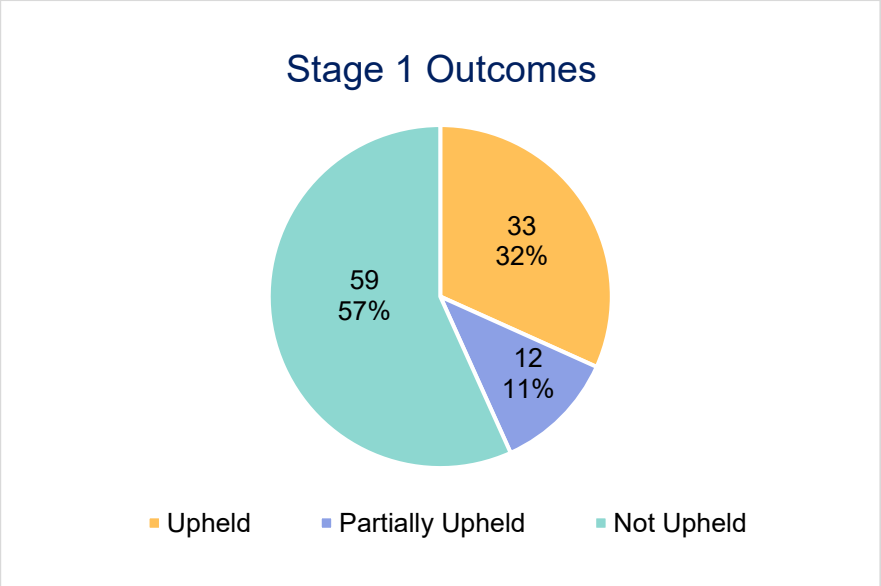
A total of **123** complaints were closed this year. Of these, **104** complaints (85%) were resolved at Stage 1 through early resolution. The table below shows the number of complaints closed at each stage and, for comparison purposes, the previous two years. There has been a significant increase in the numbers of complaints received and resolved at the early resolution stage.

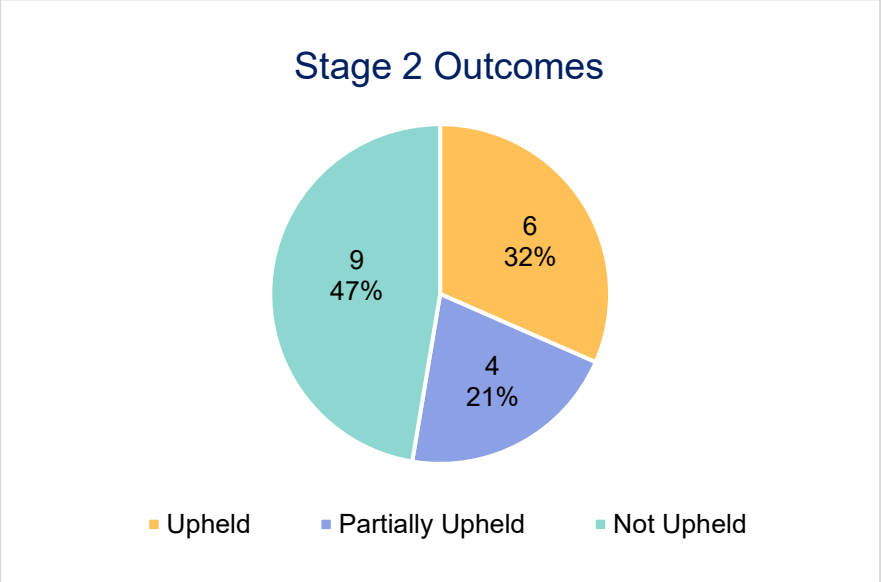
Complaints Closed	2023/24	2024/25	2025/26
Stage 1	59	44	104
Stage 2 - Investigation	12	17	0
Escalated to Stage 2	11	12	19
Total	82	73	123

Complaints Outcomes 2025-2026

Aligned to the CHP, each complaint closed is categorised as either being upheld, partially upheld or not upheld. The Complaints Manager takes leadership on reviewing decision-making, ensuring that the complaint has been resolved satisfactorily and transparently, and recognising that the culture of an organisation may impact on the way that it responds to complaints. The focus is on the need for transparency and openness, as well as an ability to apologise if service delivery has fallen short of the accepted standards. The charts below provide data relating to the outcomes of complaints closed this year.







Average Response Times

The CHP target of 5 working days was achieved at Stage 1, but the target of within 20 working days was not reached at Stage 2, where the average days to respond was 33 days. This was related both to the complexity of some individual complaints, as well as challenges in staff availability.

The table below shows the average number of days taken to respond to complaints this year and for comparison purposes, the previous two years.

Average number of days	2023/24	2024/25	2025/26
Stage 1	4	5	5
Stage 2	26	28	-
Stage 2 - Escalated	19	27	33

Responding within Timescales

The tables below show our performance in responding to complaints at each stage within the CHP target response times. The Complaints Team works to ensure that each response fully addresses all of the issues raised, and an extension can be allowed so as to provide a more comprehensive response. This year has seen an increase in Stage 2 complaints requiring an extension, due to both staff availability and the growing complexity of issues raised. While timescales remain important, full investigations must be completed before a final response is issued, and complainants are kept informed of any delays and the reasons for them.

Closed within Timescales

Closed within target timescales	2023/24	2024/25	2025/26
Stage 1: within 5 working days	48	32	72
as % of total closed at Stage 1	81%	73%	69%
Stage 2: within 20 working days	13	7	4
as % of total closed at Stage 2	57%	24%	21%

Extensions to Timescales

Closed with Extension	2023/24	2024/25	2025/26
Stage 1: after 5 working days	11	12	32
as % of total closed at Stage 1	19%	27%	31%
Stage 2: after 20 working days	10	22	15
as % of total closed at Stage 2	43%	76%	79%

Focus on Quality

An internal quality assurance process has been established to ensure compliance with the requirements of the CHP. Performance timescales and recording of outcomes are quality checked by the Complaints Manager.

Stage 2 investigation responses are checked by the Complaints Manager to ensure the quality of the response and that it answers all of the concerns raised. The Director(s) responsible for the service(s) involved are asked to review and approve the content to ensure accountability, identify trends and bring focus on learning opportunities. Stage 2 responses are signed off by the Chief Executive / Deputy Chief Executive.

Scottish Public Services Ombudsman

As the final stage of the CHP, complainants who remain unhappy with the response to their complaint at Stage 2 can ask the SPSO for an independent external review.

No complaints were escalated to the Scottish Public Services Ombudsman during this year.

Section 3 – Culture and Training

Our Values and Aims

Our Values and Aims are the core values of NHS Scotland:

- Care and compassion.
- Dignity and respect.
- Openness, honesty, and responsibility.
- Quality and teamwork.

These are aligned to the provision of high quality, person centred, safe and effective care and treatment; and maintenance of a safe and secure environment that protects patients, staff, and the public.

Staff Awareness and Training

The national e-learning Feedback and Complaints training modules are mandatory for all staff. A total of 99% of staff members had completed the e-learning modules at the end of March this year.

In addition, a complaints awareness session formed part of the induction programme for all new staff and student nurses and is delivered at Corporate Induction Days. The Complaints Team provide further support to managers resolving issues locally and to senior managers investigating complaints at Stage 2.

Section 4 – Learning

Learning from Complaints & Feedback

The State Hospital actively seeks to identify themes with a view to preventing a recurrence of an issue and to support quality improvement in service delivery. The following table outlines the key themes which emerged during this year.

Themes Emerging

20% of issues related to **Clinical Treatment**. The majority (64%) were not upheld. This encompassed a wide range of issues within individual care such as care plans, lack of progression across services, medication, rehabilitation outings, and reduction of Room 4 U time.

15% of issues related to **Patient Property & Expenses**. 39% of complaints were upheld or partially upheld. Complaints mainly related to missing/damaged items, delays or errors in benefit payments, and issues with procedures (e.g. forms and approvals).

14% of issues related to **Staff Attitude/ Behaviour/ Conduct**. 71% were not upheld. Of those upheld, the majority related to staff conduct or the ward environment, particularly noise and behaviour. These primarily concerned how the issues were addressed or managed.

14% of issues related to **Communication**. Oral communication accounted for all issues raised. 51% were upheld or partially upheld and were attributable to staff not communicating effectively. This prompted an opportunity for additional staff training.

11% of issues related to **Staff shortages**. 92% were upheld or partially upheld. The majority related to the impact of staffing pressures on the day-to-day patient experience. The focus was on reduced access to activities and escorts, and delays in routine care (e.g. walks, phone use, activities).

11% of issues related to **Patient Privacy/Dignity**. 92% of the complaints were not upheld. The majority of these complaints focused on noise, disruption from other patients and how these situations were managed and communicated by staff.

Actions taken or improvements made as a result of complaints

During the year, several complaints led to changes to policies or procedures. This included:

Complaints were received about the way Department for Work and Pensions payments were distributed to patients. Under the previous process, patients received a fixed weekly amount, with arrears paid periodically. In response, the Director of Finance and eHealth initiated a full review to identify a more efficient system that better met patients' needs. Patient feedback informed the review and, as a result, a simplified system was introduced, with benefit allocations recalculated across 52 weeks. This has helped patients to better understand and manage their finances.

Complaints were received about noise from night nurse stations disturbing patients' sleep. In response, the Director of Nursing initiated a review of staff use of televisions and radios within these areas. Communication was also issued to all staff to reinforce the importance of minimising noise and maintaining a restful environment for patients.

Complaints Experience Feedback

A feedback form is available to capture learning, although response rates are low. To encourage more meaningful engagement, the Complaints Officer attends the PPG each month to gather patient feedback in an informal setting which enables open discussion about patient experience of the process.

Section 5 – Governance and Oversight

Accountability and Governance

The Chief Executive is accountable for delivering the Complaints Handling Procedure (CHP) within the State Hospital.

The Director of Nursing and Operations/Deputy Chief Executive works closely with the Head of Corporate Governance to promote a culture of openness, transparency and learning in the investigation of complaints. The key focus is to ensure that concerns are listened to, responded to appropriately and used to support ongoing improvement in care and service delivery.

The Annual Report is submitted to the Board, and quarterly reports to the Clinical Governance Committee and the Organisational Management Team. This governance structure helps monitor key performance indicators, maintain a focus on quality, and ensure that complaints and other patient engagement activity continue to inform learning and service improvement.

Summary

The State Hospital is committed to ensuring that patients, carers, and other stakeholders are supported to share their views through a wide range of accessible feedback methods. In doing so, the Board seeks to create an environment in which feedback is welcomed and used to strengthen engagement, improve experience, and support person-centred care. The Board fully embraces the CHP which continues to support effective and early resolution of issues of concern to stakeholders, and to help to enhance quality improvement in care and services.

Contacts

If you have any questions about this report, please contact the Complaints Team on 01555 842200 or by emailing: TSH.ComplaintsAndFeedback@nhs.scot

If you require this report in an alternative format, please contact the Person-Centred Improvement Team on 01555 842072 or by emailing: TSH.PersonCentredImprovementTeam@nhs.scot

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference:	Item No: 20
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Information Governance and Data Security Officer
Title of Report:	Information Governance Annual Report 2025-26
Purpose of Report:	For Noting

1 SITUATION

In order for the Board to have an overview of the work carried out by Information Governance, an annual report is provided for consideration. The Annual Report highlights the activities during 2025/26.

2 BACKGROUND

The Information Governance Group, chaired by the Senior Risk Information Owner (SIRO) is responsible for progression of attainment levels in relation to Information Governance Standards – reporting to the Finance, eHealth and Audit Group.

The Caldicott Guardian principles are integrated within the initiatives and standards required by NHS QIS for Information Governance and attainment levels are recorded via the Information Governance Toolkit.

Committee has, over the course of the year, continued to work to improve Information Governance standards and practices across the Hospital.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2025-26.

Key areas of work addressed included:

- Information Governance Standards (DPCT).
- Information Governance, Risk Assessments.
- Information Governance Training, including national events.
- Category 1 or 2 investigations, as required.
- Personal Data Breaches.
- Electronic Patient Records.
- Information Governance Walkrounds.
- FairWarning.

Key areas of work addressed included *(contd.)*:

- Records Management.
- Freedom of Information.
- Subject Access Requests.
- MyCompliance.

Actions for the next twelve months include the conclusion of the ICO audit action plan, by completion of SIRO / deputy SIRO training in August 2026; development and delivery of FOI training; the continuance of all of the above aspects under ongoing national scrutiny and focus; plus, additional work in the following areas:

- Records Management Plan finalisation with the Keeper of the Records of Scotland.
- Transfer of MyCompliance to Corporate Services.

4 RECOMMENDATION

The Board is asked to note the progress outlined in the attached report for the year 2025-26 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP	The Report follows good practice and also links in with national Information Governance developments and requirements.
Corporate Objectives Please note which objective is linked to this paper	Better value - Ensure delivery of a cohesive approach to information governance and records management standards, including delivery of the newly formulated Records Management function.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	Information Governance Group eHealth Subgroup
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).	No privacy implications (1).

THE STATE HOSPITALS BOARD FOR SCOTLAND

INFORMATION GOVERNANCE ANNUAL REPORT
APRIL 2025 – MARCH 2026

(Including Health Records)

Lead Author	Director of Finance and eHealth / Senior Information Risk Owner
Contributing Authors	Records Services Manager Information Governance and Data Security Officer
Approval Group	The State Hospitals Board for Scotland
Effective Date	April 2026
Review Date	April 2027
Responsible Officer	Director of Finance and eHealth / Senior Information Risk Owner

Contents

1 INTRODUCTION AND HIGHLIGHTS OF THE YEAR

The Information Governance Group (IGG) is responsible for progression of attainment levels in relation to Information Governance Standards. The 2025/26 reporting year has seen continued progress in strengthening Information Governance across the State Hospital. The Group has maintained its commitment to ensuring compliance with data protection legislation, improving records management, and promoting a culture of accountability and transparency.

The Group through its regular meetings has received and scrutinised regular reports on all areas of governance, including the following – Rio audits, records management, risk assessments, training, Freedom of Information (FOI), data protection and Information Governance incidents and outcomes – as well as reviewing those items on the Corporate Risk Register relevant to the Group's remit.

Key highlights from the year include:

- 95% compliance with statutory timescales for Freedom of Information (FOI) requests, with no review requests received during the reporting year.
- Continued review of the ICO audit action plan, with the one remaining action now addressed post year-end for completion in August 2026.
- Considerably strengthened the organisation's compliance position across all areas of the data protection toolkit
- Continued development of the Electronic Patient Record (EPR) system, including integration of the CPA process and documentation with Rio – successfully implemented throughout the organisation.
- Continued to undertake unannounced IG Walkrounds to support delivery of the organisation's Records Management Plan and wider Information Governance objectives, providing clear assurance while identifying opportunities for improvement.
- Reviewed responsibility for the administration and reporting of the MyCompliance system – with agreement to integrate with Corporate Services, thereby supporting greater alignment between policy ownership, governance, and reporting arrangements and enabling a more coordinated approach to policy management.

The IGG remains focused on delivering its objectives and adapting to evolving requirements.

This report is submitted on an annual basis to the Board, through the State Hospital's internal governance and approval structure.

The Committee has, over the course of the year continued to work to improve Information Governance standards and practices across the Hospital. We encourage staff to adopt good Information Governance standards through a number of measures undertaken by the group, and to complete mandatory online Information Governance learning modules.

2 INFORMATION GOVERNANCE GROUP

2.1 Information Governance Group membership

Director of Finance and eHealth (Chair)
Associate Medical Director/Caldicott Guardian
Head of e-Health
Head of Procurement
Clinical Admin Representative
Information Governance and Data Security Officer
Senior Information Analyst & Information Technology Security Officer
Lead Nurse
Health Records Manager
Psychology Representative
Security Information Analyst
Finance Representative
Social Work Representative
Human Resources Representative
Health Centre Representative
Pharmacist Representative
AHP Representative
Risk Management Representative
Business Manager Corporate Services
Forensic Network Representative
Information Asset Owners

2.2 Role of the group

The group has a wide-reaching remit, being responsible for all matters in respect of Information Governance within the Hospital as the title suggests. The membership of the group is purposely broad. This allows the group to be representative of staff groups and departments from across the hospital.

2.3 Aims and objectives

- Ensure compliance and development of Information Governance overall as monitored by the Data Protection Compliance Toolkit (DPCT).
- Address issues arising in the hospital in relation to Data Protection.
- Address issues arising in the hospital in relation to Records Management including structure, filing, storage, and archiving.
- Address Caldicott issues including monitoring incident reports and ensuring relevant training for staff.
- Provide a forum for the various staff groups within the hospital to raise any Information Governance issues and to receive feedback from Information Governance on such matters.
- To monitor requests made in relation to Freedom of Information and Data Subject Rights Requests.

2.4 Meeting frequency

The group meets on a quarterly basis to discuss any issues as outlined above; however, the terms of reference include the option to hold ad-hoc meetings should the group require to meet outwith the quarterly cycle. Following agreement from the wider group, a small subgroup – the Information Governance DPCT Group – meets 6 monthly in order to concentrate on the assessment of the current attainment levels and supporting evidence required for the DPCT. In addition, another small subgroup also meets 6 monthly to review the Information Governance risk register (see para. 3.2).

2.5 Strategy and work plan

As noted in previous reports, the Caldicott principles have now been integrated within the initiatives and standards developed by NHS QIS for Information Governance. The DPCT are completed twice yearly in order to monitor the performance of the hospital in relation to Information Governance.

The schedule of work for the subgroup is compiled in such a way as to allow the group to review progress with DPCT. This monitoring allows the group to develop an action plan of work to be undertaken by the group members. In addition, meetings are used to address the issues that may arise such as filing, relevant training, confidentiality issues etc.

2.6 Management arrangements

The Information Governance Group reports annually to the State Hospitals Board for Scotland through the Information Governance Group Report. The Information Governance Group also reports to the Corporate Management Team as relevant.

3 KEY PIECES OF WORK UNDERTAKEN BY THE GROUP DURING THE YEAR

3.1 Information Governance Standards

The Information Governance standards was retired at the end of 2021 and was replaced with the DPCT. It has been developed from ICO's accountability framework, which supports the foundations of an effective privacy management programme. The toolkit is divided into 10 categories; within each category there are a set of statement and questions that are rated on a 1 – 4 scale

Level	DPCT Status
1	Expectations not met
2	Expectations partially met
3	Expectations met without review cycle
4	Expectations fully with review cycle

Category	Level 1	Level 2	Level 3	Level 4	Status
1. Leadership and Oversight	0%	10%	3%	87%	**Level 4**
2. Policies and Procedures	6%	35%	12%	47%	**Level 3**
3. Training and Awareness	0%	10%	0%	90%	**Level 4**
4. Individuals' Rights	17%	34%	0%	49%	**Level 2**
5. Transparency	27%	38%	4%	31%	**Level 2**
6. Records of Processing and Lawful Basis	25%	50%	7%	18%	**Level 2**
7. Contracts and Data Sharing	7%	39%	0%	54%	**Level 4**
8. Risks and DPIAs	3%	31%	0%	66%	**Level 4**
9. Records Management and Security	11%	38%	3%	48%	**Level 3**
10. Breach Response and 11. Reporting	16%	76%	0%	8%	**Level 2**
Overall Rating (2026)	11%	36%	3%	50%	**Level 2**
Previous Rating (2025)	12%	39%	27%	22%	**Level 2**
Change	**-1%**	**-3%**	**-24%**	**+28%**	**=**

Ongoing work has strengthened the organisation's compliance position across the Toolkit. Improvements have been demonstrated across all areas, with progress reflected in increased maturity levels, including movement from meeting to exceeding requirements in a number of categories. Particularly strong performance has been recorded in the Leadership and Oversight, Contracts and Data Sharing, Risks and DPIAs, and Records Management and Security categories.

The organisation now meets or exceeds its data protection obligations in six of the ten DPCT categories.

The revised approach to DPCT governance, introduced in the previous reporting period, has been effective in improving both the quality of engagement and the level of oversight. Targeted engagement with service areas, supported by a reduced number of overarching review sessions, has enabled more focused scrutiny and strengthened assurance in key areas.

Following five years of operation, the Group has identified clear opportunities to further develop the DPCT framework to better reflect organisational requirements. This includes consideration of additional domains, specifically Records Management and Caldicott principles. A formal review will be undertaken in the next reporting period, with agreed changes implemented to strengthen the framework and its effectiveness.

3.2 Information Governance Risk Assessments

The Risk Assessment Group undertook a comprehensive review of all existing Information Governance risks to confirm their ongoing relevance, particularly in the context of changes to organisational structures, group remits, and reporting arrangements. As a result, all identified risks were either reassigned to the appropriate operational areas for active management or formally closed where they were no longer applicable.

Going forward, the Group will adopt a more proactive and intelligence-led approach to risk identification and mitigation. This will include systematic analysis of incidents recorded within the organisation's incident management system to identify emerging risks and trends. The Group will also provide targeted advice and guidance to service areas on risk management and proportionate mitigation measures, supporting a more responsive and preventative approach.

A notable development during the reporting period was the closure of a longstanding risk relating to the use of facsimile machines for the transmission of information. The Risk Assessment Group identified this as requiring action and progressed a paper to the Operational Management Team (OMT) recommending the removal of fax machines. Following OMT approval, the associated risk was deemed obsolete and formally closed. This represents a clear reduction in reliance on outdated communication methods and a strengthening of information security controls.

3.3 Information Governance Training

The majority of Information Governance (IG) training continues to be delivered through the LearnPro online platform. All training modules remain mandatory for all staff, ensuring a consistent baseline of knowledge and supporting compliance with statutory and organisational requirements. Completion rates are monitored by the Training and Professional Development Manager, with formal oversight provided by the Information Governance Group (IGG).

The table below outlines completion rates for each module over the past four years.

Module	Mar 2023	Mar 2024	Mar 2025	Mar 2026
IG: Essentials (Target >80%)	95%	85%	75%	79%
IG: Series (Target >85%)	-	87%	93%	93%
Confidentiality	98%	-	-	-
Data Protection	98%	-	-	-
Records Management	98%	-	-	-

The IG: Series module has consistently achieved completion rates above the organisational target, providing clear assurance that staff are engaging with consolidated training covering confidentiality, data protection, and records management.

The completion rate for the IG: Essentials module has improved compared to the previous reporting period; however, it remains below the target threshold of 80%. This continues to indicate variation in compliance across service areas and the need for sustained focus at a local level to improve uptake.

In the context of wider organisational changes to structures, group remits, and reporting arrangements, work is underway to review how training compliance is monitored, reported, and escalated across governance forums. This includes strengthening alignment between local accountability and corporate oversight and streamlining reporting arrangements to reduce duplication.

Responsibility for completion of mandatory training remains with line managers, who are expected to actively monitor compliance within their teams and take appropriate action where required. Performance continues to be reported through established governance processes, providing visibility and supporting targeted intervention.

3.4 Category 1 & 2 Investigations

There were no Category 1 or Category 2 investigations relating to Information Governance during the year.

3.5 Personal Data Breaches

Under the UK General Data Protection Regulation (GDPR), organisations are required to maintain a record of all personal data breaches. Where a breach is assessed as posing a high risk to the rights and freedoms of individuals, it must be reported to the Information Commissioner's Office (ICO) within 72 hours of becoming aware of the incident.

At the State Hospital, all potential personal data breaches are recorded and managed through the incident management system. This provides a structured approach to recording, assessing, and monitoring incidents, and supports organisational learning and mitigation of future risks. The table below summarises the number of breaches recorded and those reported to the ICO over the past four years.

	2022/23	2023/24	2024/25	2025/26
Reported Breaches	35	24	16	17
Notified to ICO	0	0	1	0

In 2025/26, all recorded personal data breaches were attributable to the State Hospital. The total number of incidents increased marginally from 16 to 17; however, overall volumes remain stable and significantly lower than in earlier reporting periods, indicating a controlled and consistent position.

Area	Percentage
Internal Email Disclosures	41%
External Email Disclosures	29%
Information Disclosed via internal mail	11%
Others	19%

Email-related disclosures represented the dominant breach type, accounting for 70% of incidents, with other categories occurring at comparatively lower levels.

This profile reflects the volume and nature of routine information sharing across clinical and administrative functions, where email presents an inherent risk despite established controls. The persistence of low-level incidents in this area is consistent with this operational context and does not indicate a deterioration in overall control but highlights the need for continued vigilance and reinforcement of expected standards.

A range of preventative and assurance measures remain in place to maintain and strengthen Information Governance standards. These include regular staff communications through the Staff Bulletin, with targeted messaging in response to identified trends, and ongoing Information Governance Walkrounds, which provide direct engagement with staff and reinforce good practice in operational settings.

Collectively, these measures support a culture of accountability and continuous improvement, with a clear focus on reducing avoidable incidents and ensuring that personal data is managed securely and in accordance with legal and organisational requirements.

3.6 Electronic Patient Records

The Electronic Patient Record (EPR), Rio, has continued to be further developed since the major upgrade in March 2022. The project specific Rio Group continue to meet on a weekly basis to ensure developments are progressing well, and to resolve any issues that have arisen or been reported. A multidisciplinary project approval group (Rio Oversight and Development (ROAD) Group) continues to meet monthly to review ongoing requests to improve Rio as well as look at future developments. A further upgrade was successfully made to the system in October 2024. Discussions are ongoing as to a further upgrade to Rio with a projected timescale of Q3 of 2026-2027.

Regular audits continue to be carried out on various areas within Rio, with documentation and guidance updated as required. Issues are dealt with in a timely manner prior to amendments or changes in process being discussed at the Information Governance Group, or the ROAD Group.

A robust system is embedded for Requests for Change to Rio – this may involve a quick assessment and authorisation by the system owner, or a more thorough review by members of the team including IG checks and workability.

Rio is integrated with the medication prescribing system, HEPMA, as well as being the basis for processes such as for grounds access approval which are embedded in the system.

A further success during this reporting period is the integration of the CPA process and documentation with Rio – this has been successfully implemented throughout the organisation with review being ongoing.

3.7 Information Governance Walkrounds

Information Governance Walkrounds were introduced in 2015 following a recommendation from the NHS Scotland Information Assurance Strategy (CEL 26, 2011) and have continued to demonstrate their value as an effective assurance mechanism. These unannounced visits are carried out at varying intervals throughout the year and encompass all areas of the organisation where personal or sensitive information is processed.

Walkrounds are assessed using a consistent grading system to ensure comparability across visits:

Grade	Description
Excellent	No issues found
Very Good	1 – 3 minor issues found
Good	4 – 8 minor issues and/or 1 significant issue found
Improvements needed	9 - 14 minor issues and/or 2 significant issues found
Action Plan required	More than 15 minor issues, more than 2 significant issues and / or 1+ suspected breaches of legislation

Staff undertaking walkrounds continue to report a high standard of Information Governance practice across the organisation. During the reporting period, 14 areas were inspected, of which 11 achieved a rating of 'Good' or above. This included 5 areas rated as 'Excellent' and 4 as 'Very Good', indicating a strong level of compliance across the majority of areas. Three areas were assessed as 'Improvements Needed'; in each case, identified issues were addressed promptly through engagement with relevant staff and managers, demonstrating a responsive and effective approach to remedial action.

Walkrounds continue to support delivery of the organisation's Records Management Plan and wider Information Governance objectives, providing clear assurance while identifying opportunities for improvement. They also promote a culture of openness and learning by offering a practical forum for staff to seek advice, clarify requirements, and reinforce good information handling practices within operational settings.

3.8 FairWarning

The Group continues to receive exception reports detailing the volume and nature of FairWarning alerts, supporting oversight of access to personal information. A dedicated subgroup remains responsible for reviewing alert parameters and ensuring thresholds are appropriate, proportionate, and aligned with operational requirements.

Alert volumes remained broadly consistent with previous years, taking account of changes in patient activity and service demand. Patterns involving multiple staff accessing a single patient record within a short timeframe continue to be observed and are subject to ongoing review. Where necessary, alert thresholds are adjusted to ensure monitoring remains focused on exceptions of concern rather than routine and appropriate access.

The Group is satisfied that effective arrangements are in place to monitor access to personal information, with no significant concerns identified in relation to inappropriate access.

3.9 Records Management

The Records Services Department has continued to develop this year, with changes to its remit and a staff reorganisation to improve productivity. Two Administrators now focus on health records work alongside the Team Leader, while the third supports the Information Security and Data Protection Officer. This arrangement has worked well and will be made permanent over the coming year.

The plan remains under assessment by the Keeper due to a backlog within the National Records of Scotland, and no feedback had been received by the end of the reporting period. In line with the organisational review of groups and committees, it is proposed that the Records Management Group be replaced by project-specific working groups, with reporting and oversight provided by the IGG. It has also been agreed that future IGG agendas will include a specific item on Health Records matters, such as national updates on CHI numbers and SMR4 reporting.

Work continues to rationalise shared drive areas, with initial activity underway to support introduction of the national Business Classification Scheme ahead of the move to SharePoint Online. This will be a priority in the coming year, alongside consideration of additional staffing to support this work and reinforce records management practice across the State Hospital.

3.10 Freedom of Information

The Information Governance Group continues to receive regular updates on all FOI requests, including performance against statutory response times, supporting effective oversight of compliance with the Freedom of Information (Scotland) Act 2002.

In 2025/26, 301 FOI requests were received, representing a slight decrease of 3% compared to the previous year. Despite this reduction, request volumes remain significantly higher than in earlier reporting periods, reflecting sustained demand for information and continued external engagement.

Analysis of request sources indicates that the majority originated from members of the public (54%), followed by Trade Unions and Professional Bodies (10%), and Parliamentarians and their researchers (10%), with the remaining requests received from a range of other stakeholders.

Number of Freedom of Information Requests

	2021/22	2022/23	2023/24	2024/25	2025/26
Requests made	172	145	242	310	301
Completion rate within timescales	99%	91%	95%	100%	95%

Performance against statutory timescales remained strong, with 95% of requests responded to within the required timeframe. While this represents a small decrease from the previous year's 100% compliance, it continues to demonstrate a high level of organisational commitment to transparency and accountability, particularly in the context of sustained request volumes.

Where information was held, a full response was provided in 69% of cases. The remaining requests were either partially fulfilled or exempt information was appropriately withheld in line with the provisions of the legislation.

Number of Freedom of Information Reviews

	2021/22	2022/23	2023/24	2024/25	2025/26
Requests for review made	4	2	1	1	0
Upheld without modification	4	2	1	1	0
Upheld with modification	0	0	0	0	0
Substituted a different decision	0	0	0	0	0
Reached a decision where no decision had been reached	0	0	0	0	0

The number of requests for review remained low, with no review requests received during the reporting year.

The absence of review requests provides assurance regarding the quality and robustness of initial responses, as well as the effectiveness of internal processes for managing FOI requests.

The Information Governance Group will continue to monitor FOI performance, ensuring that compliance is maintained, emerging trends are identified, and learning is reflected in ongoing service improvement.

3.10.1 Freedom of Information Self-Assessment

The FOI Committee continues to lead a cycle of continuous improvement, guided by the Scottish Information Commissioner's self-assessment toolkit. This toolkit supports public authorities in evaluating their performance across six key areas of FOI compliance.

Each module is assessed using a four-point scale:

Ratings	**Meaning**
Excellent	Greatly exceeds the requirements of FOI
Good	Exceeds the requirements of FOI
Adequate	Meets the requirements of FOI
Unsatisfactory	Below the requirements of FOI

Public authorities, including the State Hospital, are expected to achieve at least an 'Adequate' rating, taking into account their specific operational context.

Standards and Criteria	**2022/23**	**2023/24**	**2024/25**	**2025/26**
1. Responding on time	Good	Excellent	Excellent	Excellent
2. Searching for, locating and retrieving information	Good	Good	Good	Good
3. Advice and assistance	Good	Good	Good	Good
4. Publishing information	Adequate	Adequate	Adequate	Adequate
5. Conduct of Reviews	Good	Good	Excellent	Excellent
6. Monitoring and managing FOI performance Standards and Criteria	Good	Good	Good	Good
Overall	Adequate	Good	Good	Adequate

While the overall rating is determined by the lowest score across the six assessment modules, the framework allows for consideration of local context. In previous years, this included factors such as the nature of the organisation's services and patient cohort, which offset lower performance in module four.

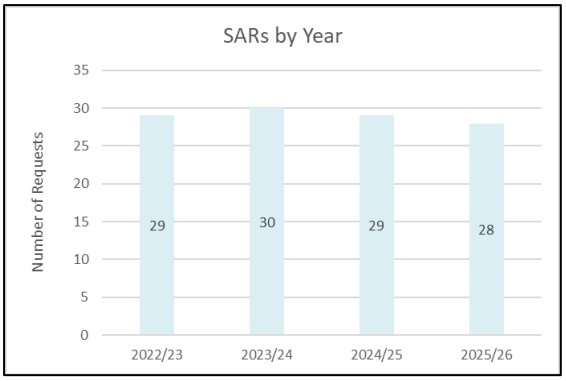
These contextual factors remain relevant; however, during 2025/26 a reduction in the volume of information published via the organisation's website, and consequently its model publication scheme, has resulted in a lower overall rating.

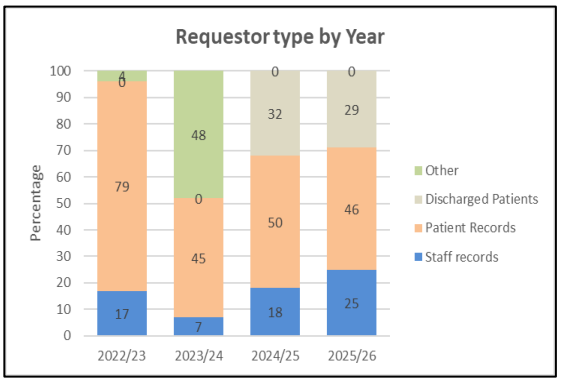
3.11 Subject Access Requests

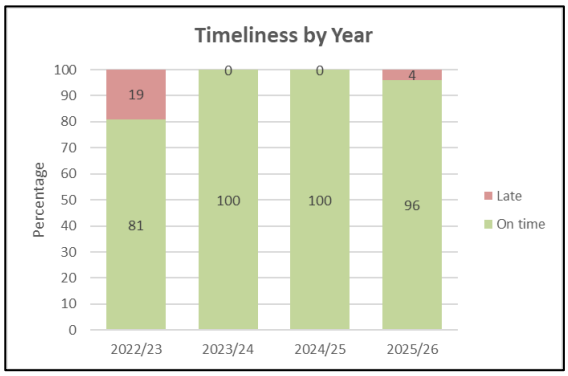
During 2025/26, the volume of Subject Access Requests (SARs) remained stable and within anticipated levels, reflecting consistent demand for access to personal information. Performance remained high, with the majority of requests completed within statutory timescales and only one request (4%) exceeding the required timeframe.

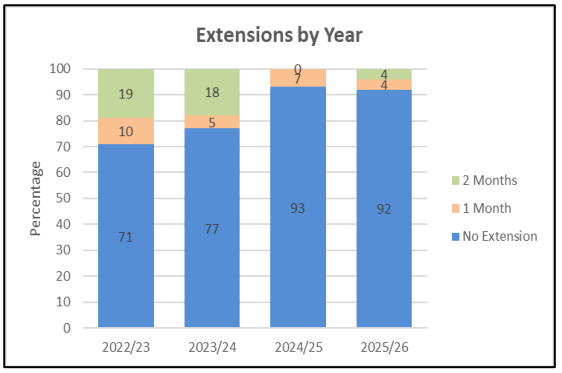
There was a further reduction in the number of cases requiring extensions, indicating improved efficiency in internal processes. This reflects stronger coordination between departments, increased familiarity with SAR requirements across service areas, and more effective deployment of resources to support request handling.

Overall performance provides assurance that robust arrangements are in place to manage SARs effectively, maintain compliance with legal requirements, and uphold individuals' rights of access to their information. Ongoing monitoring and refinement of processes will continue to support timely and accurate responses as demand remains steady.









3.12 MyCompliance

A technical issue affecting the MyCompliance system was identified in April, resulting in policy enforcement controls not operating as intended for a period during the reporting year. As a result, staff were not consistently prompted to review and acknowledge key organisational policies.

The issue has been resolved, and a structured plan is in place to reinstate policy enforcement from June, ensuring policy acknowledgements are completed in a controlled and consistent manner and improving overall compliance and awareness.

During the year, responsibility for organisational policy management transferred from Clinical Quality to Corporate Services.

In line with this, responsibility for the administration and reporting of the MyCompliance system will also transfer to Corporate Services, supporting greater alignment between policy ownership, governance, and reporting arrangements and enabling a more coordinated approach to policy management.

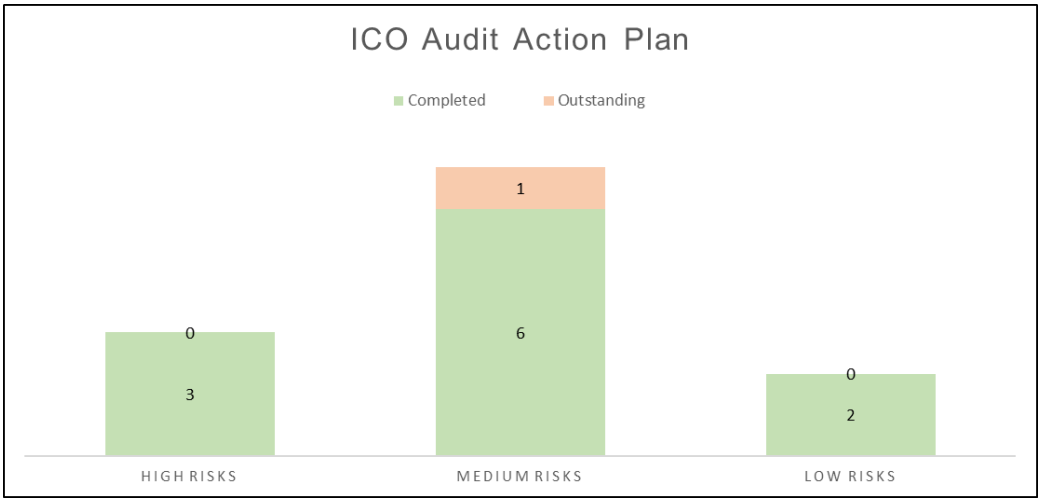
4 INFORMATION COMMISSIONER'S OFFICE AUDIT

In November 2022, the State Hospital underwent an audit by the ICO. The purpose of the audit was to assess:

- The organisation's compliance with data protection legislation,
- Its use of ICO guidance and best practice resources, and
- The overall effectiveness of its data protection governance and activities.

The audit concluded with a high assurance rating, reflecting a strong level of confidence in the hospital's data protection practices.

While the findings were largely positive, the ICO identified several areas for improvement. In response, and in consultation with the ICO, the hospital developed a 12-point action plan to be implemented over a two-year period.



At the time of reporting, one action remains outstanding, relating to the provision of specific training for the Senior Information Risk Owner (SIRO) and their appointed deputy. This action has not yet been completed within the original timeframe and remains subject to ongoing monitoring through governance arrangements.

Progression of this action will be taken forward as part of the organisation's wider development programme, with completion expected during the forthcoming reporting period.

5 IDENTIFIED ISSUES AND POTENTIAL SOLUTIONS

During the reporting year, several challenges were identified that impacted the delivery and oversight of Information Governance activities. These include:

- A technical issue affecting the MyCompliance system resulted in a period during which policy acknowledgement controls were not applied consistently, limiting assurance in relation to staff awareness of organisational policies. In response, work has been progressed to restore full functionality and to transfer system operation to Corporate Services.
- The profile of personal data breaches remained consistent with previous years, with email-related incidents continuing to represent the largest proportion of recorded breaches. This indicates an ongoing requirement to reinforce good practice in information handling.
- Information relating to transparency and publication remains an area for improvement, with limitations identified in the volume and accessibility of information published through the organisation's website and publication scheme
- The management of records and information assets continues to develop; however, variation remains across service areas in relation to structure, ownership, and retention of information, particularly within shared drive environments. Activity is underway to address this through the implementation of the Business Classification Scheme and preparation for transition to SharePoint Online, which will provide a more structured and consistent approach to information management.
- In addition, the progression of wider organisational changes to governance structures and group remits has created a need to ensure that Information Governance responsibilities remain clearly defined and appropriately aligned across committees and reporting arrangements. Work is being progressed to review and refine governance arrangements to support clearer accountability and more effective oversight.

The IGG remains committed to addressing these issues proactively and ensuring that robust governance arrangements are in place to support safe and effective information handling across the organisation.

6 FUTURE AREAS OF WORK AND POTENTIAL SERVICE DEVELOPMENTS

Work / Service Development	Timescale
Acceptance of the State Hospital's Records Management Plan by the Keeper of the Records of Scotland.	July 2026
Transfer of MyCompliance to Corporate Services.	August 2026
Completion of training and development requirements for the Senior Information Risk Owner (SIRO) and Deputy SIRO, in line with the ICO action plan.	March 2027
Development and delivery of Freedom of Information training for senior managers and Heads of Service, with an emphasis on proactive publication and strengthening compliance with publication scheme requirements.	March 2027
Maintain 80% completion for the IG: Essentials learning module.	Ongoing
Maintain 85% completion for the IG: Series learning module.	Ongoing

7 NEXT REVIEW DATE

April 2027.

Paper No. 26/68

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	27 August 2026
Agenda Reference No:	Item No: 21
Author(s):	Head of Corporate Governance
Title of Report:	Board and Committee Membership and Schedule 2027
Purpose of Report:	For Decision

1 SITUATION

This paper provides an update on Board membership, as well as proposing a schedule of meetings for 2027.

2 BACKGROUND

The Board requires to ensure that it is on a position to meet its remit through forward planning for any upcoming vacancies as well as a planned schedule of meetings.

There is also a requirement to agree a schedule of meetings held in public in advance, and to publicise these for members of the public as appropriate.

3 ASSESSMENT

On 30 November, the Board's Vice Chair will come to the end of his second four year term, creating a Non-Executive Director vacancy. Further direction is awaited from the Public Appointments Unit on how this will be taken forward in terms of recruitment.

In the meantime, this creates a vacancy for the Chair of the Audit and Risk Committee, and a process of requests of interest was taken forward within the existing Non- Executive cohort. Following this, Mr Stuart Currie has been nominated to take up this role as of 1 December 2026. The Board is also asked to note that this may also require further consideration of wider committee memberships, as well as Chair of the Remuneration Committee, with confirmation of the position be brought back to the Board at its next meeting.

The draft schedule for Board and Committee meetings for 2027 is also attached for review and agreement. This also includes a schedule of dates for regular Board Development Sessions.

4 RECOMMENDATION

The Board is invited note:

- Appointment of new Chair of the Audit and Risk Committee.
- Further revision of Committee membership will be required.
- Formally endorse the proposed schedule of meetings for 2027.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	This supports the Board in fulfilling its overall remit and purpose, and in the good administration of its function. It supports openness and public engagement.
Corporate Objectives Please note which objective is linked to this paper	This supports the overall Board remit, and oversight of the Corporate Objectives as a whole and to cross reference against each other through supporting detailed oversight.
Workforce Implications	There are no workforce implications for employees.
Financial Implications	There are no implications to highlight through reporting.
Route to Meeting Which groups were involved in contributing to the paper and recommendations.	This is Board directed and requested as a necessary part of its annual workplan, and administrative support function.
Risk Assessment (Outline any significant risks and associated mitigation)	There would be a key risk to corporate governance functionality should this paper not form part of overall corporate governance arrangements. As this is routinely considered, there are no additional risks at present.
Assessment of Impact on Stakeholder Experience	Public engagement is considered as part of the need to hold regular Board meetings in public and to advertise these and open them to members of the public. The schedule is routinely advertised through the website.
Equality Impact Assessment	There is no requirement for this.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There is no requirement for this.
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. Board members are named as required but there are no privacy implications arising.

ANNUAL SCHEDULE OF MEETINGS 2027

BOARD AND SUB-BOARD

MEETING	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
BOARD*		Thursday 25/02/27 9.30am		Thursday 22/04/27 9.30am		Thursday 24/06/27 9.30am		Thursday 26/08/27 9.30am		Thursday 28/10/27 9.30am		Thursday 16/12/27 9.30am
AUDIT & RISK COMMITTEE	Thursday 28/01/27 9.30am		Thursday 25/03/27 9.30am			Thursday 17/06/27 9.30am				Thursday 14/10/27 9.30am		
CLINICAL GOVERNANCE COMMITTEE		Thursday 18/02/27 9.30am			Thursday 13/05/27 9.30am			Thursday 12/08/27 9.30am			Thursday 11/11/27 9.30am	
STAFF GOVERNANCE COMMITTEE		Thursday 11/02/27 9.30am			Thursday 20/05/27 9.30am			Thursday 19/08/27 9.30am			Thursday 18/11/27 9.30am	
REMUNERATION COMMITTEE*						Thursday 03/06/27 9.30am			Thursday 02/09/27 9.30am		Thursday 04/11/27 9.30am	
BOARD DEVELOPMENT SESSION	Thursday 21/01/27 9.30am		Thursday 04/03/27 9.30am		Thursday 06/05/27 9.30am			Thursday 05/08/27 9.30am		Thursday 07/10/27 9.30am		Thursday 02/12/27 9.30am

*The Board and Remuneration Committee may also meet as and when required.

2027 PUBLIC HOLIDAYS:

- 1 & 4 January
- 26 & 29 March
- 24 & 27 September
- 27 & 28 December