THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

BOARD MEETING
THURSDAY, 22 OCTOBER 2026

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THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 26/05**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 27 August 2026.

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

Chair:	Brian Moore
Present:	
Employee Director	Allan Connor
Non- Executive Director	Stuart Currie
Non- Executive Director	Cathy Fallon
Chief Executive Officer	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Finance and eHealth Director	Robin McNaught
Non- Executive Director	Pam Radage
Non- Executive Director	Shalinay Raghavan
Medical Director	Prof. Lindsay Thomson
In attendance:	
Corporate Business Manager	Anne Donnelly
Social Work Mental Health Manager	David Hamilton
Acting Director of Security, Estates & Resilience	Allan Hardy
Clinical Forum Chair	Dr Joe Judge
Head of Communications	Caroline McCarron
Head of Planning, Performance and Quality	Monica Merson
Head of Corporate Governance/Board Secretary	Margaret Smith [Minute]
Director of Workforce	Stephen Wallace

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

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

2 CONFLICTS OF INTEREST

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

3 MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting held on 18 June 2026 were noted to be an accurate record of the meeting save for one minor amendment to an attendee's title.

The Board:

1. Approved the minutes of the meeting held on 18 June 2026.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the rolling action list (Paper No. 26/55) and were content with the updates and

noted the actions that had been closed. In answer to a query about progress on NHS Board self-assessment, Ms Smith confirmed that further guidance was awaited at a national level presently. Mr Moore asked if any response had been received to date from Scottish Government in respect of the Women's Service Outreach Proposal. Mr Jenkins confirmed that there has been no formal response as yet, but that he was meeting with Mental Health Directorate colleagues on a monthly basis and that the Women's Service was part of the agenda.

The Board:

1. Noted the updates.

5 CHAIR'S REPORT

Mr Moore advised that, since the previous Board meeting in June, he had attended two Board Chairs' sessions. He noted that the June meeting had focused principally on mental health, noting that Mr Jenkins would provide a summary of this within his update.

Mr Moore advised that the August meeting had included input from Mr Paul McFadden, Scottish Public Services Ombudsman, who had spoken about complaints handling across the public sector and the health service. Mr Moore highlighted that the volume of complaints had increased significantly, including within health, and that this presented implications for the processing of, and response to, complaints. He also observed that there remained a wider issue around organisational learning from previous investigations, particularly where similar themes or patterns continued to emerge. He further advised that Whistleblowing had also been discussed, noting the significance of the fifth anniversary of the implementation of the relevant standards. He referred to the forthcoming Speak Up Week and highlighted the importance of remaining alert to the importance of building confidence on the part of staff to speak up. Mr Moore noted that the Board had recently held a constructive development session on this subject and that the Board's Whistleblowing Champion, Ms Raghavan, and Mr Wallace and Ms Smith were progressing planning for Speak Up Week.

Mr Moore reported that two Board development sessions had provided useful opportunities to consider current operational challenges, including the Interim Operational Protocol, the Women's Service, the planned Admissions and Recovery model, and wider forensic services capacity. He considered the discussions on the use of data to be particularly helpful, noting Ms Merson's leadership in developing approaches to support whole-system understanding and service improvement. He also reported that work had commenced on the population health self-assessment, again led by Ms Merson.

Lastly, he noted that he had attended a recent staff induction session, as well as the Patient Partnership Group and the State Hospital TSH3030 awards ceremony. Mr Moore concluded by noting the forthcoming publication of the Programme for Government and the importance of considering any implications for the future direction of the NHS in Scotland, including mental health and forensic services.

The Board:

1. Noted the update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an overview of his activities since the previous Board meeting, beginning with the wider national context. He began by noting the recent meeting with Board Chairs in which he had led discussion on the strategic direction for mental health in Scotland. He advised that this work was not specifically focused on forensic mental health, but on the broader mental health landscape, and that key areas of discussion had included ownership, governance, workforce and the need to bring these matters together in a coherent way. He noted that the work remained under development and would need to be considered alongside the forthcoming Programme for Government and the Mental Health and Wellbeing Strategy, which was due to be published later in September.

Mr Jenkins noted the forthcoming programme for Government which would be published on 1 September, as well as that the sub-national planning process continued, with a focus on planned care performance, unscheduled care performance, the orthopaedic plan and the transformation of unscheduled care.

He also highlighted the Population Health Framework and that further follow-up with Public Health Scotland was ongoing, led by Ms Merson, on behalf of the state Hospital.

He reported that he was also involved in a Joint Commission taking a whole-system approach to mental health distress, vulnerability and demand, working with Police Scotland to consider responses to mental health-related demand and to identify opportunities for early improvements. He noted that a working group was meeting, with a target of reporting high-level impacts to the joint commission between the Director General of NHS Scotland and the Chief Constable by November or December.

In relation to the internal position, Mr Jenkins advised that a Mental Welfare Commission inspection visit had taken place. He noted that the Interim Operating Protocol (IOP) had gone live, and that the fortnightly Clinical Operational Oversight Group would commence the following Monday, chaired jointly by Professor Thomson and Ms McCaffrey. This would provide a further mechanism to support a data-driven approach across services in terms of operational delivery. He also noted that work was under way to respond to the iMatter results through a more action-focused approach, following detailed consideration with input through Organisational Development.

Mr Jenkins provided assurance on his interaction with Mental Health Directorate colleagues to provide an update on the State Hospital's portfolio of work, and that the Strategic Planning and Performance Group had also met to review the relevant reporting data and metrics which formed reporting to the Board at this meeting.

Mr McConnell asked about the Joint Commission work referred to, and Mr Jenkins provided additional clarity on the remit and range of this which was not forensic as such and covered the range of demands on the police involving the need for mental health intervention with the police often being the emergency contact, whilst not necessarily being best placed to provide the support required at the front line. The project aim was to identify and map these demands, focusing on areas of strength and those requiring improvement. Mr Currie added that the Women's Service Outreach Proposal had provided a constructive route for collaboration in this way. He also noted the pressures being experienced across the public sector in terms of volume of complaints, including pressures on the SPSO itself, and the need to ensure that learning was taken from investigatory processes. He referred to the Programme for Government, noting that it may include radical steps given the pressured financial landscape across the public sector.

Mr Moore commented that Mr McFadden had acknowledged the way which the rise in the volume of complaints were impacting NHS Boards and their ability to meet this demand, in terms of resources. Professor Thomson asked for clarity on this point for the State Hospital, and Ms Smith noted that there had been an increase in general terms within the last year and that this did align with the experience across the wider public sector. Locally there had been changes made in the handling of complaints and engagement with stakeholders to build confidence in the process itself.

The Board:

1. Noted the update from the Chief Executive Officer.

7 PATIENT STORY: EXPERIENCE OF DAYTIME CONFINEMENT (DTC)

The Board received a presentation from Ms Garrity to provide feedback from patients about their direct experience of DTC on their care and in their day to day lives in the hospital through feedback gathered through the Patient Partnership Group (PPG). This was a standing agenda item at weekly meetings with a consistent focus on three questions: what patients had found most difficult, what they had missed out on, and what suggestions they wished to make for improvement.

Ms Garrity reported that the feedback had highlighted the significant impact of prolonged periods of confinement on patients, particularly during the summer months. Patients had described difficulties arising from reduced grounds access, limited access to activities and therapeutic groups, cancelled sessions within the Sky Centre, and restrictions on ordinary daily living activities such as laundry. She noted that some issues which might appear small from an organisational perspective were of considerable importance to patients, particularly where they related to autonomy and daily routines.

Ms Garrity further advised that communication had been a recurring theme within patient feedback. Patients had reported frustration where they had not been informed in advance that placements, groups, telephone calls, video calls or grounds access would not be available. She noted that patients had also reflected on the impact on family contact, including missed opportunities to make telephone calls on important occasions. Suggestions for improvement had included more timely communication, greater consistency in practice across wards, use of hands-free telephones where appropriate, escorted walking opportunities, improved access to outdoor space, and greater continuity of staffing which they felt would support trust and familiarity.

Ms Garrity reported that a number of practical changes had already been made in response to patient feedback, including improved access to bottled water, work to support more consistent grounds access arrangements, and a resolution to concerns regarding meal containers through the provision of new crockery for meals served in rooms. She advised that patients wished to see evidence that their feedback led to meaningful change, while recognising that not every request could necessarily be fulfilled. She noted that, although patients had experienced a period of frustration and reduced confidence during the summer, there had more recently been a more positive outlook, with patients being aware of the introduction of the IOP.

Mr Moore reflected that the presentation mirrored the feedback the Non-Executive Directors had received through their regular attendance at the PPG. He thought it was important that this was formally reported through the Board, as it helped to emphasise the impacts on patient care.

Ms Radage agreed and said that when she had attended the PPG recently, discussion had also focused on consistency and concerns about fairness. At the same time, there had also been an appetite to contribute to finding potential solutions as well as understanding about the organisational recruitment drive. She thought that it may help to add in a question to discussions about any good experiences that patients may wish to report.

Ms Raghavan added that patients often spoke of poor communication and the lack of advance notice of DTC, which compounded feelings of not being heard and potentially unequal experience. Ms Fallon also noted the impact on patients and referred to the importance of wider work ongoing to eliminate DTC and the complexity of this in terms of practice and culture, as well as how to evaluate this within the context of clinical care and levels of clinical acuity. She also said that it was disappointing that small fixes like providing bottled water had not been put into place immediately. Mr Jenkins also underlined this point in terms of basic practice standards. He also acknowledged the clear need for consistency and forward planning across services, and that the new operational arrangements were introduced as a conduit through which this could be achieved.

Ms McCaffrey commented that the presentation was difficult to listen to, and that it was essential that patient feedback was central to considering the way forward. Communication was absolutely vital, so that patients were aware in advance of the plan for their care and any change to that as soon as possible. She said there should be greater predictability for patients and that the COG should provide a mechanism to do so. She advised that progress would be reported back to the Board through the COG during the interim period. She would also ensure that the Senior Charge Nurse cohort also had the opportunity to receive this presentation.

Action – Ms McCaffrey

Mr Moore noted that the paper at Item 11 would support further discussion on the IOP and DTC position in the hospital.

<u>The Board:</u>

1. Noted the noted the content of the presentation, particularly patient experiences.

2. Requested that a response is given to the PPG.

8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 26/56) from the Acting Director of Security, Resilience and Estates in respect of the Corporate Risk Register, and Mr Hardy provided a summary of the content, advising that all corporate risks were currently in date and that no new risks were proposed for inclusion during the quarter.

He reported that one risk, ND70, relating to nursing resourcing and service delivery had been escalated to Very High, and explained that this reflected sustained staffing pressures, increased clinical acuity and the Women's Service operating above its funded base. He noted that the risk had been reviewed with the risk team and escalated at the end of July, pending implementation and assessment of the interim model.

Mr Hardy further reported that two risks remained rated as high: FD90, relating to failure to implement a sustained financial model, and HRD115, relating to sickness absence levels. He noted there had been a recent increase in sickness absence, particularly linked to nursing and long-term absence. He also noted that 13 corporate risks had achieved their target rating, while 10 had not yet reached target, with only the three identified risks exceeding the Board's agreed tolerance level. He highlighted positive movement in two areas of the risk register. He advised that MD30, relating to patient obesity levels had reduced from high to medium following refinement of the risk and continued monitoring. He also reported that SD57, covering the management of Serious Adverse Event Reviews (SAERs) had moved from high to medium as a result of positive progress in relation to incident reporting and management processes.

He noted that InPhase implementation for incident management, complaints and claims was now complete and operational, although testing of local and corporate risk functionality had been delayed due to capacity pressures, including current Category 1 and Category 2 investigations. Mr Hardy advised that options for temporary secondment support from another Board were being explored to assist the team.

In answer to a query from Mr McConnell about MD56 relating to the Women's Service and how the risk was assessed should pressures on the interim service increase, Professor Thomson noted the need to continue to assess the risk, and provided additional context that at present the service had four patients with a fifth referral underway which could impact the ability to admit any further patients to the service. Ms Fallon asked for clarity on the assessment of risk around the funding position for the Women's Service, and Mr McNaught confirmed that the current funding allocation did not cover the full year, and management of this would be outlined further at Item 12.

Ms Fallon also asked about the development work that had been paused within the Risk Department, and how this would impact the management and reporting of risk for the hospital. Mr Hardy noted the need to move risk assessments and reporting on to the InPhase platform which had not yet been undertaken, but that all other development work was progressing well in the department. He thought that there was a capacity issue within the department, and efforts were being made to consider new ways of working and to try to seek further resources at present. He added that it would be helpful for fresh eyes to review this to ensure that all aspect of the department's work could continue to be delivered. Mr Jenkins added his agreement that this would be helpful.

The Board:

1. The Board reviewed the current Corporate Risk Register and approved it as an accurate statement of risk.
2. Noted the need to seek additional support for the department.

9 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a paper (Paper No. 26/57) in respect of this project, and Mr Hardy outlined the

key points. He advised that the Perimeter Security and Enhanced Internal Security Systems project had been formally completed on 30 June 2026 and had now moved into the two-year Defects and Liability period.
He reported that three principal matters remained outstanding, relating to perimeter cameras, water ingress into the cable ducts, and cameras affected by power fluctuations during generator testing. He noted that these matters had been accepted into the Defects and Liability process on the basis that there was a clear understanding of how they would be managed, with progress to be monitored through the continuing governance arrangements. He confirmed that work had commenced on the three outstanding issues and was expected to be completed by early 2027, subject to weather and other external factors. He confirmed that although the Project Oversight Board had now closed, oversight would continue through fortnightly meetings. He also confirmed that the post-occupancy evaluation had commenced in line with the Scottish Capital Investment Manual, and that the final report would be brought back to the Board once complete.

Mr Hardy noted that Securitas would provide maintenance support over the two-year period, including on-call arrangements and an embedded site engineer, and the support provided by the State Hospital's Systems Manager and the availability of project knowledge from colleagues who had been involved. He concluded by noting the financial position and advising that corporate risks within the Security Directorate were being reviewed and refined to support transition to business as usual operations, and that a further risk relating specifically to the Defects and Liability period would be added to the Corporate Risk Register.

There was agreement around the table that this was a positive outcome, and that conclusion of the project was welcomed. The need to keep security systems under review in terms of performance and sustainability was underlined, as well as projection of any future maintenance costs. Mr Hardy provided further detail on the way in which this had already commenced. Mr Jenkins also provided further background on the nature of the associated costs to the project, particularly relating to the complexity of the technology involved and the need for specialist advice. In addition, it was confirmed that as the Project Oversight Board had closed, the governance route for oversight of the Defects and Liability period and future risks as well as post evaluation reporting would be confirmed.

Action – Mr Walker

Mr Moore expressed thanks to all staff involved in the project, and in bringing it to a conclusion particularly to the Programme Director, Mr David Walker, as well as to Mr Hardy.

The Board:

1. Noted the content of the report, confirming project completion.

10 PERFORMANCE AND ANNUAL DELIVERY PLAN (ADP): QUARTER 1 2026/27

The Board received a paper (Paper No 26/58) 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 during the last quarter.

Ms Merson provided an overview of the report noting the way in which many of the workstreams were covered in dedicated reporting to the Board as part of today's agenda. She reported that eight of the 12 corporate KPIs had been rated green, demonstrating that these indicators were meeting or exceeding their targets and highlighted the four KPIs that had not done so. She noted care and treatment plan completion had improved from red to amber, with a completion rate of 92.3% against a target of 100% and advised that the transition to electronic patient records and clearer data ownership should support further improvement in administration of this during the next quarter.

Ms Merson further reported that patient activity remained below target at 54.3% and was rated red, which was unusual for Quarter 1 given expected seasonal variation. She advised that DTC and staffing pressures had affected patients' ability to participate in activity. Sickness absence was also rated red, at 6.65%, with a significant increase in nursing absence during the quarter. The KPI for Clinical Risk Assessments being reviewed annually remained rated amber, although administrative issues had been identified and changes made. She also noted that attendance at CPA meetings

had been included for monitoring.

In relation to the ADP, Ms Merson advised that 72 actions had been identified for delivery during the year, including four carried forward from the previous year. She reported that the majority of Quarter 1 actions had been rated green, with six rated amber and one rated red. She highlighted progress in relation to the Women's Service, including submission of the Strategic Assessment and proposed Outreach Proposal to the Scottish Government. She noted the amber actions and the work underway as well as the red action which related to DTC.

The report was welcomed with its format demonstrating the areas where good progress had been made, as well as those areas in which further support was required. There was a minor point on matching the whole number reporting to the percentages to ensure correlation, which Ms Merson would undertake for the future.

Action – Ms Merson

Ms Radage noted the timing of the culture change programme planned for October and how this would align with the IOP and current operational activity; and also, the need to continue to monitor attendance at CPAs particularly by key workers to ascertain if the interim model was supporting improvement. Mr Jenkins acknowledged the need to insure against the risk of overwhelming staff cohorts, and the need to carefully coordinate the organisational development workstream as it was rolled out. Ms McCaffrey added that the measurement for key worker attendance at CPAs was currently subject to wider review to ensure its accuracy and relevance, and this would be reflected in future reporting.

The Board:

1. Noted the content of the report.

11 DAYTIME CONFINEMENT: INTERIM OPERATING PROTOCOL

The Board received a paper from the Director of Nursing and Operations (Paper No. 26/59) to provide an update on the introduction of the IOP as well as summarising levels of DTC across the hospital for the period up to 31 July 2026.

Ms McCaffrey advised that the IOP had been formally approved by CMT at the start of August, although some associated practices had already begun to be introduced in advance of formal implementation. She explained that the interim model was not, of itself, designed to eliminate DTC, but rather to create a stable platform to support improved predictability, planning and consistency during a challenging operational period. She outlined further that a key aim of the IOP was to enable services to anticipate operational requirements more effectively, so that patients could be informed in advance and plan their day and work accordingly. She emphasised the importance of protecting patient activity wherever possible, while also maintaining a clear focus on safe practice. She noted that early implementation had already helped to identify areas that were managing well and those requiring further support, allowing attention to be directed to where it was most needed.

Ms McCaffrey reported that the COG had been developed to replace the Daytime Confinement Oversight Group and the Clinical Model Oversight Group, with a stronger focus on the use of available data to direct decision-making. She advised that the group would commence on 31 August and would be co-chaired by herself and Professor Thomson. She also highlighted continued progress in nursing recruitment, while noting that sickness absence remained a challenge and would be considered in more detail at today's meeting through workforce reporting. She concluded that patient feedback remained a crucial measure of the effectiveness of the interim model.

The robust and detailed nature of the IOP was noted, with consideration of the levels of DTC being experienced, as well as the variation across hubs and services. Ms McCaffrey added that it should be possible to identify those areas most vulnerable to DTC as well as variation in practice across the hospital, which could be a contributory factor. She noted that the new model was in its early days but that it was possible to see some areas performing better which may help learning and sharing of good practice as well as empowering the local multi-disciplinary teams. A further

important factor was to strengthen local teams and reduce the movement of staff across the hospital which also supported connection with patients.

Dr Judge asked about the projected end to the IOP, and if there was confidence that the required nurse recruitment would be realised. He noted concerns from the Clinical Forum that the IOP may be extended beyond the end of November. Ms McCaffrey said that she did not anticipate a need to extend the IOP and confirmed that nursing resourcing was getting closer to achieving the agreed over recruitment position. At the same time, she thought that it would be important to ensure that this did not become a cycle that the hospital returned to in the future, and that there may be wider issues that required continued development over time.

The Board agreed that it would be helpful for the Non-Executive cohort to meet at the end of September to receive an update on progress, and an opportunity to consider impacts of the IOP.

Action – Secretariat

The Board:

1. Noted the report, and the implementation of the IOP.
2. Requested a further update meeting for Non-Executives to receive an update.

12 FINANCE REPORT

The Board received a paper (Paper No. 26/60) from the Director of Finance and eHealth, presenting the financial position for the current year to 31 July 2026 (Month 4). Mr McNaught provided a summary of the key aspects of the report.

He advised that the Board was reporting a small favourable variance at Month 4, while noting that a number of areas of financial pressure remained. He advised that nursing expenditure remained the principal area of focus, particularly in relation to staffing for the Women's Service, and confirmed that Scottish Government had agreed that the required funding identified for the Women's Service for the year would be provided. He explained that the current allocation of £3.1m was insufficient to meet the full-year requirement and that actual monthly costs were therefore being tracked against that allocation until it was fully utilised, which was expected during Quarter 3. He advised that expenditure beyond that point would create a deficit during the remaining months of the year, which would then be addressed through an additional allocation agreed to be settled around year end. He noted that Scottish Government colleagues were content with the current position, projections and the approach being taken to account for spend against the allocation.

In relation to capital expenditure, Mr McNaught advised that known pressures for 2026/27 were being assessed against the available budget, with the principal demand at that stage sitting within estates. He reported that one significant eHealth requirement, the replacement of the organisation's data storage system, exceeded the annual capital allocation at approximately £300k and was required due to the expiry of manufacturer support later in the year. He confirmed that, following review of available options and the absence of additional Scottish Government capital funding for IT, the replacement would instead be progressed through the recurring revenue budget under an affordable finance agreement with IBM, enabling implementation within the required timescale.

Mr McConnell asked for clarification of the agreement with Scottish Government in respect to the Women's Service, and Mr McNaught confirmed that as full utilisation was reached of the £3.1m allocation, the government would assess how the outturn progressed from that point to yearend, to give an accurate level of funding required at that stage with an allocation settlement, rather than basing this on a future estimation at this point in time. It was expected that existing directorate budgets would continue as planned. This was discussed and noted as a reasonable way forward.

Mr Currie raised a point around the vacancy position within nursing and likelihood of reaching the stated over recruitment position and placing this in the context of the costs of use of overtime and the Supplementary Staffing Register (SSR). He also referenced attendance management and most particularly within the nursing cohort referring to the costs of this which was not simply financial but also human in terms of impacts on patients and staff. Ms McCaffrey spoke of the pressure to

respond to demand, which was through using existing staff resources whilst at the same time the long-term goal remained to meet the savings target for the year.

Mr McNaught spoke to the efforts across all directorates to achieve their savings targets, and that detailed work was being driven forward to support this. He clarified a point raised about the data for nursing overtime and for the over recruitment position, noting that the data included spend to date but that there were some savings there due to the vacancy offset. He noted the Women's Service data was provided separately to clarify this point. Ms McCaffrey responded to a concern regarding how to ensure that overtime rates did not continue at the current levels in the longer term by saying that there was an awareness and focus on this presently to ensure that this would not be the case.

Ms Raghavan asked about wider Public Sector Reform, and the need to reduce spending across the national landscape, and Mr McNaught noted that there were no current or specific indications for change to recurring allocations. Mr Jenkins referred to the upcoming Programme for Government which may be consequential and may outline governmental aims in terms of the Service Renewal Framework; and also, to the ongoing work for NHS Boards on the Population Health Framework and the longer terms impacts expected in that regard. Mr Moore concurred with these points and noted the potential for impact on financial and workforce frameworks across all NHS Boards in the medium to longer term.

The Board were content to note the update provided.

The Board:

1. Noted the content of the report, and the financial position to Month 4.

13 QUALITY ASSURANCE AND QUALITY IMPROVEMENT REPORT

The Board received a paper from the Head of Planning, Performance and Quality (Paper No. 26/61) and Ms Merson advised that this covered activity across quality improvement and quality assurance since the last Board meeting. She outlined that the Clinical Quality Department had continued to deliver a comprehensive clinical audit programme, with three local audits completed during the reporting period. She noted that the master audit sheet now provided ward and service leadership teams with improved visibility of compliance and areas for improvement, and that the Clinical Governance Group had reviewed emerging themes and agreed actions to address and monitor them.

She reported that CPA performance had remained largely stable, supported by effective multidisciplinary team collaboration, and that CPA dashboards were being rolled out to give Heads of Service improved access to information on professional attendance and performance. She also advised that peer review panels had met twice to review CPAs in depth, with feedback provided to Responsible Medical Officers and clinical teams, and that the format had been well received.

In relation to quality improvement, Ms Merson highlighted the TSH3030 sprint as a key achievement for Quarter 1, with 11 teams completing the sprint during May. She advised that improvements had been identified across patient participation, health and wellbeing, therapeutic gardening and outdoor activity, creative arts-based interventions, and strengthened patient voice in decision-making, including through the Making Meetings Matter project. She also noted progress in therapeutic improvement work, including Better Decisions Together, alongside improvements in multidisciplinary communication and the standardisation of work processes.

Ms Merson further reported that realistic medicine work had continued to progress against the action plan, including development of structured decision-making, work using the Dundrum models, and a human factors project using the Systems Engineering Initiative for Patient Safety model to review enhanced observations and better understand decision-making and patient care pathways. She advised that this work would report later in the year and continue into 2027. She also noted that 75 national guidance documents had been reviewed during the reporting period, with 11 remaining under review and actions being identified for further improvement. The report also included evaluation matrices being reviewed through the Forensic Health Steering Group.

Ms Fallon welcomed the paper and confirmed its helpfulness in demonstrating the level of activity in this area. She thought that the variety of projects underway through quality improvement was reassuring and a positive development especially given some of the pressures the hospital had been experiencing. Ms Radage agreed with this point and the insights that TSH3030 gave, linking it to culture change and supporting staff in speaking up and a route through which to offer solutions. There was agreement that the Board would like to offer its appreciation of all of the efforts made by both staff and patients, and that Ms Merson would do so. The work on Enhanced Care Plans was also noted as being important, and that this would be reported in due course.

The Board:

1. Noted the Quality Assurance and Quality Improvement Report.

14 CLINICAL GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 14 May 2026; as well as a summary report (Paper No 26/62) of the key areas of reporting and discussion at the meeting which had taken place on 13 August 26. The Committee Chair, Ms Fallon, reported that the most recent meeting had been very positive and highlighted discussion on Supporting Healthy Choices and the link to the Quality Assurance and Quality Improvement reporting; and also, that reporting on complaints aligned with the national increases seen nationally and discussed earlier in this meeting. Further that patient involvement in research was noted as being helpful.

The Board:

1. Noted the approved minutes and reporting.

15 CLINICAL FORUM

The Board received the draft minute of the meeting that took place on 11 June 2026. Dr Joe Judge, Committee Chair, sad that it had been very helpful to have Mr Moore and Ms McCaffrey attend the meeting to discuss impacts of DTC. The Clinical Forum continued to carefully consider the impacts on both clinical care as well as on professional staff groups being required to undertake duties that fall outwith their professional roles. There continued to be concern about this, and in particular about whether the increased recruitment position would resolve the pressures as a whole and about the projected timescale for this.

Ms Fallon added that the minutes also demonstrated the importance of reflective practice, and that this would be important going forward in terms of staff perceptions of clinical acuity.

The Board:

1. Noted the draft minutes.

16 STAFF GOVERNANCE REPORT

The Board received a paper (Paper No 26/63) 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 report, noting that the Staff Governance Committee had considered the report in detail, particularly in relation to attendance management. He advised that sickness absence had continued to rise since March and had reached 8.83% in July. He acknowledged that this was disappointing following earlier improvement, but noted that absence levels were influenced by a range of factors, including the working environment and current resourcing pressures. He highlighted that nursing absence was the principal area of concern, having almost doubled compared with July of the previous year and sitting at just under 14%, with long-term sickness identified as a key factor. Mr Wallace reported that non-nursing departments were performing more positively, with absence below 5% at 4.48%, and that this position would continue to be managed carefully. He advised that the HR team continued to work with line manager as well as Occupational

Health and the Staff Care Specialist to support staff to return to work.

In relation to recruitment, Mr Wallace advised that 18 nursing staff were due to commence between August and October, which would broadly return the organisation to a break-even position. He confirmed that further recruitment would continue, taking account of the requirements of the Women's Service, and noted that nursing interviews were taking place that day as part of the proactive approach being taken.

Mr Wallace further advised that there had been an increase in employee relations cases, and he confirmed that plans and timelines were in place for completion of those cases. He also highlighted a rise in Working Time Directive breaches, which appeared to be beginning to plateau, and noted that this reflected ongoing workforce resilience and nursing capacity pressures. He advised that this would remain an area of focus, alongside support for staff wellbeing.

Mr Currie underlined the unsustainable nature of sickness absence levels, and the way in which high levels of absence affect efficiency as well as the ability to recruit new staff, and the urgent need for improvement. He thought that there was a risk of staff finding it increasingly difficult to return to work, the longer their absence continued. At the same time, he noted that at the last Staff Governance Committee, the Occupational Health (OH) Annual Report showed an increase in self-referrals from staff which was heartening as it indicated that this was seen as a positive intervention. Mr Wallce echoed this point and highlighted the proactive nature of the support being offered through OH, and also that a sustainable workforce helped to drive efficiency in service delivery. He added that it should be recognised that one of the key factors influencing absence was working environment and these impacts could be cyclical. Therefore, there was a need to increase workforce resilience in terms of responding to peaks in demand, and this should engender improvement in absence.

Ms Fallon asked if there had been any trends identified on the numbers of staff placed on formal monitoring for sickness absence, and Mr Wallace responded that the number tended to spike with increases in short term absences and the monitoring put in place on that basis but overall, these were lowering due to the levels of long-term absence. Ms Fallon also noted the KPI target for recruitment timescales, and Mr Wallace advised that this had seen improvement and there was a concentrated push underway to meet the target.

Mr McConnell commented on the year-on-year increase in nursing sickness absence and placed this within the context of the State Hospital being a special board delivering direct patient care. Mr Wallace agreed that this was a long-term challenge it should be expected that there would be spikes experienced locally. He noted that for the State Hospital, within year, there had also been periods of improvement as well.

Mr Moore summarised the discussion and noted the Board's concern the high levels of sickness absence within nursing in particular, whilst accepting that this was not a matter of a quick fix. He noted the impacts of this across the whole organisation, and the pressures currently being experienced. Lastly, he emphasised that this was not a sustainable position in the longer term, and acknowledged the efforts being made at an Executive level to address this.

The Board:

1. Noted the content of reporting.

17 WHISTLEBLOWING UPDATE QUARTER 1

The Board received a paper (Paper No 26/64) from the Director of Workforce which provided an update on activity relating to the Whistleblowing Standards for Quarter 1.

Mr Wallace advised that no formal whistleblowing cases had been raised during Quarter 1. He reported that two anonymous concerns had been submitted directly to the State Hospital and, although these had not met the criteria for consideration under the Whistleblowing Standards, they had been escalated and managed through business as usual processes. He asked the Board to note the content of the Quarter 1 report.

In her role as Whistleblowing Champion, Ms Raghavan advised that recent discussion with Mr Wallace and Ms Smith had highlighted the prescriptive nature of the Whistleblowing Standards in relation to anonymous concerns, including the position that the Independent National Whistleblowing Officer (INWO) would not accept anonymous complaints. However, even where a concern did not meet the criteria for a formal whistleblowing complaint, it would still be considered and acted upon where it contained specific information about potential wrongdoing in the workplace.

She noted the importance of encouraging staff to speak up and raise concerns while ensuring that appropriate governance arrangements were in place when concerns were received through that route. She also observed that anonymous concerns may indicate that some staff did not yet feel sufficiently safe to identify themselves, and that this should be addressed further through Speak Up Week.

The Board:

1. Noted the content of reporting.

18 STAFF GOVERNANCE COMMITTEE

The Board received the approved minute of the meeting that took place on 21 May 2026; as well as a summary report (Paper No 26/65) of the key areas of reporting and discussion at the meeting which had taken place on 20 August 26.

As Committee Chair, Ms Radage advised that the Staff Governance Committee had held full and comprehensive discussions on all of the key performance indicators considered earlier by the Board today. She highlighted the achievement of reducing sickness absence rates below 5% in some areas, noting that this demonstrated the cumulative impact of improved data intelligence, a more proactive Occupational Health response and the wider workforce measures that had been developed over time. She confirmed that the Committee had received robust assurance through its discussions across a range of areas and welcomed the positive progress being made.

The Board:

1. Noted the content of the minutes and reporting.

19 FEEDBACK AND COMPLAINTS ANNUAL REPORT 2025/26

The Board received a paper (Paper No 26/66) from the Head of Corporate Governance presenting the Feedback and Complaints Annual Report 2025/26.

Ms Smith provided a summary of the key points and highlighted that the format and much of the content were prescribed by the Scottish Government to support national comparison across NHS Boards. She noted that the report described how feedback was encouraged, aligned with the Carers' Strategy and reflected key engagement with patients, including through the PPG. She advised that, while the report had been designed to be attractive and engaging and would be published on the website for carers and others to access, an easy read version was also being developed so that patients could engage with it through the PPG and ward community meeting arrangements.

Ms Smith highlighted the key metrics within the report, noting in particular that the number of complaints received had increased significantly during 2025/26 and that this trend was continuing into the current year. She advised that no single theme had explained the increase during the year, although DTC had begun to feature during Quarter 4. She noted that the increased volume was consistent with wider trends across NHS Scotland, the Scottish Public Services Ombudsman and the broader public sector. She observed that, while increased complaints could appear challenging, it was also positive insofar as it demonstrated that patients and carers were engaging with the process, had confidence in it and considered it worthwhile to raise concerns.

Ms Smith further advised that the vast majority of complaints continued to be resolved at the early resolution stage, usually within five working days, which provided the best outcome for patients, carers and staff. She noted that identifying themes could be difficult given the small patient cohort and the individual nature of many complaints, but that the report had sought to set out reasons, issues and learning points arising from complaints. She concluded by thanking her team for their work throughout the year, including their contribution to producing a more accessible and visually engaging report.

The report was received positively, with agreement that the refreshed format was attractive and presented the information clearly. Ms Fallon commented on the focus on taking learning and reflected that this approach may be helpful in reporting more widely. She also thought that it was helpful that complaints awareness was part of staff induction sessions. Ms Radage added that it also demonstrated the importance of the Patients' Advocacy Service, and the way in which this helped to build trust and involvement.

Mr Jenkins commented on the continual improvement approach taken towards feedback and complaints management within the hospital over recent years, and that this report helped demonstrate increased engagement and transparency in the area. Lastly, Mr Moore summarised by underlining the refreshed form of the report and the improvements demonstrated.

The Board:

1. Noted the content of reporting.

20 INFORMATION GOVERNANCE ANNUAL REPORT 2025/26

The Board received a paper (Paper No 26/67) from the Director of Finance and eHealth presenting the Information Governance Annual Report 2025/26, and Mr Lawton provided a summary overview for the Board.

He advised that the report provided assurance that information governance arrangements across the State Hospital remained effective and had continued to mature during 2025/26. He reported that the Information Governance Group had maintained oversight of key governance areas, including data protection, records management, freedom of information and the continuing development of the electronic patient record system.

He highlighted three principal areas of assurance. Overall compliance had continued to strengthen, with improvement shown through the data protection compliance toolkit, where the organisation was meeting six of the ten assessment areas. Operational performance had also remained strong, with more than 300 freedom of information requests received during the year and a 95% compliance rate achieved against statutory timescales. He noted that no requests for review had been received, which provided assurance regarding the quality of the responses issued, and that subject access request performance had also remained positive, with the majority completed within statutory deadlines.

Mr Lawton further reported that progress had continued in strategic areas, including the electronic patient record system, integration of CPA documentation, records management improvements and the planned transfer of MyCompliance, in respect of policy management responsibilities, to the corporate team to support better alignment between governance and policy management. He acknowledged the areas that reporting identified the need for further work and that email-related incidents continued to account for most personal data breaches, although incident numbers remained low and stable. He also recognised the need to strengthen transparency and proactive publication arrangements.

He concluded by advising that the State Hospital's Records Management Plan had been formally accepted by the Keeper of the Records of Scotland and that the final outstanding Information Commissioners Office (ICO) audit action had now been completed, meaning all ICO audit recommendations had now been fully implemented. These two points represented important developments and provided further assurance regarding the continued improvement of information governance arrangements.

Mr Moore congratulated Mr Lawton and his team on these achievement and thanked him for his report. Ms Fallon echoed this and commented on the volume of work represented by reporting. She asked for clarity about the reported access to patient records, and Mr Lawton provided assurance on the close and proactive management of this at the State Hospital, with a system of routine alerts in place to monitor this. This gave confidence that there had been no issues found with inappropriate access to patients' records. Mr Jenkins also underlined the strength of the governance arrangement in place in this respect.

In answer to a further question about the move to SharePoint, and any expected resourcing issues due this, Mr Lawton confirmed that the Records Manager is leading a programme of records management reviews prior to the change to ensure a smooth transition, and that the Communications Team would also be leading on this in respect to SharePoint Online.

Mr Moore also asked about the FOI self-assessment and for further background on Category 4 in terms of publishing information. Mr Lawton noted the need to make information available to the public, and the added complexity that State Hospital patients did not have direct internet access. He also referred to the drop in the number of publications through the model publication scheme, which was related to website accessibility requirements, and that the intention was to be able to build up the number of publications made available. He noted that the Scottish ICO had directed organisations to report annually on the number of additions made each year to the model publication scheme, as a new requirement. There was agreement around the table that the more information available online the better, meaning there would be less need for individual FOI requests.

Mr Moore summarised for the Board, and thanked Mr Lawton and his team for their work and stated that the report provided a good level of assurance on the present position as well as the progress being made where required.

The Board:

1. Noted the content of reporting.

21 BOARD AND COMMITTEE MEMBERSHIP AND MEETING SCHEDULE

The Board received a paper (Paper No 26/68) from the Head of Corporate Governance. Ms Smith advised that the paper included the draft Board and Committee meeting schedule for the following year for formal agreement. This had been prepared in advance to enable members to place the dates in their diaries. She noted that the schedule also reflected an increase in regular Board Development Sessions to six per year, recognising that these sessions had become increasingly helpful.

Ms Smith further advised that, following discussion with Mr Moore and the Public Appointments Team regarding a forthcoming Board vacancy, permission to commence recruitment had not yet been received. In the meantime, she confirmed that Mr Currie had agreed to take on the role of Chair of the Audit and Risk Committee from 1 December and noted that wider Committee membership would require further consideration.

The Board:

1. Endorsed the recommended schedule of meetings and change to Chair of the Audit and Risk Committee.

22 ANY OTHER BUSINESS

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

23 DATE AND TIME OF NEXT MEETING

The next meeting held in public would take place at 9.30am on Thursday 22 October 2026.

24 CLOSE OF MEETING

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

The meeting ended at 12.37pm.

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	D Walker	December 2026	**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 **October 2026:** Confirmed that risk review is being taken forward and will report through CMT and position will be included in next CRR report to Board.

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 at December Board.
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.	D Walker	December 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 Board. **October Update:** This is being reviewed with plan to progress work as outlined as part of overall risk approach – reporting will reflect this going forward.
4	August 2026	Patient Story	Confirm feedback and thanks to patients through PPG for their helpful contributions	K McCaffrey	Immediate	October Update: Confirmed that Thanks on behalf of the Board have been passed to PPG for their contribution and the way this had supported Board understanding. **CLOSED**
5	August 2026	Security Project	Confirm how the evaluation report would be routed as POB closed	D Walker	December 2026	**October Update:** Confirmed that this report will be reported through CMT in November and any escalation required to Board thereafter.
6	August 2026	Performance and ADP Plan	Verify whole numbers/percentages in future reporting	M Merson	Immediate	October Update: data verified in comparison to percentages reported within reporting as required. **CLOSED**

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
7	August 2026	Daytime confinement / IOP	Arrange meeting for end September for NXD cohort for updates	Secretariat	Immediate	**October Update:** Meeting took place 29 September. **CLOSED**

Last updated – 15.10.26 MS

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 22 October 2026

Agenda Reference No: Item No: 7

Sponsoring Director: 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.

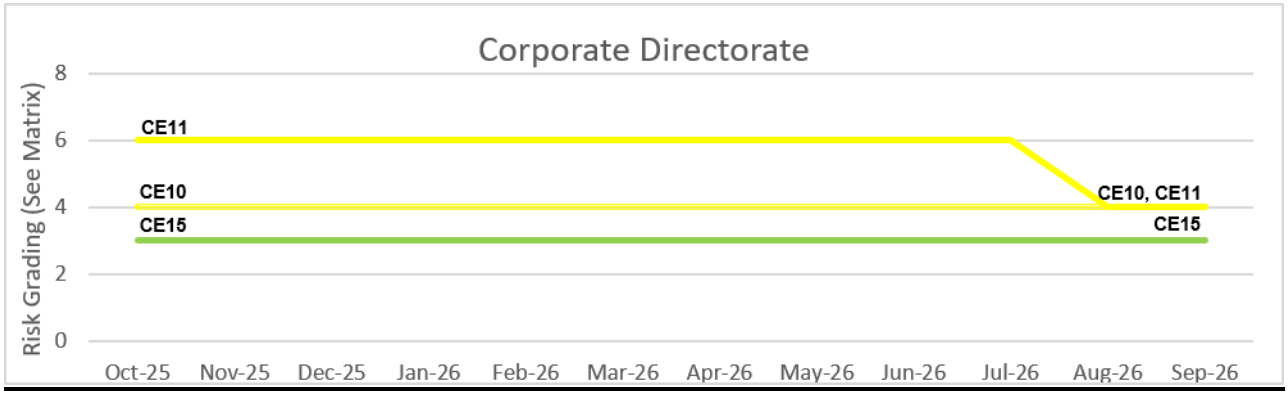
3.3.1 Risk Matrix

	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

CE11 Risk of Patient Injury was reviewed in line with the updated HIS Risk Matrix and has changed from 'Moderate x Unlikely' to 'Major x Rare', reducing the risk rating from 6 to 4 whilst remaining at 'Medium'. The guidance now specifies 'Specified Injuries' (Fractures) as a 'Major' Impact. Sustained low levels of patient injuries have supported reducing the likelihood from Unlikely to Rare.

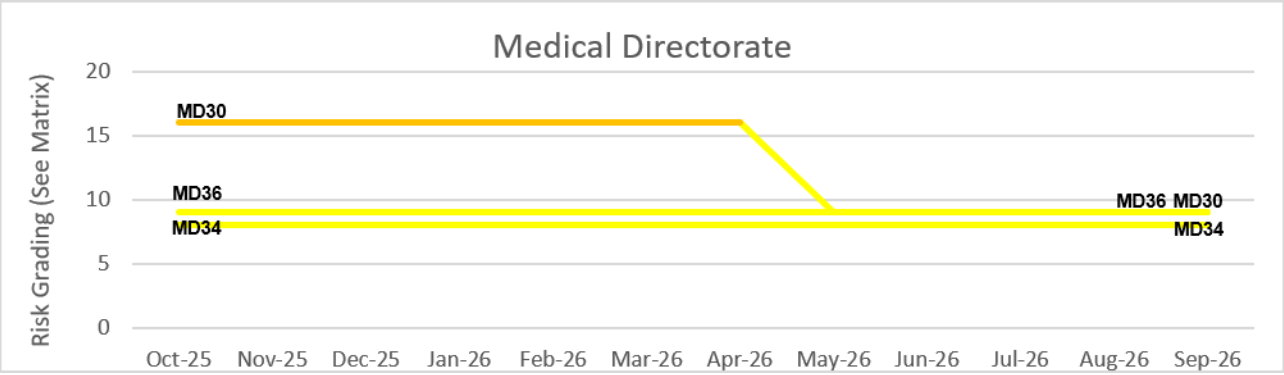


Risk key

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.

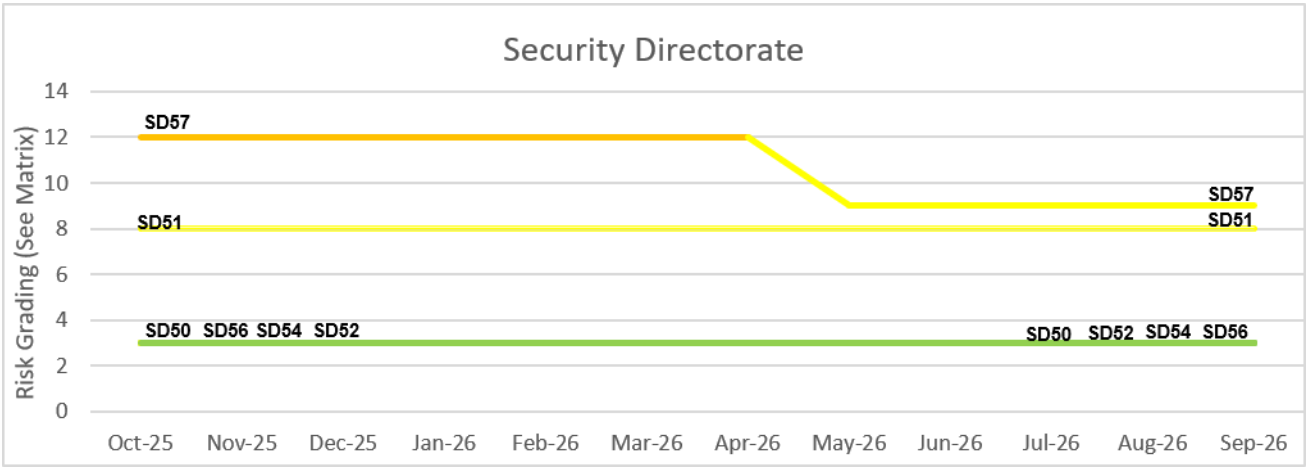


Risk key

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

SD51- Major or Extreme Failure of Physical or Electronic Security System is currently under review following practical completion of the Security Systems Project. The risk owner has engaged with relevant Heads of Department and Programme Director to identify any potential risks during the two-year Defects and Liability period, also taking cognisance of the agreed outstanding works to be completed within this period. This will be reported through CMT and the Board will be advised of any changes to the risk rating at the December meeting.

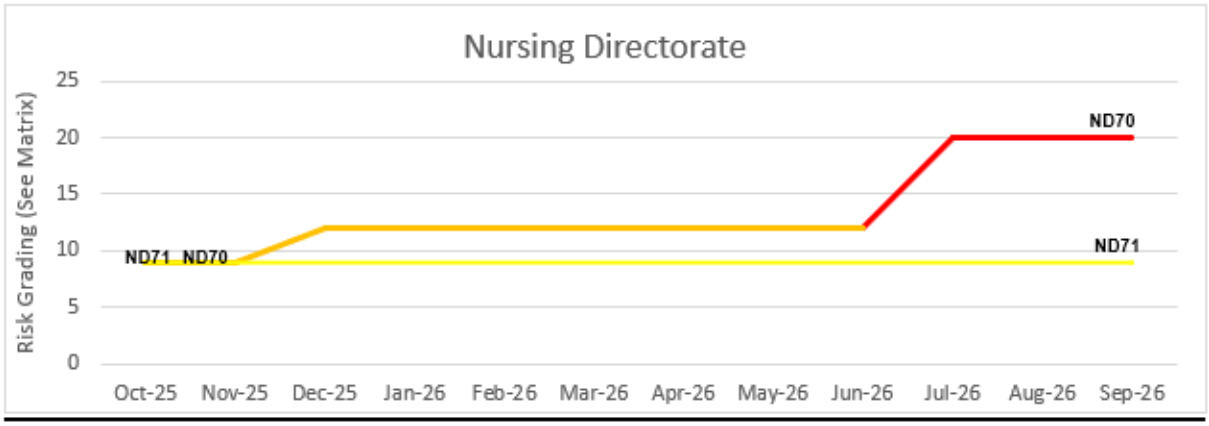


Risk key

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 - Failure to utilise our staffing resources to optimise excellent patient care and experience was reviewed by the risk owner and has been increase to 'Very High' and was approved at CMT in September 2026. An update is provided in section 3.5.1.

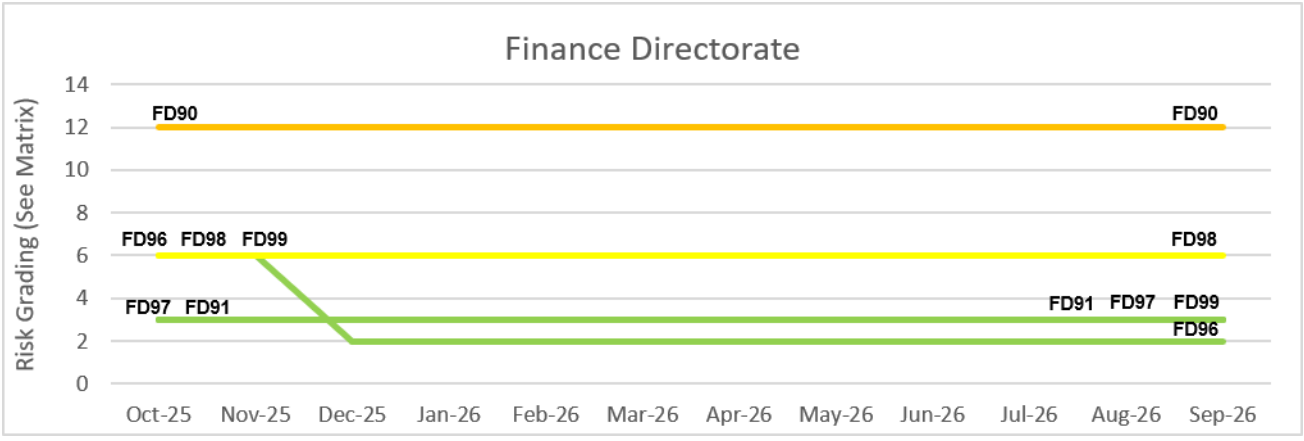


Risk key

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. An update on 'High' risk FD90 is in section 3.5.2.

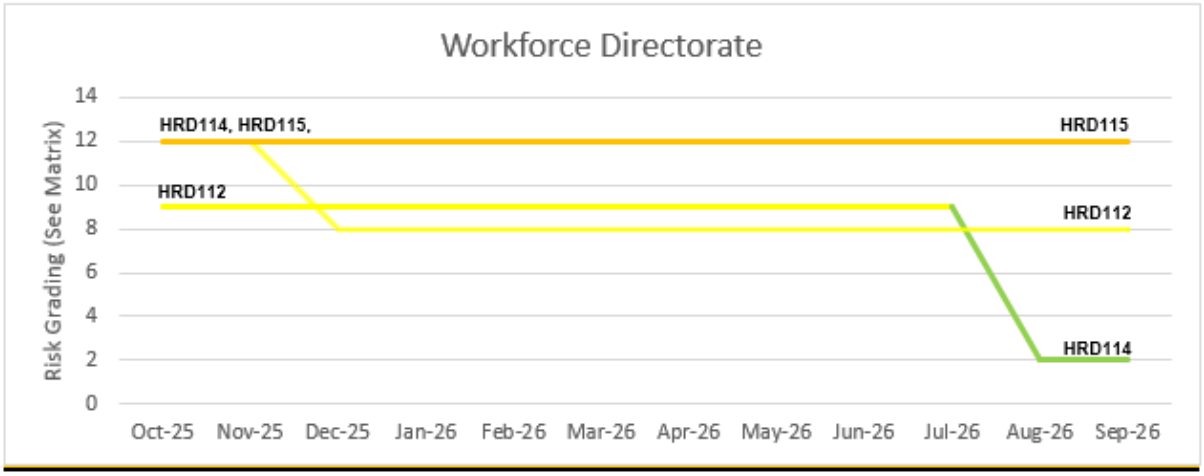


Risk key

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

HRD114 Reduction in hours decreased to Negligible x Unlikely (Low) now meeting the target grading. All areas within TSH have fully implemented the 36-hour working week, no significant concerns or issues have been raised since the implementation with the majority of backfill now in place. Risk will continue to be monitored and will be moved to Local Risk Register if risk remains at 'Low'.



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.

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. Further detail is provided in Agenda item 8 - Daytime Confinement: Interim Operating Model.

3.5.2 High

FD90 - Failure to implement a sustainable long-term model

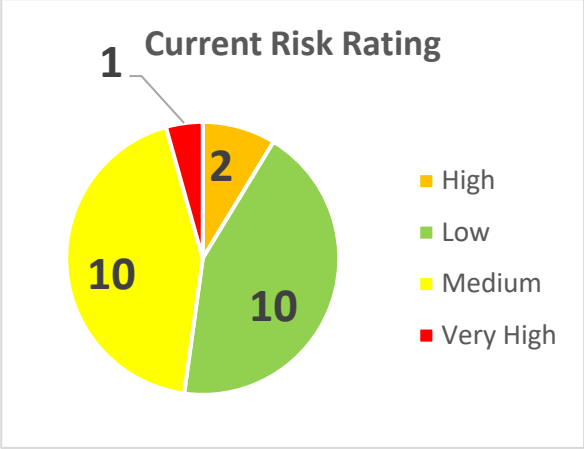
FD90 reflects ongoing national financial challenges and expected budget constraints from the Scottish Government for 2026/27. Quarterly meetings with the Scottish Government and monthly internal reviews are in place. Recurring funding for Women's service remains a risk, so

the overall risk level still remains ‘High’. Further detail is provided in Agenda item 9 – Finance Report.

HRD115 - Sickness Absence

HRD115 remains at ‘High’. Despite sustained improvement over the last 12 months (a 1% reduction), the has been recent increases in long-term absence and industrial injuries. Further detail is provided in Agenda Item 14 – Staff Governance Report.

3.6 Risk Distribution



Currently 14 Corporate Risks have achieved their target grading, with 10 currently not at target level (Up from 13 since the last report after HRD114 was reduced as detailed in section 3.3.7). 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:

- **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 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.

- **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. Following practical completion of the Security Systems Project, SD51 is currently under review.

- **ND71 Serious Injury or Death as a Result of Violence and Aggression** – Currently graded Moderate x Possible (Medium), reflecting the assessed impact and likelihood of staff harm from the latest violent incident data. An established review process is in place to learn from incidents that meet the criteria for serious injury or death and shared with relevant stakeholders.

- **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.

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, HRD114,		FD98,	MD34, SD51,	
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 Consequential Risk

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.

The increase risk rating of ND70 has a direct correlation with FD90 and HRD115. Failure to effectively utilise hospital resources will continue to result in reduced quality of patient experience, increased the risk of adverse events, complaints, and restrictive practices and highlights a single system pressure impacting on patient experience, service delivery, staff wellbeing, and organisational reputation. This position could be further exacerbated by pressures on resources throughout the forthcoming winter period. The current ‘geo political’ situation adds further pressures to the financial position relative to utilities and food costs.

3.8 Local Risk Register

There are no Local Risks requiring escalation to the Corporate Risk Register at this time.

3.9 CRR Development

The plans to utilise InPhase for Corporate and Local Risks has been delayed until October 2026 due to staffing pressures.

A review of the CRR paper for the Board has been undertaken to improve the risk oversight during Board meetings. It is proposed to include High level details within the CRR paper and more detailed discussions taking place within the correlating directorate paper.

This will allow the Board to assess risks during the course of the meeting and at the conclusion assess if the risk register is reflective of the discussions that have occurred. A consequential risk statement can then be noted once all the relevant risks have been considered.

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	Oct 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	Oct 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	Oct 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	Dec 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	Dec 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	Dec 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	Dec 26	Clinical Governance Committee	Clinical Governance Group	Not at Target
Corporate SD 50	Service/Business Disruption	Major or Extreme Security Incident or Breach	Extreme x Likely	Major x Unlikely	Major x Unlikely	Security Director	Security Director	Dec 26	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	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	Dec 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	Dec 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	Dec 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	Dec 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	Dec 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 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	Mar 27	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	Not 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	Mar 27	Audit and Risk Committee	Security, Risk and Resilience Oversight Group	At Target
Corporate FD 91	Service/Business Disruption	IT system failure	Moderate x Likely	Negligible x Possible	Negligible x Possible	Finance & Performanc e Director	Head of eHealth	Dec 26	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 96	Service/Business Disruption	Cyber Security	Moderate x Likely	Negligible x Unlikely	Negligible x Unlikely	Finance and Performanc e Director	Head of eHealth	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 Performanc e Director	Head of eHealth	Mar 27	Audit and Risk Committee	Finance, eHealth and Audit Group	At Target
Corporate FD 99	Reputation	Compliance with NIS Audit	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performanc e Director	Head of eHealth	Dec 26	Audit and Risk Committee	Finance, eHealth and Audit Group Audit and Risk Committee	At Target

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
Workforce HRD114	Workforce	Impact of reduced working week	Major X Possible	Negligible x Unlikely	Negligible x Unlikely	Director of Workforce	Head of HR	Dec 26	Staff Governance Committee	Workforce Governance Group	At Target

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2026
Agenda Reference No:	Item No: 8
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Director of Nursing and Operations Medical Director
Title of Report:	Daytime Confinement (DTC): Interim Operating Protocol Report
Purpose of Report:	For Noting

1 SITUATION

An Interim Operating Protocol 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 was 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 30 September 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.

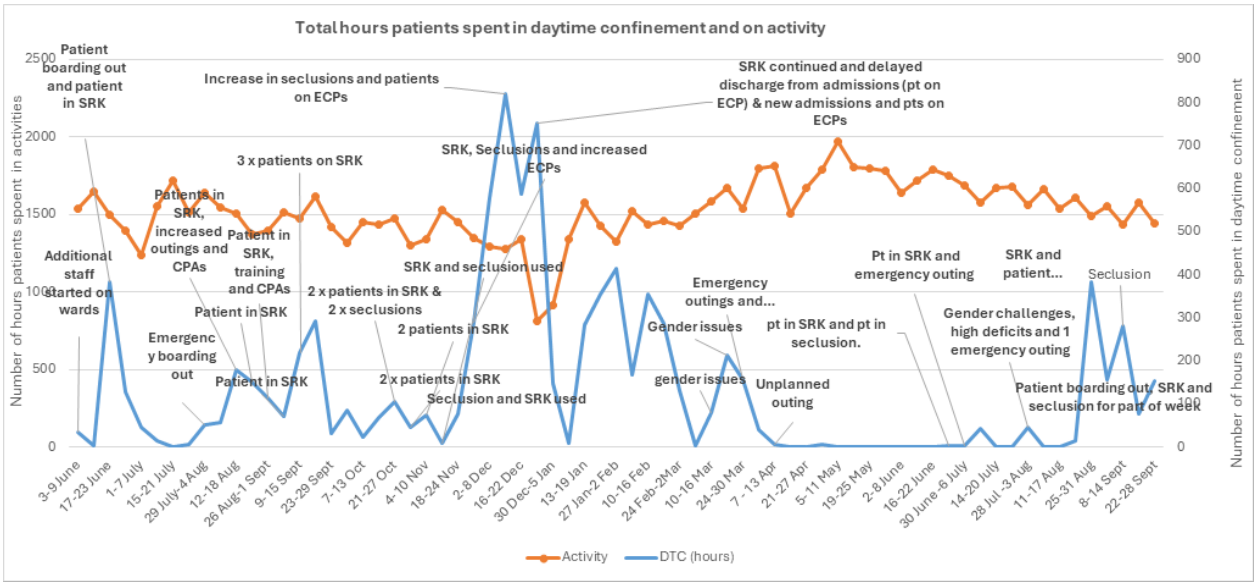
The protocol has been developed collaboratively with contributions from Nursing, Medical, Security & Estates Directorates, operational management and Staff Side representatives and has undergone a formal draft and consultation process prior to finalisation.

The Clinical Operations Group (COG) has been established to oversee the Interim Operating Protocol and monitor levels of DTC. This group replaces the DTC oversight Group and the Clinical Model Oversight Group (CMOG). It meets on a fortnightly basis with all heads of service and clinical leads in attendance and is co-chaired by the Director of Nursing and Operations and the Medical Director.

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 ASSESSMENT

Chart 1



3.1 Hospital wide run chart (Chart 1)

August - has seen an increase in DTC from 91.75 hours in July to 398.6 in August. There was a decrease in the number of activities being provided to patients with the lowest week having 1488.9 hours (week beginning 25 August) as opposed to the approx.1600 in July. There were two emergency outings in August which is the same number as July. The total time a patient experienced DTC ranged from 0.5 hours to 14.25 hours. There was one new episode of SRK being used within the T&R service (this patient has required SRK previously) and two seclusions (one in Admissions and Assessment and one in ID). It should be noted that in week four of the reporting period a patient was boarded out for four out of the seven days.

September - has seen an increase in DTC from 398.6 hours to 667.7 hours. There was a decrease in the number of activities being provided to our patients with the lowest week having 1433 hours (week beginning 8 September) as opposed to the approx. 600 in July. This could be linked to grounds access hours changing and the wet weather experienced during September. The holiday weekend had minimal negative impact on activity across the site. There were two emergency outings in September which is the same number as August.

3.2 Clinical Operations Group (COG) update

The fortnightly Clinical Operations Group has now been established and has met on three occasions during this reporting period. The meeting is co-chaired by the Director of Nursing & Operations and the Medical Director. There is a data set that has been collated by Clinical Quality provided to all attendees prior to the meeting. The Services are asked to speak to their own data detailing what evidence-based decisions are taken based on the available data sets, the challenges and opportunities and the plans for the forthcoming two week period. The data set provides the evidence in a clear format which identifies any issues or concerns and any variation in practice.

3.3 Interim Operating Protocol (IOP)

The Interim Operating Protocol is now in place and 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.

This also enables identification of key areas requiring improvement at service level looking at process and practice which contributes to operational challenges. It supports services to identify tests of change; examples of this include different approaches to improving activity at Ward/ Hub level, a focus on effective rostering, improved deployment practices and testing different roster patterns.

3.3.1 Gender Balance

The Board have previously been made aware of the impact of Gender Balance on resourcing. This is being looked at by COG. There is currently a risk assessment tool in use, which is not a validated tool and there is no comparative practice in the other three high secure services. Each service is monitoring the impact of trying to work with the agreed Gender balance, whilst there is further work looking at the evidence base for risk-based decision making and clarity regarding the occasions which specifically require the deployment of male staff. Once this is available then consideration of the best way forward will be discussed and agreed in partnership. The workforce governance group continues to look at various ways of encouraging male applicants given the known challenges regarding reduction of males entering the nursing profession.

The protocol will remain under continual review throughout implementation to ensure any emerging issues are identified and addressed promptly.

3.4 Recruitment

Recruitment to redress the variance from the establishment continues.

- 11 RNs are on induction from 19 October
- Four RNs are on induction from 16 November
- Seven HCSW will receive their PIN and be able to practice as RNs
- This is an overall increase of 22 Registrants
- Nine HCSW have been recruited, and start dates are being finalised this week.

3.5 Patient Impact

The Patient Partnership Group (PPG) has discussed the impact of DTC with patients on a weekly basis throughout the reporting period. Feedback has been consistent over several months, with patients reporting that extended periods of confinement continue to adversely affect their wellbeing, recovery, rehabilitation opportunities, and contact with family and friends

3.6 Key Themes Raised by Patients

Key themes include reduced access to family contact through telephone and video calls, restricted access to grounds which many patients identify as an important coping strategy, and disruption to therapeutic, rehabilitation and exercise activities that support recovery. Patients also reported difficulties accessing routine amenities resulting in a perceived reduction in dignity and quality of life.

Across all themes, patients have consistently requested earlier and clearer communication regarding DTC restrictions and greater assurance that issues raised through the Patient Participation Group are informing decision-making and service improvements.

3.7 Solutions and Mitigations Discussed

The following themes emerged repeatedly as potential mitigations:

- Improved access to hands-free telephones or alternative communication methods when ward telephones are inaccessible, during confinement to rooms.
- Prioritisation of family contact, telephone access and grounds access during periods of reduced service provision.
- Exploration of arrangements that maximise grounds access during staffing pressures.
- Greater staffing consistency and increased availability of ward-based staff familiar with individual patients and ward routines.
- Continued implementation and monitoring of the Interim Operating Plan to reduce DTC and minimise disruption to patients' day-to-day experiences.

Patient feedback and concerns raised through the PPG have been routinely communicated to Senior Nursing Staff and the Service Leadership Teams throughout the reporting period. To further strengthen engagement and provide direct assurance to patients, the PPG extended an invitation to the joint Chairs of the Clinical Oversight Group, the Director of Nursing and the Medical Director to attend a future PPG meeting. This invitation has been accepted and will provide an opportunity for patients to share their experiences and feedback directly with senior leaders, while also receiving updates and assurance regarding progress against the Interim Operating Plan and wider actions being taken to reduce DTC.

Feedback collected through the PPG demonstrates a clear and sustained patient narrative. While patients acknowledge the staffing challenges, they continue to report significant impacts arising from DTC. There is a strong expectation from patients that practical measures to mitigate these impacts will continue to be prioritised and that progress against actions is communicated openly and visibly

During Q2 (1 July to 30 September 2026), 36 complaints relating to nursing were received. The main themes concerned staffing pressures and the impact on patients, daytime confinement, meals being taken in bedrooms, and reduced access to activities, appointments, the shop and family contact. Other concerns related to communication, staff interactions, patient property, clinical and ward care, and food provision. Three complaints received during the quarter were withdrawn.

During this reporting period, 37 complaints were closed, including complaints carried forward from the previous quarter. Of these, 21 were upheld, two were partially upheld and 14 were not upheld.

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP /	Working towards a full understanding of DTC and its elimination.
Corporate Objectives Which Corporate Objective(s) does this paper support: Better Care Better Health Better Value Better Workforce	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. Which one of the following three option applies: There are no privacy implications. There are privacy implications, but a full DPIA is not required. There are privacy implications and a full DPIA is included.	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2026
Agenda Reference No:	Item No: 9
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Deputy Director of Finance
Title of Report:	Finance Report to 30 September 2026
Purpose of Report:	For Noting

1 SITUATION

This report provides an update on financial performance for Month 6 – September 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 £57,504k has been received from the Scottish Government including:

- Baseline Recurring - £54,187k.
- Earmarked Recurring (women's services + realistic medicine) - £3,140k.
- Non Recurring - £177k.

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

- Forensic Network Allocation: £335k.
- Capital depreciation uplift: £1,859k.

This results in a total annual revenue budget of £59,699k reflected in the annual position. In addition, £282k capital resources have been allocated.

At this stage, a number of non-recurring budget allocations remain outstanding, including additional Agenda for Change reform funding and further capital funding associated with works identified following the Arran 2 incident. These allocations will be incorporated into the budget once confirmation has been received.

3.2 Financial position 2026/27 – allocated by Board Function / Directorate

There is a £379k underspend year to date, primarily attributable to vacancies across the organisation, particularly within Nursing, Psychology, Allied Health Professionals (AHPs), Estates and Housekeeping.

Although vacancy levels remain significant, recent recruitment activity has led to an increase in substantive staffing levels. Recruitment continues to be a key priority, both to reduce reliance on overtime, supplementary staffing and additional hours, and to strengthen workforce resilience. Overall vacancy levels have reduced by 10 WTE since last month, with further onboarding expected over the coming months. Whilst vacancies continue to support the current financial position, associated staffing costs are being partially replaced through overtime, supplementary staffing and additional hours in order to maintain safe service delivery.

Vacancy levels have been partially offset using overtime, supplementary staffing and additional hours. 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, utility costs, computer storage updates and the implementation of Microsoft 365. The net impact of these movements is 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	4,727	2,373	2,375	(2)	0	
Central Reserves	2,138	0	(1)	1	0	0
Chief Exec	2,892	1,443	1,450	(6)	25	26
Finance	3,277	1,670	1,656	14	35	33
Human Resources Directorate	1,305	649	631	19	17	15
Medical	6,157	3,070	2,775	295	46	39
Nursing and AHPs	29,104	15,626	15,661	(35)	458	443
Security And Facilities	10,098	5,080	4,987	93	130	126
	59,699	**29,912**	**29,533**	**379**	**711**	**682**

3.2.2 Capital Charges – £2k overspend

Capital charges are £2k above budget year to date as a result of new assets being brought into operational use. Additional budget will be allocated to offset these costs. Any depreciation costs above the £2,868k baseline allocation will be funded by the Scottish Government and this assumption has been reflected in the current budget position.

3.2.3 Central Reserves – £1k underspend

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 – £6k overspend

The overspend within Chief Executive Directorate relates to an unfunded post within the corporate services team. However, the overall overspend is partially offset by the current underspend within Communications, which reduces the net financial pressure across the Directorate.

3.2.5 Finance – £14k underspend

An underspend of £60k on pay costs, arising from vacancies across the Directorate, has been offset by a number of cost pressures. These include the stock write-off associated with the transition to the new Genesis system, increased expenditure on legal counsel, higher bank charges, and the purchase and implementation of a new patient banking system.
In addition, the eHealth budget continues to face pressures from Microsoft 365 licensing costs, computer storage upgrades, and increased service contract expenditure. The financial pressures within eHealth are currently being managed through the appropriate use of non-recurring reserves.

3.2.6 Human Resources – £19k underspend

Vacancies continue to exist within Occupational Health, Human Resources, and Learning and Development, contributing to an underspend in pay costs. Following a review of the corporate training budget, additional expenditure has been incurred during the month, reducing the year-to-date underspend position.

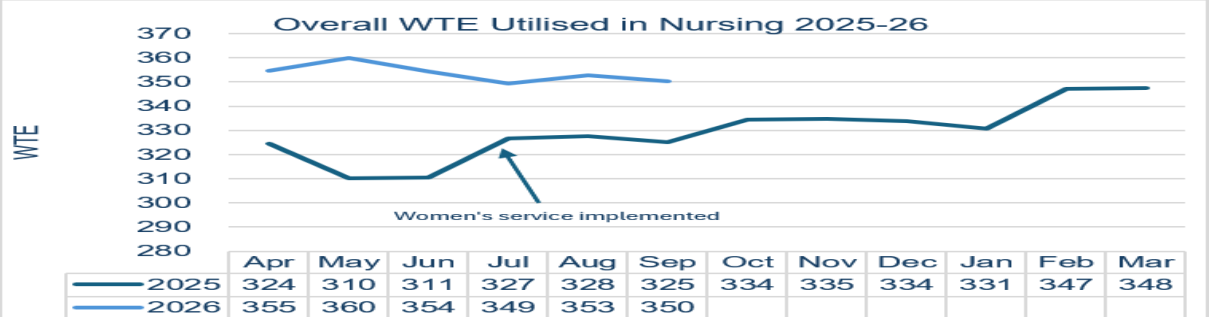
3.2.7 Medical – £295k underspend

Clinical Psychology continues to report a significant underspend of £205k, primarily as a result of ongoing vacancies. A further underspend of £73k is being reported within Medical Services, which is attributable to vacant posts and an income benefit.
Recruitment activity is currently underway to fill vacancies within Psychology, with consideration being given to skill mix to maximise recruitment opportunities.
Drug expenditure had increased in earlier months this year and was creating a financial pressure but has reduced in recent months with a breakeven position now being reported.

3.2.8 Nursing and AHP – £5k overspend

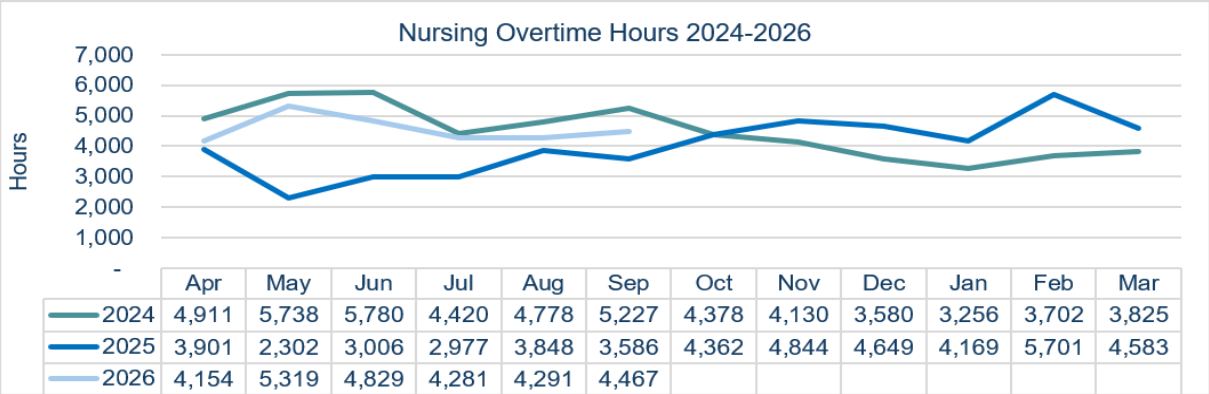
Non recurring funding of £3.1 million has been allocated to support delivery of the women's service. Year-to-date expenditure currently stands at £2.2 million and based on current spending levels, the estimated annual cost of the service remains approximately £4.5 million. At the current rate of expenditure, the allocated funding is expected to be fully utilised by the end of Month 8 (November). Based on current expenditure trends, a funding shortfall of approximately £1.4m is anticipated should the Board funding levels remain unchanged.

While reliance on overtime is reducing, recent recruitment and increased hours being covered by supplementary staffing has increased the overall workforce capacity. When substantive staffing, overtime, additional hours and supplementary staffing are considered collectively, the total nursing workforce available to the organisation has increased.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2025	324	310	311	327	328	325	334	335	334	331	347	348
2026	355	360	354	349	353	350						

Year-to-date expenditure on nursing overtime totals £1,499k, with a further £718k incurred through the supplementary staffing register.



	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	4,291	4,467						

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

3.2.9 Security - £93k underspend

The underspend within Security is primarily driven by staffing vacancies across a number of areas, including Estates (£84k), Housekeeping (£63k), Risk (£51k) and Security (£106k). These pay savings are partially offset by cost pressures arising from the Enhanced Security Project (£105k) and additional repair works (£51k) required following the recent incident.

A proportion of the staffing costs associated with the Enhanced Security Project will be recharged to Securitas from August onwards, which will help to mitigate the ongoing revenue impact.

Utility costs are also expected to increase during the winter months as consumption rises, with budgets continuing to experience underlying pressure from inflationary increases incurred in previous years.

3.3 Assessment – Savings

The recurring savings target for 2026/27 is 3% of baseline funding, equating to £1,620k. Whilst the year-to-date savings target has been achieved, continued delivery of recurring savings remains essential to ensure achievement of the full-year target of £1.62m

Directorate	Annual Target £k	YTD Target £k	Savings Achieved £k	Surplus/ (Shortfall) £k
Chief Exec	44	22	17	(5)
Finance	48	24	24	0
Human Resources Directorate	38	19	20	1
Medical	127	64	68	4
Nursing And Ahp's	799	399	397	(2)
Security And Facilities	564	281	283	2
	1,620	**809**	**809**	**0**

3.4 Capital Resource Limit

3.4.1 Annual allocation - utilisation

The annual capital resource has been allocated at £282k. Capital expenditure bids have been reviewed, with the following projects identified as current priorities now to be taken forward:

Project	**£**
Refurbishment of main turnstiles	20k
Upgrade to Plexus water monitoring system	24k
Harris water risk assessment remedial work	25k
IT equipment – laptop replacement	20k
Occupational Health building cladding work	8k
Lighting upgrades	15k
Fire exit door upgrades	100k
Total	**212k**

The remaining £70k of in-year capital funding will be addressed through a review of the current capital programme, with a particular focus on Estates-led projects. These bids will be prioritised as part of the ongoing capital planning process during Q3, with funding allocations and delivery timescales agreed accordingly.

The Scottish Government has confirmed that additional capital funding will be provided to fully support the window restrictor replacement programme required following an incident in April. This funding is expected to total approximately £160k. A contractor has been appointed, the order has been placed, and work is anticipated to commence in October/November.

In addition, funding is also expected to be provided for £8k of essential door replacement works, which arose from the same incident and will be treated on a similar basis.

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 underspend of £379k.
- That the forecast outturn remains breakeven, subject to continued management of financial risks and receipt of anticipated funding.
- The continued financial pressures arising from nursing overtime, utility costs, the Enhanced Security Project, and revenue costs associated with the Arran 2 incident.
- The reduction in vacancy levels following recent recruitment activity, with further workforce improvements anticipated as new staff are onboarded.
- The ongoing requirement to monitor expenditure associated with the Women's Service and ensure funding continues to align with actual service delivery costs.
- That the recurring savings programme remains on track, with year-to-date savings achieved in line with target.

4.2 Capital

- The current capital resource limit of £282k.
- The prioritisation of capital projects through the Capital Planning Group.
- The planned review of the remaining £70k capital resource during Q3 to identify and prioritise additional projects.
- Confirmation from the Scottish Government that additional capital funding will be provided to support the Arran 2 window restrictor replacement programme and associated door replacement works.
- The continued progression of capital projects to ensure available resources are utilised effectively and aligned with organisational priorities.

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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 Finance, eHealth and Audit Group Partnership Forum
Risk Assessment (Outline any significant risks and associated mitigation)	None Identified.
Assessment of Impact on Stakeholder Experience	None Identified.
Equality Impact Assessment	No implications.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	None Identified.
Data Protection Impact Assessment (DPIA) See IG 16. Which one of the following three options applies: There are no privacy implications. There are privacy implications, but a full DPIA is not required. There are privacy implications and a full DPIA is included.	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2026
Agenda Reference No:	Item No: 10
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

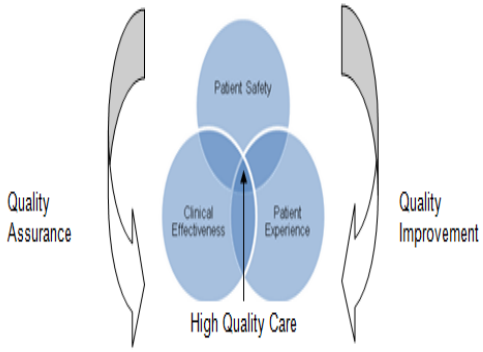
2 BACKGROUND

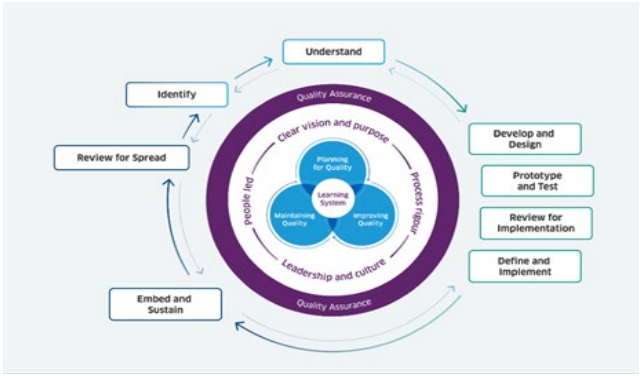
Quality assurance and improvement at the State Hospital align with the Clinical Quality Strategy 2024–2029, approved by the Board in August 2024. This strategy outlines the direction and goals for enhancing clinical care, aiming to improve patient experiences through person-centred, safe, high-quality 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 patient 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 NHS Scotland.
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.

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 improvement plans are discussed at the commissioning group.

Within this reporting period, there have been four local audits supported by the Clinical Quality Department and actioned through the Commissioning Groups. The Lithium Monitoring audit with excellent adherence and the High Dose Antipsychotic Monitoring, Medicine Trolley and Medicine Fridge audits all with moderate assurance. The Medicines Committee have agreed improvement plans for these audits.

A number of other audits have been completed but have not been tabled at their commissioning group for approval as yet.

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	Commissioning Group
Medication Trolley Audit												Medicines Committee
Medicine Fridge Audit												Medicines Committee
HEPMA Audit									n/a			Medicines Committee
PMVA Post Physical audit			n/a				n/a	n/a				Patient Safety
Unvalidated progress notes												Information Governance Group
Nurse progress note on each shift												Information Governance Group
Controlled Drugs Audit (pharmacy)	-		-	-								Medicines Committee
RMO contact with patients												Information Governance Group
Observations of Care												Physical Health Steering Group
PMVA Seclusion Audit						n/a	n/a	n/a	n/a			Patient Safety
Oxygen cyclinder checklist												Medicines Committee
Epilepsy Audit		n/a	n/a	n/a	n/a	n/a		n/a	n/a			Physical Health Steering Group
Clinical Care Policy Audit							n/a	n/a	n/a			Patient Safety
PRN Audit						n/a	n/a		n/a			Medicines Committee
Nutritional Screening Tool Audit												Physical Health Steering Group
Mechanical Restraint Audit				n/a		n/a	n/a	n/a		n/a		Patient Safety
Diabetes Audit		n/a					n/a		n/a	n/a		Physical Health Steering Group
Clozapine Audit	n/a	n/a							n/a			Medicines Committee
Consent To Treatment												Medicines Committee
Lithium Audit	n/a		n/a			n/a	n/a	n/a	n/a			Medicines Committee
High Dose Anti Psychotic					n/a		n/a		n/a			Medicines Committee

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 August 2026 and will be included in Clinical Quality annual reports going forward.

1.2 CPA oversight monitoring report

The September 2026 CPA flash report showed that the majority of interventions continued to demonstrate random variation throughout the reporting period, although some areas showing improvement were noted:

- RMO, Psychology, Security and Social Work met or exceeded their KPI attendance target.
- Provision of OT reports increased from 55% in August to 67% in September.
- Improvement in all Pharmacy interventions however attendance at 56% was still below the 60% KPI attendance target.

There were also some areas for improvement that were noted:

- A downward shift was observed in the median compliance rate for the intervention “Medical staff discuss their report with the patient prior to the CPA”, falling from 69% to 57%.
- Nursing – The proportion of patients who had their report discussed with them prior to their CPA decreased from 73% to 56%, while nursing report provision reduced from 91% to 72%. Senior Charge Nurses are asked to review the Nursing CPA Oversight Monitoring Report available within RiO to determine whether these reductions are attributable to non-compliance with the CPA process.
- Key Worker attendance also declined from 32% to 17%. However, overall nursing attendance remained high at 94%. This matter will be further monitored and addressed through the quarterly KPI reporting process.
- Psychology - The proportion of patients who had their report discussed with them prior to CPA decreased from 86% to 71%, and report provision decreased from 86% to 63%. Again, the Psychology CPA Oversight Monitoring Report available on RiO should be reviewed for context around this reduction.
- Social Work – provision of the Social Work Report decreased from 77% to 61%. Further investigation required.
- Dietetic interventions across all areas remained low during the reporting period. This was anticipated following the departure of a member of the Dietetics team from The State Hospital, which temporarily reduced service capacity.

Following the transition to hub-specific teams within Arran and Lewis, work will commence to reconfigure the Tableau dashboard to reflect the revised service structure. The updated dashboard is expected to be available in the near future for all Heads of Clinical Services.

2. QUALITY IMPROVEMENT

2.1 QI Forum

The QI Forum continues to play a key 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 Current Portfolio

Twelve active QI projects are underway, these include:

- Three ScIL projects from the current cohort.
- Four Realistic Medicine projects focusing on reducing unwarranted variation across TSH processes.

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

2.2 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 and raising awareness local through training and Project Management Resource Hub.

Healthcare Improvement Scotland have agreed to raise awareness of the Scottish Approach to Change through presenting at TSH's Seminar Series in the Autumn.

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, with participants commencing their quality improvement projects. TSH has been successful in securing one participant on Cohort 56 commencing in November 2026.

2.3.2 – Scottish Quality and Safety Fellowship (SQSF) Programme

Two members of staff were successful in applying to undertake the Scottish Quality and Safety Fellowship which commences this month.

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 commenced in September 2026 with six staff in attendance. The course is delivered over four half day sessions between September 2026 and January 2027 with participants building a portfolio over this time and delivering a local project.

2.4 Realistic Medicine

The Realistic Medicine Team continues to progress delivery of the approved 2026/27 action plan. A six Month update report was submitted and approved by Clinical Governance Group on 1 October and will be submitted to the Scottish Government on the 9 October 2026.

Work continues on a project focusing on the patient referral process, using DUNDRUM-1 and DUNDRUM-2 assessments 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 continues 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.

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 August to 30 September 2026, 36 guidance documents have been reviewed: 18 documents were considered either not relevant or were overridden by Scottish guidance and nine were shared for information. Of the nine remaining documents, four from the MWC require discussion within the relevant review group regarding any further action and five are required to follow the gap analysis process. Of these five, three have had a gap analysis completed, one gap analysis is pending, and one guidance document had only minimal recommendations relevant to the State Hospital therefore the review group agreed that a full gap analysis was not required.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix /action required
MWC	8	4	(4 pending)
HIS	3	3	0
National Institute for Health & Care Excellence (NICE)	25	2	5

There is currently one additional gap analysis pending completion. Meetings are set up monthly with the Clinical Quality Facilitator and Practice Nurse to review any physical health guidelines outstanding. Due to prioritisation of clinical workload, the NICE guideline for Menopause was only recently reviewed and deemed relevant to the State Hospital. A gap analysis has been created and will be reviewed by a multi-disciplinary team.

Table 3: Evaluation Matrix Summary

Body	Title	Steering Group	Current Situation	Publication Date	Projected Completion Date
NICE	Menopause: Identification and management	PHSG	With Practice Nurse and GP to review for relevancy to the State Hospital setting. Decision made late September that a full gap analysis would be required. Gap analysis created and will be circulated to MDT for review process to commence.	April 2026	December 2026

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2026
Agenda Reference No:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	PA to Medical Director & Associate Medical Director
Title of Report:	Medical Appraisal and Revalidation – 1 April 2025 to 31 March 2026
Purpose of Report:	For Noting

1 SITUATION

It is a requirement of NHS Education for Scotland that an annual report on Medical Appraisal and Revalidation is placed before the Board.

2 BACKGROUND

Revalidation is the process by which doctors demonstrate to the General Medical Council (GMC) that they are up to date and fit to practise and comply with the relevant professional standards. The information doctors provide for revalidation is drawn by doctors from their actual practice, from feedback from patients and colleagues, and from participation in continued professional development (CPD). This information feeds into doctors' annual appraisals. The outputs of appraisal lead to a single recommendation to the GMC from the Responsible Officer in their healthcare organisation, normally every five years, about the doctor's suitability for revalidation.

Within the State Hospital, an agreed data set for annual appraisals is collated centrally by the Appraisal and Revalidation Administrator (this is the PA to the Medical & Associate Medical Director). This includes Clinical Effectiveness Data, Pharmacy Audits, CPA / Restricted Patient and Medical Record Keeping Audits.

3 ASSESSMENT

The Revalidation and Appraisal Committee meet twice yearly, in May and November.

3.1 Revalidation Policy

The Revalidation and Appraisal Policy was approved by the Senior Management Team on 3 August 2016 and is available on the Intranet under HR Connect. The Policy was reviewed at the Revalidation and Appraisal meeting on 7 November 2023.

3.2 Responsible Officer

Professor Thomson has undertaken Responsible Officer training and attends Responsible Officer Network meetings.

3.3 Revalidation System

Revalidation system has been used for 12 Consultants and two specialty doctors in 2025-26. This includes one doctor on secondment to Scottish Government. One Consultant is appraised and revalidated through the Chief Medical Officer system. In 2025, we added the GP who provides a service to patients at the State Hospital to our list as his responsible officer will be Professor Thomson, however, the GP will be appraised by NHS Lanarkshire.

3.4 Appraisals

From 1 April 2025 to 31 March 2026, of the 15 medical staff within the State Hospital revalidation system, all were appraised during this period.

3.5 Revalidation

All revalidations are up to date.

3.6 Multi-source feedback

Multi-source feedback using the SOAR system is now being submitted by medical staff at appraisal meetings. This is required once per five year cycle.

3.7 CARE Questionnaire

The CARE questionnaire was issued to patients in September 2026 for all Consultants and the Consultant Psychotherapist. Questionnaires for Specialty Doctors will be issued in early 2027.

3.8 SOAR Appointment System

SOAR appointment system was introduced to avoid delays in annual appraisals. A doctor will be invited to an appraisal appointment at mutually agreed times on three occasions. Standard letter to doctors who are not engaging in the process in terms of attending an appointment or submitting paperwork has been prepared. This has never been used to date.

3.9 Case based discussions are included in the appraisal process

There is a monthly allocated slot open to Trainees, Specialty Doctors or Consultants where cases can be discussed by the medical staff group.

3.10 Medical Appraisal Revalidation Quality Assurance Review 2025-26 (MARQA)

We submitted the Medical Appraisal and Revalidation data return to NES on 26 May 2026. We are awaiting feedback on our submission. They will present their findings to the Revalidation Advisory Board Scotland (national stakeholders group) in due course and will publish the finalised report shortly thereafter on their website.

4 RECOMMENDATION

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

Consultants

Last Date for Recommending Revalidation	Date of Revalidation	Appraisal 01/04/20-31/03/21	Appraisal 01/04/21-31/03/22	Appraisal 01/04/22 – 31/03/23	Appraisal 01/04/23 – 31/03/24	Appraisal 01/04/24 – 31/03/25	Appraisal 01/04/25 – 31/03/26	Appraisal 01/04/26 – 31/03/27	AMP Training Forensic	AMP Training Core & Capacity	Last date to register for refresher training	Refresher training	Planned training
15/10/2026	16/10/2021	01/10/2020	26/10/2021	31/10/22	30/11/23	12/12/24	24/11/25	03/11/26	31/08/22	21/06/18	Jan 2028	17/01/23	-
31/08/31	29/07/26	31/08/2020	01/06/2021	25/10/22	03/10/23	10/12/24	20/01/26	21/01/27	01/02/19	29/05/21	Jan 29	**25/01/24**	-
09/02/30	12/02/2025	01/06/2021	16/03/2022	17/01/23	29/01/24	23/01/25	01/02/26	26/01/27	25/11/19	21/06/18	March 28	30/03/23	-
31/07/31	11/05/26	30/03/2021	26/01/2022	24/02/23	On mat leave	20/03/25	07/11/25	04/02/27	01/02/19	31/10/19	Aug 2029	**07/08/24**	-
26/12/2027	02/05/2022	27/11/2020	04/10/2021	28/11/22	16/11/23	6/11/24	24/11/25	15/12/26	20/09/21	29/05/21	**Aug 26**	**24/04/26**	-
27/03/2029	11/10/2023	02/02/2021	08/03/2022	06/02.23	07/03/24	13/02/25	26/02/26	04/03/27	01/02/19	29/05/21	Jan 28	**17/11/23**	-
20/12/2026	24/05/2021	23/11/2020	25/10/2021	29/09/22	12/10/23	21/11/24	12/02/26	26/01/27	01/02/19	29/05/21	Jan 28	17/11/23	-
27/07/31	28/07/26	16/02/21	11/02/22	30/01/23	25/01/24	28/01/25	23/01/26	19/01/27	01/03/23	29/05/21	April 29	01/03/24	-
19/03/2030	14/10/24	05/10/2020	12/11/2021	10/02/23	05/02/24	17/02/25	09/01/26	22/01/27	05/01/23	09/12/19	Jan 28	05/01/23	-
17/08/28	-	-	-	-	*	01/10/24	28/10/25	20/10/26	22/07/20	-	July 30	15/07/25	-
08/01/28	-	-	-	-	23/06/23 (Tayside)	12/12/24	07/11/25	19/11/26	30/10/18	-	Nov 28	17/11/23	-
15/10/30	-	-	-	-	-	-	10/02/26	11/02/27	17/01/24	-	Jan 29	-	-

** finished on training scheme and took up post as consultant*

Specialty Doctors

Last Date for Recommending Revalidation	Date of Revalidation	Appraisal 01/04/20-31/03/21	Appraisal 01/04/21-31/03/22	Appraisal 01/04/22 – 31/03/23	Appraisal 01/04/23 – 31/03/24	Appraisal 01/04/24 – 31/03/25	Appraisal 01/04/25 – 31/03/26	Appraisal 01/04/26 – 31/03/27	AMP Training Forensic	AMP Training Core & Capacity	Last date to register for refresher training	Refresher training	Planned training
01/02/32	11/05/26	-	05/10/2021 19/10/2021	18/10/22	24/10/23	12/11/24	11/11/25	10/11/26	6-8/7/21	-	**Feb 31**	**26/02/26**	-
04/08/2029	-	-	-	-	-	19/03/25	26/02/26	-	01/08/24	-	July 29	-	-
05/10/2029	-	-	-	-	-	-	-	17/11/27	08/10/25 Initial training	-	Sept 30	-	-
03/08/2026	-	-	-	-	-	-	-	07/01/27	-	-	-	-	-
27/11/29	-	-	-	-	-	-	-	11/02/27	-	-	-	-	-

Appraised by Other Organisations

Last Date for Recommending Revalidation	Date of Revalidation	Appraisal 01/04/20-31/03/21	Appraisal 01/04/21-31/03/22	Appraisal 01/04/22 – 31/03/23	Appraisal 01/04/23 – 31/03/24	Appraisal 01/04/24 – 31/03/25	Appraisal 01/04/25 – 31/03/26	Appraisal 01/04/26 – 31/03/27	AMP Training Forensic	AMP Training Core & Capacity	Last date to register for refresher training	Refresher training	Planned training
13/12/2028	20/02/25	15/10/2020	12/10/2021	23/11/22	15/11/23	31/03/25	18/02/26	-	-	29/05/21	**Oct 30**	13/10/25 Multi-specialty	-
18/11/2028	29/09/23	20/07/2021	10/03/2022	15/03/23	15/03/24	13/03/25	05/02/26	04/02/27 I	01/02/19	29/05/21	Nov 2028	17/11/23	-

Primary Care

Last Date for Recommending Revalidation	Date of Revalidation	Appraisal 01/04/20-31/03/21	Appraisal 01/04/21-31/03/22	Appraisal 01/04/22 – 31/03/23	Appraisal 01/04/23 – 31/03/24	Appraisal 01/04/24 – 31/03/25	Appraisal 01/04/25 – 31/03/26	Appraisal 01/04/26 – 31/03/27	AMP Training Forensic	AMP Training Core & Capacity	Last date to register for refresher training	Refresher training	Planned training
10/07/27	July 2022	25/03/2021	08/03/2022	16/03/23	20/03/24	01/04/2025	01/04/2026	-	Not required to undertake AMP training but requires to be fully up to date with relevant GP training within NHS	-	-	-	-

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	N/A
Corporate Objectives Which Corporate Objective(s) does this paper support: Better Care Better Health Better Value Better Workforce	Review and action absence related issues and prioritise support mechanisms and staff wellbeing to provide staff and line managers with the support required; and where absence is required, support staff to return to work at the earliest opportunity. Strengthen leadership and develop positive culture. Continue to support training and development for all staff at every level across the organisation.
Workforce Implications	Revalidation and appraisal are requirements to work as a doctor and essential to ensuring our continued medical workforce.
Financial Implications	NIL
Route to Board Which groups were involved in contributing to the paper and recommendations.	HIS requirement. Report will be shared with MAC.
Risk Assessment Outline any significant risks and associated mitigation.	No significant risks identified
Assessment of Impact on Stakeholder Experience	Captures feedback on stakeholder experience and provides opportunity to improve this
Equality Impact Assessment	EQIA Screened – no identified implications
Fairer Scotland Duty The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do.	N/A
Data Protection Impact Assessment (DPIA) See IG 16. Which one of the following three options applies: There are no privacy implications. There are privacy implications, but a full DPIA is not required. There are privacy implications and a full DPIA is included.	For example: There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2026
Agenda Reference No:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Consultant Forensic Psychiatrist / Medical Educational Supervisor Consultant Forensic Psychiatrist
Title of Report:	Medical Education Report
Purpose of Report:	For Noting

1 SITUATION

The General Medical Council (GMC) Quality Improvement Framework for Undergraduate and Postgraduate Medical Education in the UK outlines expectations for the governance of medical education and training. GMC standards specifically highlight the importance of Board-level oversight in ensuring quality and accountability.

This report is presented to the Board within that context and covers the period from 1 August 2025 to 31 July 2026.

2 BACKGROUND

Dr Prathima Apurva serves as Director of Medical Education and Educational Supervisor at The State Hospital, with responsibility for postgraduate medical education governance, supervision arrangements, training quality assurance and the resolution of training-related governance issues. Undergraduate medical education is led by Dr Natasha Billcliff and Dr Stuart Semple.

Dr Apurva reports internally to Professor Lindsay Thomson, Medical Director at TSH, and externally to Dr Michelle McGlen, Training Programme Director for Forensic Psychiatry Higher Training in Scotland, as well as to local Training Programme Directors for Core Psychiatry Training.

3 ASSESSMENT

3.1 Undergraduate training

The State Hospital continued to support undergraduate psychiatry education through supervised visits and placement opportunities. In February 2026, several fifth-year University of Edinburgh medical students were scheduled to attend, with numbers managed to preserve the quality and safety of the learning experience. Demand for visits remained strong, although the practical constraints of a high-secure setting and limited transport links require careful coordination. Further quantitative information on student numbers, teaching activity and feedback will be added once confirmed by the undergraduate leads. (I have completed this based on my involvement with medical students).

Student numbers in the last academic year were:

University	Student placement days	Students total
Edinburgh University	111	66
Glasgow University	27	4
Dundee University	4	2
All Universities	**142**	**72**

These figures represent a 14% increase in student placement days and a 3% increase in student numbers compared to the previous academic year, which saw 125 student placement days with 70 students total.

3.1.1 Student Feedback

Feedback was collected from 44 medical students during the 2025/26 academic year, a modest increase on the previous year (38 students). Students rated the placement very highly, with an average usefulness score of 4.6/5 and an average enjoyment score of 4.7/5. The majority of respondents awarded the placement 5/5 for both usefulness and enjoyment.

Across all collected feedback, medical students consistently reported that their placements at The State Hospital were highly valuable, enjoyable and educational. They particularly valued the opportunity to gain insight into forensic psychiatry within a high secure setting, observe the management of complex mental disorders, and understand the interface between mental health services and the criminal justice system. Students frequently praised the enthusiasm, friendliness and teaching provided by consultants, specialty doctors and other members of the multidisciplinary team. Tours of the hospital, including ward areas and the Skye Centre, were commonly highlighted as particularly informative. Direct contact with patients, attendance at ward rounds and multidisciplinary meetings, and opportunities to discuss cases with experienced clinicians were repeatedly identified as important learning experiences. Several students commented that the placement increased their interest in forensic psychiatry as a potential career.

Suggestions for improvement were generally minor and practical. The most common theme was a desire for greater opportunities for direct patient contact. Several students noted that placements taking place on Mondays involved a larger number of meetings and fewer opportunities for clinical interaction. Other suggestions included providing clearer pre-placement information regarding travel, arrival arrangements and what to expect during the visit, improving communication regarding meeting points, and providing access to learning materials during quieter periods. A small number of students suggested that shadowing other professional groups or spending additional time in rehabilitation and activity areas would further enhance the placement experience.

Overall, feedback indicates that The State Hospital continues to provide a highly valued undergraduate learning experience, with students describing the placement as unique, welcoming, informative and one of the most interesting aspects of their psychiatry training.

3.1.2 Medical ACT

No Medical ACT bids were submitted during 2025/26. Despite an increase in undergraduate teaching activity, The State Hospital's Medical ACT allocation reduced from £47,253 in 2025/26 to £45,305 in 2026/27, a reduction of £1,948 (4.1%).

Discussions with the Medical ACT team confirmed that the reduction was not due to any error in the activity data submitted by The State Hospital. Although the number of student placements and placement days increased during the year, funding is allocated according to each Board's proportional share of national undergraduate teaching activity. With a substantial increase in medical student numbers at Scottish universities, other Boards increased their activity by a greater proportion, resulting in a reduction in The State Hospital's share of the overall funding allocation.

The reduction also reflects wider pressures on the national Medical ACT budget following the addition of a new medical school at St Andrews without a corresponding increase in overall ACT funding.

3.2 Postgraduate training

3.2.1 Core Training

Core trainee placements continued during 2025–26, drawing doctors from both the West and East of Scotland rotations. From August 2025 to February 2026, the hospital had three Core Trainees, providing the full trainee complement required for the on-call rota. From February to August 2026, this reduced to two Core Trainees. Planning is in place to restore the full complement in February 2027. The State Hospital remains a geographically challenging placement to fill because many trainees can access forensic experience closer to home and placement at TSH removes them from their host service on-call rota. Individual timetables can also be affected by psychotherapy commitments. These issues are managed through early liaison with educational supervisors, review of each trainee's learning opportunities and escalation where attendance patterns may limit curriculum coverage.

3.2.2 Induction Programme

A comprehensive multi-day induction programme continues on a six-monthly basis and is coordinated across clinical, security, workforce, e-health and training teams. Training Committee feedback described the programme as comprehensive, more thorough than induction in other placements, and proportionate to the high-secure environment. Improvements identified during the year included introducing doctors who join outwith normal rotation dates at clinical team meetings; adding information governance and health-records input; covering seclusion reviews, serious reportable incidents and physical health complications; scheduling the site tour earlier; and resolving delays in access to RiO, Vision and Docman. Security induction covers keys, radios, personal attack alarms, hospital procedures and practical familiarisation. CPR, breakaway and HCR-20 training remain part of the core offer, with attendance and completion followed up.

3.2.3 First on-call Rota

From August 2025 to February 2026, three Core Trainees and the non-training grade medical workforce provided the full complement required for the on-call rota. From February to August 2026, the number of Core Trainees reduced to two, creating a temporary gap in the trainee contribution to the rota. The hospital currently has four Specialty Doctors, strengthening the non-training grade workforce, and the Core Trainee complement is expected to return to three in February 2027. The Training Committee monitored rota accuracy and escalation arrangements; a discrepancy between the intranet rota and the version circulated to doctors was identified and responsibility for coordination was clarified. No rota concerns were recorded in the August meeting, and rota compliance and workload continue to be monitored.

3.2.4 Higher Training

Higher training remained well supported by experienced Consultant Trainers. During 2026, local programme housekeeping included confirming approved higher trainers and posts, reviewing Recognised Trainer status, and ensuring trainers had considered the Royal College resources on changes to formative assessment and the forthcoming FourteenFish ePortfolio. Preparatory work also began to offer HCR-20 training to new ST4 trainees following the February 2027 national induction.

Specialty Trainees dedicate part of their weekly schedule to research and special interest activities, and as a result, they generally spend less time at the State Hospital compared to Core Trainees and non-training grade Specialty Doctors. Their role is distinct and represents a progression from Core Training. It is important to maintain a clear distinction between their responsibilities and those of other non-Consultant grade doctors, as they continue to develop towards readiness for Consultant-level practice.

The national forensic psychiatry programme maintained an overall satisfaction ranking of fifth in the UK in the 2026 GMC National Training Survey. Local and regional intelligence indicated a positive and stable training environment at The State Hospital, with no forensic psychiatry department appearing on trainee or trainer priority lists. Survey findings included positive indicators relating to professional development, resources to train, induction, wellbeing support and facilities. The service also offers distinctive curriculum experience in high-secure forensic psychiatry, complex risk assessment and management, forensic Mental Health Act work and the care of patients with severe and enduring mental illness in secure settings. Small cohort sizes limit interpretation of some survey indicators; workload will therefore continue to be monitored through supervision, trainee feedback and educational governance.

3.2.5 Teaching Programme

A structured series of seven lectures is delivered by Consultant Psychiatrists to Trainee Doctors during the initial three months of their placement at the State Hospital. The programme covers core topics in Forensic Psychiatry, providing a foundational understanding of the field and its practical applications.

To support continuous improvement, trainees are asked to complete feedback forms before leaving each lecture, with completed forms retained for review and used to improve future content. The Training Committee also reviewed scheduling conflicts between local lectures and external teaching and agreed that the introductory Mental Health Act teaching should be delivered early, as a foundation for the remainder of the programme. Evaluations continue to consider engagement, alignment with expectations, usefulness of the knowledge and skills taught, relevance of presentation materials and overall quality.

Local Training Committee minutes during 2025–26 recorded no concerns regarding clinical supervision, workplace-based assessments, levels of responsibility or the overall workload and training experience. Trainees considered responsibilities appropriate and learning opportunities well balanced. The committee reinforced that supervision should match the doctor’s level and encouraged trainees to make full use of workplace-based assessment opportunities.

Educational governance continued to provide a regular route for identifying and addressing practical issues affecting training.

3.2.6 Monthly Educational Programme

Over the past year, a monthly Educational Forum has continued to run successfully in a webinar format, organised by Dr Jana De Villiers. This initiative provides trainee psychiatrists with valuable opportunities to present clinical cases, academic papers, and audit or research findings. In addition, the forum features educational sessions delivered by both internal and external speakers.

The forum plays a key role in supporting trainees' learning, professional development, and portfolio enhancement. It has been well received by participants, with six core trainees and three higher trainees actively contributing as presenters throughout the year.

3.2.7 New to Forensic' (N2F) Education Programme

The 'New to Forensic' (N2F) education programme is a joint initiative between NHS Education for Scotland (NES) and the School of Forensic Mental Health (SoFMH). It is designed to support both clinical and non-clinical staff who are either new to forensic mental health services or seeking to deepen their understanding of the field. The programme promotes self-directed learning and adopts a multi-disciplinary, multi-agency approach.

Participants are supported throughout their study period—typically six months to one year, depending on prior experience—by a mentor who is an experienced mental health professional. The programme comprises 15 chapters, all but one of which include case scenarios involving patients across a range of settings, from high secure hospitals to community psychiatric care. At The State Hospital (TSH), all trainee psychiatrists who have not previously completed the programme are registered with N2F upon arrival. In some cases, trainees may have already undertaken the programme during earlier placements or have substantial prior experience in forensic settings. Materials are provided to enable completion of the programme under the guidance of their Consultant clinical supervisors.

Administrative coordination is managed through the Medical Education support team, with registration and completion arrangements linked to the Forensic Network. Training Committee minutes confirmed that all eligible trainees were registered and that most had completed the programme by July 2026, with one assessment still in progress at that point. Five trainees were formally signed off during 2025–26. The committee also promoted progression to the Essentials of Psychological Care programme following N2F completion.

3.2.8 State Hospital Visits

Requests for taster visits and short observational placements continued from medical students, Foundation doctors, Core Trainees and doctors considering a career in forensic psychiatry. These visits provide insight into high-secure practice, therapeutic relationships, multidisciplinary working and recovery-focused care. Demand must be balanced against supervision capacity, operational requirements and the need to maintain a safe, meaningful experience for each visitor.

3.2.9 Clinical Attachments for International Medical Graduates (IMGs)

Interest in clinical attachments from International Medical Graduates continued during 2026, including enquiries from doctors with prior psychiatry experience seeking exposure to secure forensic practice. Requests are considered in relation to educational value, supervisory capacity, governance, confidentiality and the operational requirements of the hospital. The established process supports appropriate observership opportunities while maintaining patient safety and professional standards.

3.2.10 Psychotherapy Training

Dr Adam Polnay, Consultant in Forensic Psychotherapy, provides part-time input at the State Hospital. His contributions include facilitating Balint and Reflective Practice sessions for non-Consultant grade doctors, offering a valuable space for clinical reflection and professional development.

In addition, Dr Polnay supports Core and Specialty Trainees in identifying opportunities to engage in individual and group psychotherapy activities and coordinates reflective practice timetables. Training Committee discussions encouraged trainees to register their interest promptly so that suitable patient work could be allocated. These experiences form an essential component of core psychotherapy training requirements and continue to be highly valued during placements at The State Hospital.

3.2.11 Recruitment and Trends in Working Patterns

Less Than Full Time working continues to be an important feature of the trainee workforce and requires flexibility in placement, supervision and rota planning. National recruitment to Forensic Psychiatry remained strong: the August 2026 round achieved a 100% fill rate, with three new residents appointed in the West and one in the North. Across Scotland, the programme comprised two trainees in the North, two in the East, four in the South East and seven in the West. Workforce needs and geographical distribution continue to be monitored.

At programme level, the Forensic Psychiatry Specialty Training Committee continued work on formative assessment changes, entrustability scales, appropriate caseloads, support for neurodiverse trainees and those whose first language is not English, and consistency in assessment standards. A proposed Highland placement received support in principle, offering the potential for additional rural forensic experience. The programme also recognised uncertainty caused by the delayed introduction of the FourteenFish ePortfolio and continued to use existing portfolio arrangements pending formal guidance.

3.2.12 Representation at External Committees Relevant to Medical Education

Over the past year, I have represented the State Hospital at several key committees and review panels relevant to postgraduate medical education, including:

West of Scotland Specialty Training Committee and the National Forensic Psychiatry Specialty Training Committee;

Bi-annual NHS Education for Scotland Annual Review of Competence Progression panels; and National and regional work on recruitment, trainer approval, curriculum implementation, study leave arrangements and quality management. In August 2026, the national STC recorded a 100% fill rate and favourable survey feedback across the programme. A September 2026 test of change also separated approved travel, accommodation and subsistence costs from the resident doctor’s £600 notional study leave allocation, seeking to reduce geographical disadvantage.

This representation ensures that The State Hospital remains actively engaged in regional and national discussions on training standards, curriculum development, trainee progression, workforce distribution and educational quality. During 2026, the organisation also contributed to implementation planning for revised formative assessments and the new ePortfolio, while continuing local monitoring of trainee workload, wellbeing and access to high-quality supervision.

4 RECOMMENDATION

The Board is invited to note the positive and stable position of medical education at The State Hospital during 2025–26. Key strengths include high-quality supervision, strong induction and wellbeing support, distinctive high-secure curriculum opportunities, active trainee feedback and sustained engagement with regional and national education governance.

The national forensic psychiatry programme retained a strong UK position for overall satisfaction and achieved a 100% fill rate in August 2026. Priorities for the forthcoming year are to maintain Consultant capacity and protected educational time, monitor workload and placement attendance, strengthen assurance that essential induction requirements are completed, and support trainers and trainees through changes to formative assessment and the ePortfolio.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	The report supports the organisation's commitment to high-quality medical education, training, clinical governance and workforce development, in line with General Medical Council standards for undergraduate and postgraduate medical education. It provides Board-level oversight and assurance regarding the quality and governance of medical education and training at the State Hospital.
Corporate Objectives Which Corporate Objective(s) does this paper support: Better Care Better Health Better Value Better Workforce	Better Care and Better Workforce. The paper supports Better Care through high-quality medical education, supervision and training, helping to maintain appropriate clinical standards and learning opportunities. It supports Better Workforce through the development, supervision and education of trainee doctors and through continued engagement with regional and national medical education arrangements.
Workforce Implications	Medical education has ongoing workforce implications in relation to Consultant and educational supervisor capacity, protected educational time, trainee placement and attendance, induction, supervision and on-call rota arrangements. The report identifies continued monitoring of workload and placement attendance, maintenance of Consultant capacity and protected educational time, and support for trainers and trainees through forthcoming changes to assessment and ePortfolio arrangements.
Financial Implications	There are no new financial implications arising directly from this report. The report notes that the Medical ACT allocation reduced from £47,253 in 2025/26 to £45,305 in 2026/27, a reduction of £1,948 (4.1%), despite increased undergraduate teaching activity. The reduction reflects the Hospital's proportional share of national undergraduate teaching activity and wider pressures on the national Medical ACT budget.
Route to Board Which groups were involved in contributing to the paper and recommendations.	The paper is sponsored by the Medical Director and is presented to the Board for noting.
Risk Assessment Outline any significant risks and associated mitigation.	Key risks relate to maintaining appropriate trainee numbers and attendance, Consultant and supervisory capacity, completion of essential induction requirements, workload and on-call arrangements, and ensuring trainees have appropriate opportunities to meet curriculum requirements. These risks are mitigated through educational supervision, Training Committee oversight, monitoring of workload and attendance, early liaison regarding placement issues, induction and training arrangements, and engagement with regional and national medical education governance structures.

Assessment of Impact on Stakeholder Experience	Positive impact. The report provides assurance regarding the quality of the learning experience for medical students and trainee doctors. Undergraduate feedback was strongly positive, with students valuing the educational experience, clinical exposure and teaching provided, while opportunities for improvement have also been identified. Postgraduate education is supported through induction, supervision, structured teaching, feedback and educational governance arrangements.
Equality Impact Assessment	No new policy or service change is proposed by this paper and no specific adverse equality impact is identified. Existing medical education arrangements recognise the need for appropriate support and flexibility, including Less Than Full Time working and programme-level consideration of support for neurodiverse trainees and trainees whose first language is not English.
Fairer Scotland Duty The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do.	The paper is presented for assurance and noting and does not propose a strategic decision or change to services. No specific socio-economic inequality impact is identified within the report. Medical education arrangements continue to take account of accessibility and geographical considerations affecting training, placements and study leave.
Data Protection Impact Assessment (DPIA) See IG 16. Which one of the following three options applies: There are no privacy implications. There are privacy implications, but a full DPIA is not required. There are privacy implications and a full DPIA is included.	There are no privacy implications. The report provides aggregate information on medical education activity, training and feedback and does not propose any new processing of personal data.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	22 October 2026
Agenda Reference No:	Item No: 13
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 up to 30 September 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.

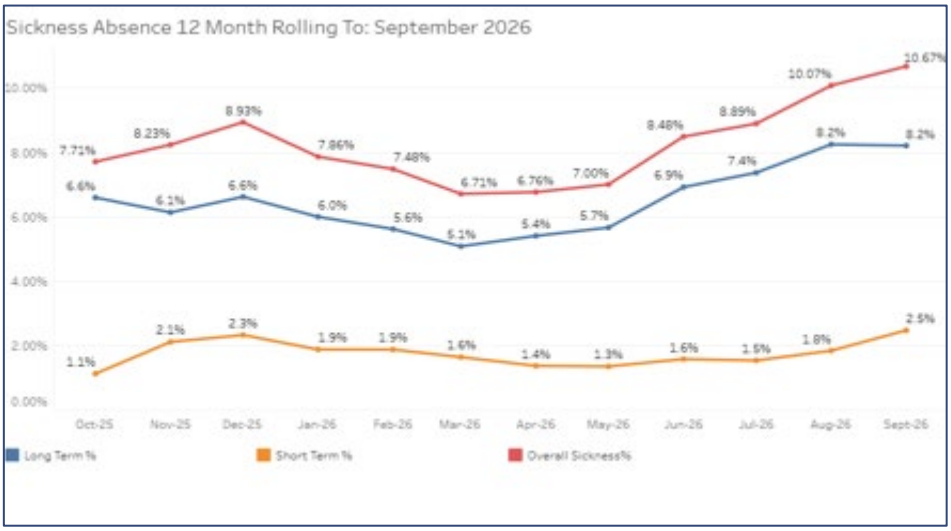
3 ASSESSMENT

3.1 Attendance Management

3.1.1 TSH Sickness Absence current position

Sickness absence has continued to rise since the lowest point of the year (6.71% in March 2026) fuelled by an increase in long term absence, particularly within Nursing. The most recent rise from August (10.03%) to September (10.67%) was driven by an increase in short term absence with long term absence plateauing. This is illustrated in graph one below.

GRAPH 1 – All Staff

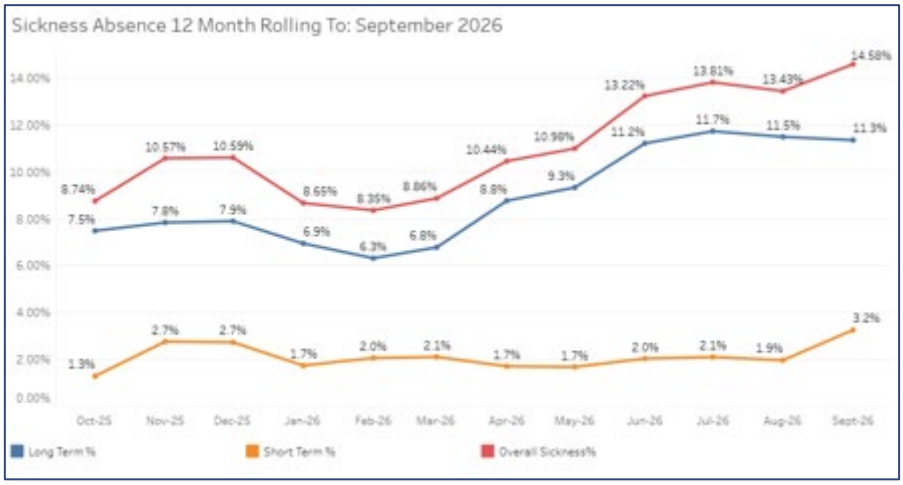


3.1.2 Nursing Sickness Absence

There has been a significant increase in absence within Nursing as outlined below (from 8.35% in February 26 to 14.56% in September 26). The total absence spike was almost identically mirrored by long term absence, although this looks to have plateaued in July/August.

The current position reinforces a clear link between working environment and overall wellbeing, 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 the current model and changing levels of demand. The approach to actively addressing absence is outlined below, but will be covered in detail at Staff Governance Committee in November, along with further analysis and trends on absence within TSH.

GRAPH 2 – Nursing hubs

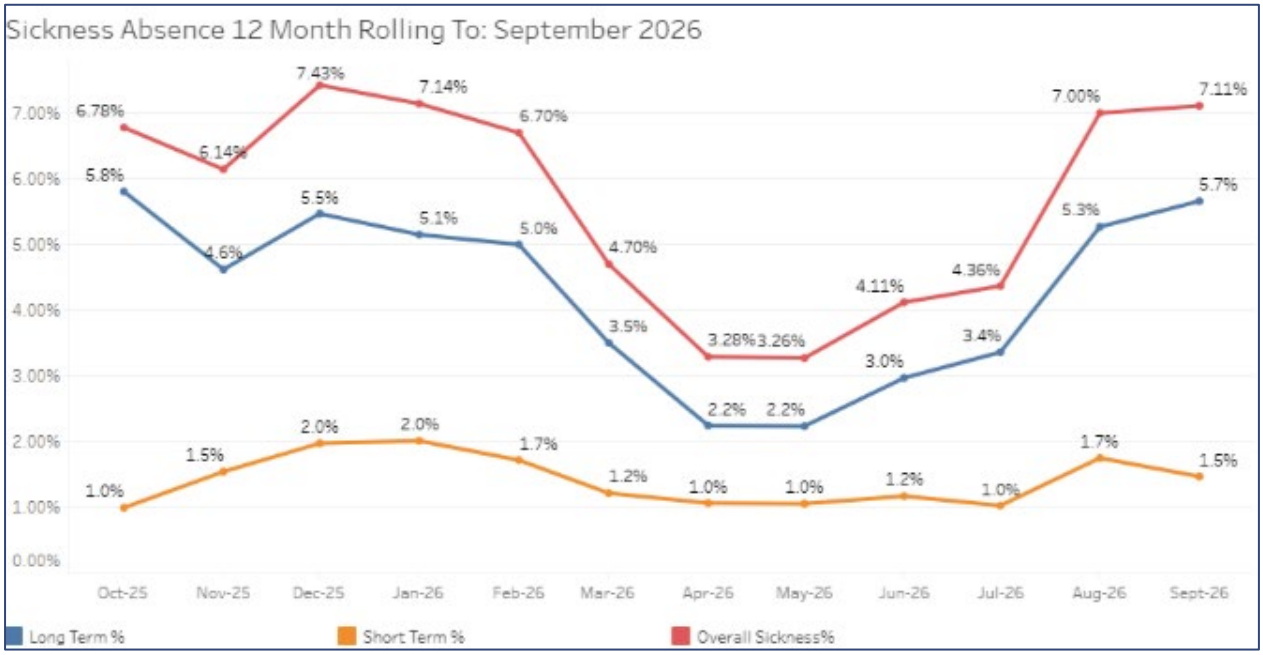


3.1.3 Departments out with Nursing

Non-Nursing ward areas have seen a smaller, but noticeable increase in absence over the last two months, which has been led by long term absence increasing by circa 2.7%.

Only three departments outwith nursing did not achieve the target of 5% in September 2026.

GRAPH 3 – Non-Nursing Staff



3.1.4 Attendance Management Observations

Patterns / Trends for TSH	Short-term absence: 2.46% (an increase of 0.5% in month) Long-term absence: 8.2% (an increase of 0.13% in month)
Reasons	The principal causes of long-term absence were: • Anxiety, stress, depression and other psychiatric illnesses. • Injury/fracture. • Other known causes not otherwise classified. The principal causes of short-term absence were: • Gastrointestinal. • Other Muscular Skeletal. • Anxiety, stress, depression and other psychiatric illness.
Activity	At the time of reporting, 21 employees had been invited to a Stage 1 Attendance Management meeting during September, four Stage 2 and no Stage 3 meetings held. Based on **85 active monitoring records**: • **45%** are monitored for between **3 and 5 months**. • **51%** are monitored for between **6 and 9 months**. • **5%** are monitored for between **10 and 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 table below reflects the August 2026 position. TSH remains ranked third of all Boards due to the scale of long-term absence.

Sickness Absence Comparison – Nationally Reported Figures (August 2026)

Sickness Absence Statistics by NHS Board

1st August 2026 - 31st August 2026

	Absence Rate			Instances			Absence Reason	
	Total	Long Term [1]	Short Term [2]	Total	Long Term [1]	Short Term [2]	Yes	No [3]
Scotland	**6.50**	**4.39**	**2.11**	**35,488**	**11,646**	**23,842**	**32,368**	**3,120**
NHS Ayrshire & Arran	6.69	4.84	1.85	1,955	712	1,243	1,793	162
NHS Borders	5.67	3.69	1.99	595	180	415	547	48
Public Services Delivery Scotland [4]	3.43	2.45	0.97	704	230	474	637	67
NHS 24	10.14	6.72	3.42	640	198	442	624	16
Healthcare Improvement Scotland	5.40	4.52	0.88	68	34	34	65	3
Public Health Scotland	3.19	2.06	1.13	120	30	90	116	4
Scottish Ambulance Service	10.13	7.38	2.75	1,340	523	817	1,281	59
The State Hospital	9.61	7.38	2.23	135	70	65	128	7
National Waiting Times Centre	6.21	4.16	2.04	551	193	358	495	56
NHS Fife	7.11	5.21	1.91	1,786	715	1,071	1,698	88
NHS Greater Glasgow & Clyde	6.65	4.61	2.04	8,448	3,088	5,360	7,886	562
NHS Highland	6.68	4.59	2.09	2,142	684	1,458	1,713	429
NHS Lanarkshire	7.99	5.95	2.03	2,938	1,249	1,689	2,605	333
NHS Grampian	4.95	2.88	2.07	3,114	719	2,395	2,691	423
NHS Orkney	5.91	4.52	1.39	115	41	74	109	6
NHS Lothian	5.88	3.50	2.38	5,401	1,354	4,047	4,873	528
NHS Tayside	6.71	4.35	2.36	2,756	817	1,939	2,516	240
NHS Forth Valley	7.08	4.74	2.34	1,434	457	977	1,385	49
NHS Western Isles	6.10	4.24	1.86	189	61	128	185	4
NHS Dumfries & Galloway	6.56	4.03	2.53	913	256	657	885	28
NHS Shetland	4.31	2.42	1.89	144	35	109	136	8

3.1.6 Ongoing Challenge

The continuing challenge in relation to Sickness Absence levels requires to be addressed at an individual, team and organisational level: where we focus only on the indicator (absence level), we are at risk of solely managing the consequences and failing to address the conditions that contribute to it.

The robust approach to 'Maximising Attendance' has previously seen short-term improvements in attendance in 2025 and 2026, and therefore we must continue to focus on this approach, specifically:

- Effective Line Manager Interaction (1st and Regular Point of contact)
- Pathway usage, review and improvement for commons absences
- Proactive approach to supporting employees back to work.
- Improving linkage with Occupational Health and Staff Care Specialist.

Alongside this approach, sustained improvement will only be possible where:

- Prioritising Organisational Health remains a key focus. (Culture Assessment and Development, Team Dynamics, and Leadership being immediate priorities).
- The perception of Safety in the Working Environment is also key. This links to our approach to recruitment and reaching our establishment, along with understanding and addressing perceptions of safety in the workplace, which is scheduled for our next Nursing Partnership Forum.
- This work will complement our Maximising Attendance approach and ensure we have a proactive approach to managing absence, with defined pathways, regular reviews and support for managers.

Addressing all these areas, whilst acknowledging that we will see peaks and troughs, will provide the only approach to sustainable improvement.

3.2 Recruitment

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

Time to Hire KPI is 75 Days	The average time to hire in September was 44 days. This turnaround time was largely based on support services and admin posts and whilst illustrative of the successful process being implemented by the service.
Vacancies Advertised	During September 2026, there were seven advertisements.
Nursing Recruitment	Ward-Based Nursing The following nursing staff are due to commence employment: • October induction - 11 Registered Nurses. • November Induction – 4 Registered Nurses 9 HCSWs have been recruited and are awaiting start dates. Seven HCSWs to transfer to Registered Nurses (Subject to PIN). Further advert for Registered Nurses placed 13 October 2026 aligned to planned inductions in Q3.

3.3 Employee Relations - Live Cases

There are 10 formal cases to report.

3.3.1 Eight are Formal Conduct

Six are connected to one event and the investigation report was submitted to the commissioning manager on 1 October 2026. Investigation Outcome Meetings will take place in mid-October.

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. The second is due for completion in mid-November.

3.3.2 Two are Formal Grievance

During the reporting period, the grievance which was raised in February has progressed to Stage 2 but has been delayed at request of the employee.

In September, a Formal Grievance was raised and is now commencing to Investigation prior to Stage 1 Grievance Hearing.

3.4 Leavers

Monthly turnover for September 2026 was 0.78%, representing 5 leavers (5 WTE) during the month. This is broadly consistent with September 2025, when the monthly turnover rate was 0.67% and four employees (4.12 WTE) left the organisation.

For the financial year to date, turnover stands at 4.20% (29 leavers; 26.75 WTE), compared with 3.29% (20 leavers; 19.78 WTE) at the same point in 2025.

The Annual Exit Report Review was presented to the Staff Governance Committee in August 2026.

3.5 Job Evaluation

3.5.1 Progress & Status

Two new job descriptions were submitted in late September with panels scheduled.

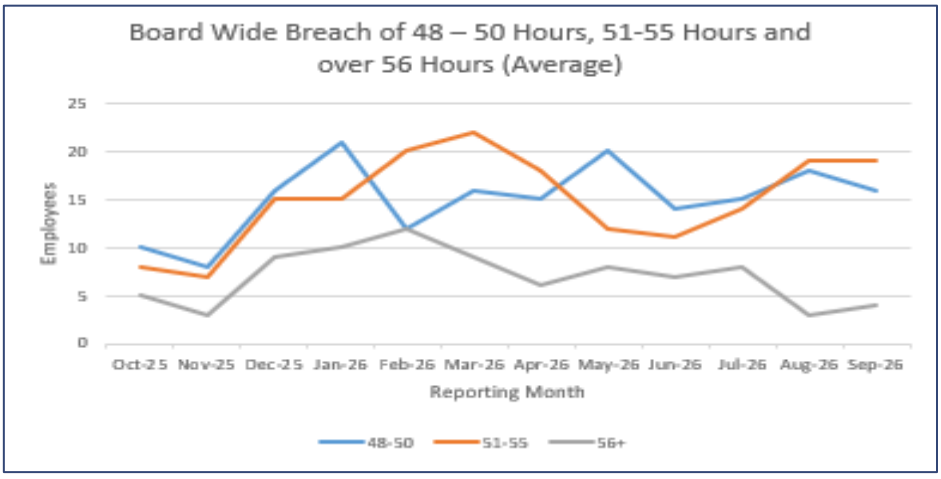
3.5.2 Band 5 Reviews

No new reviews submitted. Two remain under consideration for approval.

3.6 Working Time Regulations Overview - Board Wide Breach of 48-hour (average)

Board wide, there were 39 staff who breached the average 48-hour working week as defined by WTD as highlighted above. This number has reduced by one from the 40 staff who breached in August 26.

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.

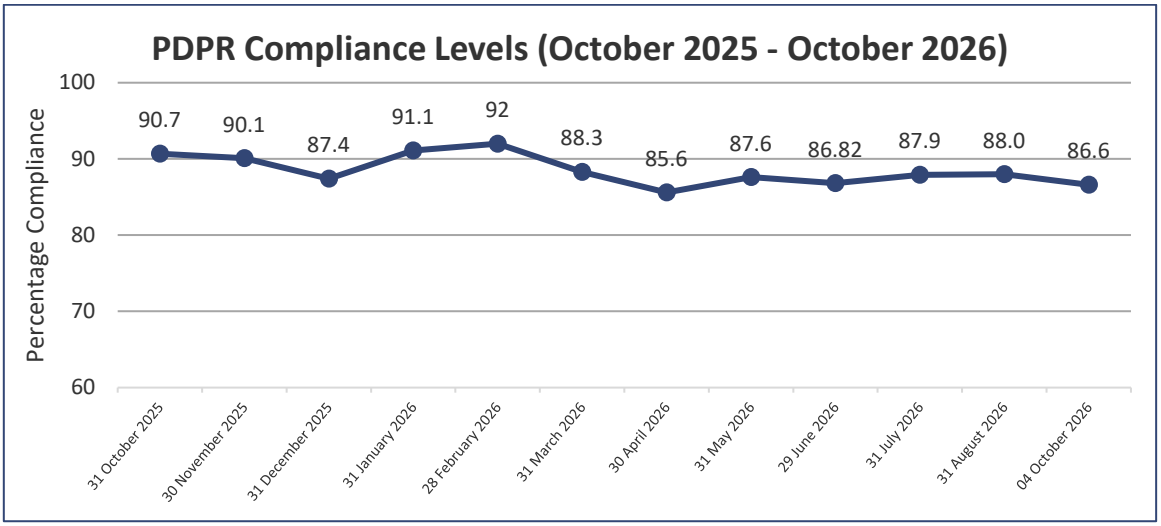


Within Nursing Wards, the number of employees exceeding the 48-hour limit increased from 31 in August to 35 in September 2026. Nursing accounted for 35 of the 39 Board-wide breaches. The number of breaches, and compliance with waivers, will continue to be monitored through the Nursing Partnership Forum.

3.7 PDPR Compliance

The chart below provides details of PDPR compliance for the period from October 2025 – October 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	4. Better Workforce Support the Independent National Whistleblowing Standards and support this workstream locally including promoting awareness for staff.
Workforce Implications	None
Financial Implications	None
Route to Board Which groups were involved in contributing to the paper and recommendations.	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. Which one of the following three options applies: There are no privacy implications. There are privacy implications, but a full DPIA is not required. There are privacy implications and a full DPIA is included.	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Report:	22 October 2026
Agenda Reference No:	Item No: 14
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Head of eHealth
Title of Report:	eHealth 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 the eHealth Department, an annual report is provided for consideration.

The eHealth Annual Report highlights the activities of the department during 2025/26 – encompassing the following –

- Information team.
- Infrastructure team.
- Project Management.

2 BACKGROUND

The State Hospital's eHealth department builds on the national commitment to provide a suitable digital infrastructure for the Board and for NHS Scotland, with a strong focus on delivering national initiatives and programmes.

In addition, there are significant Board-specific projects which require to be addressed in order to maintain the desired level of provision for both staff and patient needs.

This report provides an update in respect of the above work streams, in relation to contributing to the delivery of high quality service and developments based on identified needs in the short, medium and longer-terms.

3 ASSESSMENT

The report highlights the main areas of activity and issues from 2025/26.

Key achievements include:

- Made Purple proof of concept.
- Single sign on.
- Rio rollout.
- Tableau rollout.
- Rio / CPA development.
- SafeCare implementation.
- Network, Firewall and Security upgrades.
- Windows11 deployment.
- Menumark.
- Patient shopping system / patient finance system.
- InPhase implementation (Datix replacement).

Actions for the next twelve months include:

- Implementation of Harlequin Patients' Monies.
- Disaster Recovery Test Plans.
- Digital storage, backup and recovery system replacement.
- Sensitivity labeling.
- Office 365 SharePoint.

4 RECOMMENDATION

The Board is asked to **note** the progress outlined in the enclosed report for the year 2025/26 and the key plans for the coming period.

MONITORING FORM

How does the proposal support current Policy / Strategy / ADP	The Report follows good practice and also links in with the eHealth Strategy
Corporate Objectives Please note which objective is linked to this paper.	Better Value (3f) – Enhance and strengthen digital innovation for the organisation; and the digital inclusion programme. Better Value (3h) – Deliver the actions identified by the NIS audit, to maintain cyber security and resilience.
Workforce Implications	Not applicable
Financial Implications	No financial implications if approved
Route to the Board Which groups were involved in contributing to the paper and recommendations?	eHealth SubGroup
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None
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).	None identified
Data Protection Impact Assessment (DPIA) See IG 16. Which one of the following three options applies: There are no privacy implications. There are privacy implications, but a full DPIA is not required. There are privacy implications and a full DPIA is included.	There are no privacy implications.

THE STATE HOSPITALS BOARD FOR SCOTLAND

eHEALTH ANNUAL REPORT

2025-2026

Responsible Director	Finance and eHealth Director
Lead Author	Head of eHealth
Contributing Authors	Senior Project Manager Information & Data Lead Infrastructure Operations and IT Security Manager
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1 OVERVIEW

Digital technologies are embedded in all services delivered at The State Hospital. From patient movement to business intelligence the eHealth department are at the forefront of driving digital change and innovation within the organisation. With the drive to “Digital First” the security of the systems and data they contain is critical and this is the responsibility not just of the eHealth department but of the hospital as a whole. To ensure this security we need to meet the requirements of the Network and Information Security policy (NIS) and General Data Protection Regulation (GDPR) while also meeting Scotland’s Digital Health and Care Strategies.

Digital technologies continue to develop with the emergence of Artificial Intelligence (AI) bringing great promise for health care. The deployment of Microsoft CoPilot has brought AI to the desktop for staff and many are the seeing the benefits this can bring in assisting with their daily workloads. Caution, however, is needed – as AI should be seen as an assistant with workloads rather than a replacement for skilled staff. AI does have a cost and at present we only have a small deployment of CoPilot licenses across the hospital, with a wider deployment planned once funding is identified as available.

Patients have also seen benefits from digital technologies with the successful deployment of the Made Purple proof of concept. This has brought real benefits to both staff and patients to whom it has been available in the transitions ward, and the deployment of the system has been extended until December 2026. It is hoped that there will be a site wide deployment of the Made Purple system in 2027 – dependent on the availability of funding which is under review in Q3 of 2026.

The rollout of Single Sign On (SSO) has reduced the number of passwords needed by staff. Once logged in, staff can access several systems without the need for individual passwords for each item. The rollout was not problem free, but it succeeded and has contributed to the security of the systems in use across the hospital.

The infrastructure team has had another demanding year. The replacement of unsupported software has consumed considerable resources with only a small impact on the day-to-day service delivery. We have increased our senior infrastructure analyst team by one and have successfully recruited for a vacant infrastructure analyst post. Recruitment has again been difficult with one post having twice to go out to advert. Developing the infostructure team has been a significant focus with the delivery of ITL4 service management and Microsoft Azure training being delivered across the year.

The Information team continues to build on previous successes with continued developments in Rio and Tableau. The delivery of more new forms and data dashboards has helped enhance the services provided by the hospital, with new development requests regularly received as staff see the benefits that can be delivered from the work undertaken by this team.

The project team have provided support and guidance to staff in the delivery of mobile devices to support patent care and systems to modernise how patient funds are managed. There remains a list of projects to be delivered and this is slowly growing due to the creation of a Digital Inclusion group that allows staff to discuss their digital aspirations and help identify routes and processes needed to enable compliant delivery of their ideas.

2 INFORMATION AND BUSINESS INTELLIGENCE TEAM

This year, the team supported the organisation's ongoing digital transformation, delivering a wide-ranging programme of business intelligence and systems development across clinical, operational, and corporate services. Significant progress was made in enhancing key applications and reporting capabilities, and supporting organisational priorities through new dashboards, system upgrades, and data integration projects.

Extensive development was delivered within Rio, including Care Programme Approach (CPA) processes, admissions and referrals, clinical documentation, gender integration, and service reporting. A major achievement was the successful upgrade to the latest Rio platform version. The organisation's reporting capability continued to expand through Tableau, with legacy reports replaced by automated dashboards including Corporate KPIs, CPA monitoring, incidents, weight management, and medicines. User training supported increased adoption of self-service reporting and data-driven decision-making.

The team also provided technical support for eRostering, helping to deliver the SafeCare implementation and a major system upgrade. Work continued to reduce reliance on unsupported applications, while comprehensive data flow documentation was developed to strengthen information governance and understanding of organisational information assets. The team continued to represent the organisation at national Excellence in Care working groups, contributing to the development of new measures and standards.

3 INFRASTRUCTURE TEAM

The Infrastructure Team continued to maintain, secure and modernise the organisation's core digital infrastructure throughout the year, while supporting a significant programme of clinical, corporate and technical change. Alongside the day-to-day delivery of IT services, the team progressed major upgrades across the network, server, endpoint and security environments, supported nationally driven Microsoft 365 and cyber security initiatives, and provided technical expertise to a wide range of organisational projects.

A significant proportion of the team's work takes place behind the scenes and is essential to maintaining safe and reliable digital services. This includes maintaining the availability and security of core infrastructure; managing user accounts, devices and access; monitoring and responding to faults and security alerts; applying security updates; maintaining backup and recovery arrangements; supporting suppliers; and replacing ageing or unsupported technology.

3.1 Core Infrastructure and Resilience

A programme of infrastructure upgrades and lifecycle improvements continued throughout the year. This included upgrades to the firewall, wireless Network Access Control environment, network switching infrastructure and Exchange servers, together with ongoing improvements to the organisation's wireless network. Work on the wireless upgrade has progressed across the hospital, with the Skye Centre remaining to be completed.

The organisation's Public Key Infrastructure (PKI) has also continued to be modernised, including replacement of certificate services and the updating of the organisation's Root Certificate. This supports secure and trusted communication between systems and devices across the digital estate.

Core infrastructure continues to be routinely maintained and security patched, including the backup environment of virtual infrastructure, servers, firewall and network access control systems. The identification and removal or mitigation of unsupported systems also remains an ongoing priority. These activities contribute to the resilience of the organisation's digital services and its ability to recover from equipment failure, cyber incidents and other forms of disruption.

3.2 Endpoint Modernisation

The Windows 11 deployment has been a significant programme of work for the team. In addition to the initial deployment, devices have subsequently been upgraded from Windows 11 version 24H2 to 25H2, alongside the continuing replacement of desktop and laptop hardware where required. Preparatory work will also continue as future Windows versions are introduced.

The team has continued the transition from traditional on-premises device management to Microsoft Intune. This includes the migration of device configuration and security controls, together with the repackaging and deployment of applications to managed endpoints. This work also supports implementation of the national Windows and Microsoft 365 security baseline requirements. The organisation has deployed a Windows 11 security baseline through Microsoft Intune as part of these arrangements.

Device security arrangements are also being strengthened through the migration of removable-media controls into Intune and Microsoft Defender for Endpoint, providing improved control over the use of removable storage devices. Recent work has included development and testing of Intune-based USB and removable-device control arrangements.

The team has also continued the refresh of mobile devices, which is moving towards a planned annual replacement programme to maintain supported and suitable hardware.

3.3 Cyber Security and Technical Assurance (see also section 6)

Cyber security considerations are increasingly embedded within the Infrastructure Team's day-to-day activities rather than being treated as a separate technical function. During the year, the team has continued to implement technical improvements arising from cyber security audit, assurance and national security activity. This includes endpoint and device security, configuration management, vulnerability reduction, patching, monitoring and the removal or mitigation of unsupported technology.

The team continues to investigate and respond to cyber security alerts and incidents and to work with national NHS Scotland cyber security services where appropriate. Technical work is also being undertaken in support of the organisation's Cyber Security Action Plan and wider assurance requirements.

The increasing integration of infrastructure and security means that upgrades and technology replacement programmes are now considered not only in terms of functionality and supportability, but also their contribution to reducing cyber risk and improving organisational resilience.

3.4 Support for Digital and Organisational Projects

In addition to maintaining the core infrastructure, the team provides technical expertise and infrastructure support to a wide range of clinical, corporate and digital projects. During the year this has included work associated with Made Purple, additional HEPMA requirements, Menumark, the Patient Shopping EPOS system, the Patient Library system, upgrades to RiO, HEPMA Rio TIE system and RiO infrastructure migration activity requested by the supplier.

This work can include assessment of infrastructure and security requirements, configuration and implementation of supporting technology, liaison with suppliers, testing and troubleshooting, and ensuring that new or changed services can operate within the organisation's existing digital environment.

3.5 Operational IT Services

Alongside planned projects and improvement programmes, the Infrastructure Team continues to provide the day-to-day operational support required to maintain the availability, security and reliability of the organisation's digital services. This includes Joiner, Mover and Leaver account administration, password and access issues, computer and account troubleshooting, hardware and software support, IT advice, backup restores, infrastructure monitoring and fault resolution. Development of the ServiceNow helpdesk call-logging environment has also continued, supporting the ongoing development of IT service-management arrangements.

This combination of operational support, infrastructure lifecycle management, security improvement and project activity enables the team to maintain existing services while progressively modernising and strengthening the organisation's digital environment.

4 PROJECT MANAGEMENT

The Team completed the successful delivery and closure of the Digital CPA project. The supported rollout was completed across all Clinical Teams, the solution transferred to business as usual, and the End Project Report and benefits realisation arrangements captured outcomes, lessons learned and recommendations for future digital initiatives. This work was recognised with a Staff Excellence award.

4.1 Patient Digital Inclusion

The Made Purple Proof of Concept went live in October 2025 and was subsequently extended to December 2026. The evaluation found that the platform was safe, usable and valued by patients and staff, with 2,169 individual logins and 4,723 total logins recorded between October 2025 and June 2026. Patients reported benefits including greater autonomy, choice, confidence, wellbeing and connection with life beyond hospital. A full evaluation report has been completed and the business case for continuation and a controlled, phased hospital-wide rollout is being finalised, subject to funding, governance, staffing, patient-banking integration and service-specific requirements. In the meantime, the system has been funded for the Transitions service until December 2026.

4.2 Microsoft 365

OneDrive has been rolled out and Microsoft 365 Copilot was deployed to 88 users, supported by national training and local communications. Preparatory governance, records management, security and accessibility work for SharePoint Online has progressed, including a local test site and submission of hub-site and template requirements. SharePoint rollout remains dependent on national configuration, sensitivity-label guidance and hub-site provisioning.

4.3 Patient finance

The Patient Shop EPOS system was successfully implemented and went live on 24 February 2026, following completion of requirements, supplier selection, funding approval and implementation planning.

The Team is supporting Finance and Procurement with the implementation of Harlequin Patients' Monies, which will replace the current Trojan system ahead of its end of life. Contracts, data protection arrangements, system configuration and data migration have progressed, and user acceptance testing is nearing completion following development of additional procurement functionality. The go-live date will be agreed once final testing and sign-off are complete.

4.4 Other

The Team supported the successful VISION and Docman re-provisioning project for the Health Centre. The hosted VISION solution went live on 17 June 2026 following migration planning, configuration, staff training and testing. A project closure meeting was held in July, with work continuing to develop options for exporting VISION data to support reporting and Tableau dashboards.

The Team delivered the implementation of InPhase, replacing Datix as the organisation's incident and risk management platform. InPhase went live on 11 March 2026 following data migration, testing, staff communications and training, and the project transferred to business as usual in April 2026 with an End Project Report and lessons learned completed.

Following a successful NetSupport pilot in the Patient Learning Centre, the product was accepted as an appropriate way to address security concerns while supporting patient access to educational technology. Funding was agreed and work has progressed on the associated Microsoft 365 licensing and hardware refresh needed for implementation.

The Team continued to support Catering and Dietetics with the MenuMark implementation. Supplier-led training is scheduled across October and November 2026, with fuller system access being used to assess functionality and benefits.

The Team also continued to provide project management support for the Rio EPR, including weekly development meetings and the ROAD group. The latest planned Rio upgrade went live in October 2026.

The Digital Innovation Event was delivered on 27 January 2026, bringing together State Hospital colleagues and external contributors to explore how innovation can support services in a high-secure setting. This has been followed by the establishment of ongoing monthly Digital Innovation Group activity and development of a wider digital roadmap, including work on 360-video use cases, tablets for clinical quality audits and psychological assessments.

5 KEY EHEALTH PROJECTS 2026/27

- Implementation of Harlequin Patients' Monies.
- Disaster Recovery Test Plans.
- Digital storage, backup and recovery system replacement.
- Sensitivity labeling.
- Office 365 SharePoint.

6 CYBER SECURITY

Cyber security has continued to be a significant area of focus throughout the year. The threat landscape continues to evolve rapidly, including the increasing use of automation and artificial intelligence by threat actors. This reinforces the need for the organisation to continually review and strengthen its preventative, detective, response and recovery capabilities.

Following recent cyber security audit and assurance activity, the organisation has continued to develop a structured programme of improvement covering governance, technical controls, resilience, incident response and staff awareness. Increasingly, the emphasis is not simply on demonstrating that policies and procedures exist, but on being able to demonstrate that appropriate security controls are implemented, effective and subject to ongoing review.

6.1 Information Security Management System

A significant development during the year has been the introduction of a revised suite of information security policies forming the foundation of the organisation's Information Security Management System (ISMS). The overarching Information Security Management System and Governance Policy establishes a structured approach to the governance, management and continual improvement of information security. The framework is aligned with the National Cyber Security Centre Cyber Assessment Framework (NCSC CAF) and ISO/IEC 27001:2022 and supports compliance with the Network and Information Systems Regulations (NIS), UK GDPR and NHS Scotland cyber resilience expectations.

The development of the ISMS represents a move towards a more structured and evidence-based security assurance model, bringing together information security governance, risk management, technical and organisational controls, incident management, assurance and continual improvement. This approach will assist the organisation in responding to evolving national cyber security and regulatory requirements while providing a sustainable framework through which security improvements can be prioritised, implemented and evidenced.

6.2 Technical Security Improvements

The focus on strengthening technical security controls has continued throughout the year. Systems and infrastructure have been maintained and security updates applied in accordance with manufacturer and national recommendations wherever possible.

The Windows 11 programme and migration towards Microsoft Intune have provided an opportunity to modernise the way endpoint security is managed. This work includes implementation of national security baseline requirements and strengthened configuration of managed devices.

Additional technical improvements have included work around removable-media and device control, infrastructure lifecycle management, security patching and the removal or mitigation of unsupported systems. Intune-based removable-device controls have recently been part of this programme.

We also continue to investigate security alerts and implement appropriate remedial actions when potential threats or vulnerabilities affecting TSH are identified.

6.3 Cyber Incident Response and Organisational Resilience

Cyber security is not solely concerned with preventing incidents. An increasing emphasis is being placed on ensuring that the organisation is able to respond effectively, maintain critical services and recover if a significant cyber incident does occur. Cyber incident response arrangements have therefore continued to mature. The organisation's Cyber Incident Response Plan provides a structured approach to detecting, managing, responding to and recovering from cyber security incidents and defines how cyber incident management interfaces with business continuity and disaster recovery arrangements.

A multidisciplinary cyber desktop exercise was undertaken during the year to test the organisation's response to a significant cyber incident. The exercise involved representation from across the organisation and demonstrated good engagement and readiness, while also identifying opportunities to further strengthen response and recovery arrangements.

Of particular importance was consideration of how the hospital could continue to deliver safe patient care and maintain critical organisational functions during significant disruption to digital systems. Exercises of this nature provide valuable opportunities to test arrangements in a safe environment, identify dependencies and capture lessons for future improvement.

6.4 Cyber Awareness

People / staff remain an important component of the organisation's cyber defences. Cyber security awareness therefore continues alongside improvements to technical controls. Phishing simulation exercises and awareness activity are used to help staff recognise potential threats and understand their responsibilities in protecting organisational and patient information. Further phishing campaigns and awareness activities will continue to be developed, complementing the technical controls implemented across the organisation.

6.5 Forward planning

Cyber security and infrastructure resilience will remain continuing priorities.

The organisation will continue to develop the ISMS and associated assurance arrangements, progress actions arising from cyber security audit and assessment activity, strengthen technical security controls, maintain and modernise infrastructure, and test its ability to respond to and recover from significant cyber incidents.

The Infrastructure Team will also continue to work with national and regional NHS Scotland colleagues. Recent regional infrastructure discussions have included Microsoft 365 security baselines, SharePoint migration and governance, resilience, certificate management, emerging technology risks and other shared infrastructure and security challenges.

Together, these activities support the organisation's continuing objective of maintaining digital services that are secure, resilient, supported and capable of meeting the changing needs of patients, staff and the wider organisation.

7 EHEALTH COLLABORATIVE WORKING

The eHealth department continues to represent the hospital at several national eHealth groups and work where possible with other National or Territorial Boards. We still have sight of all relevant national programs and projects within NHS Scotland, and benefit from national solutions wherever practical and applicable.

The groups on which State Hospital eHealth staff are represented include:

- National Digital Leads Group.
- National Information Leads Group.
- National Infrastructure Group.
- National IT Security Group.
- West of Scotland Infrastructure Group.
- West of Scotland IT Security Group.
- M365 Project Group.

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT AND RISK COMMITTEE **ARC(M) 26/03**

Minutes of the meeting of the Audit and Risk Committee held on Thursday 19 June 2026.

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

Chair:

Vice Board Chair	David McConnell

Present:

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

In Attendance:

Acting Director of Security, Estates, and Resilience	Allan Hardy
Internal Auditor, RSMUK	Asam Hussain
Chief Executive	Gary Jenkins
Information Governance & Data Security Officer	Ken Lawton [Item 5]
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning, Performance & Quality	Monica Merson
Board Chair	Brian Moore [Items 1-12]
External Auditor, KPMG	Matthew Moore
Head of Corporate Governance	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr McConnell welcomed everyone to the meeting. 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 received and approved the minutes of the meeting held on 19 March 2026.

The Committee:

1. Approved the minutes of the meeting on 19 March 2026.

4 MATTERS ARISING – ROLLING ACTION LIST UPDATE

There were no matters arising. The Committee noted the Rolling Action List as either being completed or not yet due.

The Committee:

1. Noted the Action List and actions taken.

5 INTERNAL AUDIT REPORTS

The Committee received the Freedom of Information (FOI) and Subject Access Requests (SAR) Audit Report and Mr Lawton joined the meeting for this item. Mr Hussain highlighted that the review had considered the policies, procedures, governance arrangements and controls in place for managing FOI and SAR requests between September 2025 and May 2026. The audit had resulted in an opinion of Reasonable Assurance, with positive findings on the organisation's structured approach, supporting policies, defined responsibilities, training and governance oversight. Mr Hussain noted two exceptions relating to FOI compliance: one acknowledgement letter had not been issued, meaning the privacy notice had not been shared, and search forms had not been completed by departments undertaking searches. Both actions had been agreed for completion by the end of June and Mr Hussain concluded that, overall, the report was positive, with these exceptions explaining why the opinion had not been one of Substantial Assurance.

Mr McConnell thanked Mr Hussain for the report and invited Mr Lawton to comment before opening for questions. Mr Lawton welcomed the report and in response to a question from Mr Currie regarding if the actions had been addressed, he advised that both actions had been addressed.

Ms Radage thanked Mr Lawton for the clarification and acknowledged the significant volume of work undertaken by the team. She added that a non-executive walkaround had highlighted the scale of activity in this area and expressed appreciation for the work carried out quietly in the background. Mr Jenkins endorsed the comments and excellent report and recognised Mr Lawton's diligence and expertise in supporting the organisation on these matters.

Mr McConnell thanked everyone for their contribution.

<u>The Committee:</u>

1. Noted the outcome of the Freedom of Information and Subject Access Requests Audit Report

6 INTERNAL AUDIT

a) Audit Progress Report

The Committee received the Internal Audit Progress Report, presented by Mr Hussain, which provided an update on delivery of the 2026/27 audit plan. Mr Hussain advised that the first review had been completed, the cyber security review was ongoing, and the remaining reviews on Occupational Health and PMVA had been planned and provided assurance that the plan remained on track.

b) Action Tracker Report

Mr Hussain presented the Internal Action Tracking Update and advised that 13 actions were included on the tracker. Eight had been closed as implemented, two were not yet due, and responses had not been received for three medium-priority actions relating to the roster compliance review at the time the paper was prepared. He added that responses had since been received from the specified owners, with some actions implemented and others requiring further work, including ongoing national progress on the SSTS and Optima interface. He advised that the updated responses would be shared following the meeting and underlined the need to secure future updates in good time for Committee reporting.

Mr McConnell thanked Mr Hussain for the updates and opened for questions.

Mr Currie expressed concern that responses had not been received in time for inclusion in the Committee paper. He emphasised that papers issued in advance provided the Committee with its opportunity to scrutinise information effectively, and that a lack of response limited this scrutiny. He

acknowledged that there may have been reasons for the delay but stressed the importance of meeting deadlines and ensuring timely responses in future. Mr Connor also shared the view that lack of responses was concerning. He also noted that the narrative relating to roster protocols required updating, as it had been superseded by work on the reduced working week and a revised roster protocol, which had been approved through the Partnership Forum and implemented from 6 April 2026 and that the narrative should be updated to reflected this.

Mr Jenkins added that it should never be the case that there was a no response and this would be picked up directly with the teams.

Action: Mr Jenkins

Mr Hussain acknowledged the concerns and advised that the lack of response was unusual. He advised that the report would be updated, as indicated, and shared with the Committee for completeness and expressed the expectation that this would not happen again.

Action: Mr Hussain

The Committee:

1. Noted the Audit Progress Report.
2. Noted the Action Tracking Report.

7 ANNUAL REPORT FOR YEAR ENDED 31 MARCH 2026

Mr Hussain presented the final Internal Audit Annual Report for 2025/26 and advised that the Annual Internal Audit Opinion was positive, confirming that the organisation had an adequate and effective framework for governance, risk management and internal control. He noted that, of the five pieces of work completed, one area relating to Estates and Facilities Management had received a negative assurance opinion, while the remaining reviews had received positive opinions. Mr Hussain highlighted that actions were underway to address the issues identified and advised that, overall, it had been a positive year.

Mr McConnell noted that the Annual Report had previously been considered in draft form and that the assurance provided would support the Committee's reporting to the Board on the Annual Report and Accounts. He confirmed with Mr McNaught that the issue relating to Estates and Facilities Management had been reflected in the Annual Governance Statement, together with the associated action plan, and noted that this had been recognised through the appropriate route.

The Committee:

1. Noted the Annual Audit Report for year ended 31 March 2026.

8 CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register, presented by Mr Hardy, who advised that all corporate risks were up to date, with no overdue risks and no new risks proposed. The overall risk profile remained stable and had improved, with two high risks downgraded to medium. There were no very high risks, and high risks had reduced from five to three, relating to finance, sickness absence and use of resources for patient care. Mr Hardy noted that 13 risks had achieved their target level, while 10 had not, with only the three high risks exceeding tolerance. He highlighted that consequential risk narrative had been added to provide wider context on the impact and interdependencies between finance, staffing and patient care. He also advised that the new InPhase system had been rolled out for risk management, risk registers and complaints, supporting improved reporting and assurance.

Mr McConnell thanked Mr Hardy for the report and noted that it was particularly helpful, given the reformulation and re-categorisation of some higher risks and the inclusion of consequential risk narrative and invited comments or questions.

Ms Radage welcomed the report and noted that it demonstrated the dynamic nature of the risk management process. She sought clarification on MD30 (relating to rates of patient obesity) specifically the distinction between the KPI referring to patients gaining less than 15% of their admission body weight and the commentary referring to eligible patients and asked who was included within that cohort. Ms Merson clarified that inclusion criteria for the new KPI on weight management included all patients. Exclusion criteria related to patients with no monthly weight recorded and any patient who was recorded as underweight, both of which represented very low numbers.

Mr Connor sought clarification on ND70 (relating to best use of nursing resources to support care) and noted that the graph appeared to show the risk had been elevated to high in December 2025, while the narrative referred to recent data and staffing challenges and issues continuing in February 2026. He queried whether the narrative required to be amended to better align with the timeline shown in the graph. Mr Hardy advised the narrative was not reflective of the position and agreed to update and recirculate the report. Mr Jenkins clarified that the report represented a snapshot in time and advised that the Corporate Management Team had recently considered escalation of this risk further to reflect the current operational position. He highlighted this as a matter of openness and transparency and noted the ongoing pressures being experienced and the need to consider these in the context of the timing of the report.

Action: A Hardy

Mr Currie welcomed the inclusion of consequential risk narrative, noting that it provided helpful context on the direction of travel, wider organisational impact and interdependencies between risks. He also welcomed the addition of the governance committee column, which provided assurance that risks were being considered by the relevant governance committees before being reported to the Audit and Risk Committee. He emphasised the importance of confidence in any regrading decisions and noted that the report demonstrated progress across the hospital, while providing a clear overview of current challenges and developments.

The Committee:

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

9 RISK AND RESLIENCE ANNUAL REPORT 2025/26

The Committee received the Risk and Resilience Annual Report for 2025/26, presented by Mr Hardy, who provided an overview of the department's remit and key developments across risk, resilience, business continuity, incident reporting, health and safety, Duty of Candour, systems management, training and risk culture. He advised that risk had been embedded across governance structures, resilience arrangements remained strong, incident reporting had increased, and serious incident review processes had improved. Duty of Candour cases and RIDDOR incidents had reduced, fire safety work had progressed with no fires reported, and InPhase had been implemented on time and within budget. Priorities for 2026/27 included expanding InPhase, strengthening local risk registers, developing dashboards and supporting departments to manage risks effectively.

Mr McConnell thanked Mr Hardy for the overview and opened for questions.

Mr Jenkins queried the total incidents figure in table 3.5.3 for 2024/25 which appeared to be incorrect. Mr Hardy clarified that the correct total figure for incidents in 2024/25 should read 4,171 and that it appeared the leading digit in the 2024/25 column total was missing.

Ms Radage welcomed the report and acknowledged the significant work undertaken by the team. She sought clarification on the incident closure data in section 3.2.2, noting that the figures for full closures in 2024/25 and 2025/26 did not appear directly comparable with previous years.

Ms Radage further asked for clarification on Golden Hour training and whether risk and resilience reporting should also be considered for the Staff Governance Committee. Mr Hardy explained that the reporting metric had changed, with incidents now categorised in more detail as modified work or full closure, rather than under a broader staff resource category. He then explained that Golden Hour training focused on the initial management of an incident, particularly the first hour, and provided staff with templates and guidance to support timely and structured response. Ms Smith clarified that Staff Governance Committee received reporting on staff governance risks from the Corporate Risk Register and that work was ongoing to develop the working environment report. It was agreed that the matter would be picked up as an action and discussed at the next agenda setting meeting to consider how relevant risk and resilience reporting could be reflected through Staff Governance without duplicating Clinical Governance arrangements.

Action: Secretariat

Mr Currie welcomed the report and acknowledged the significant work undertaken by the Risk and Resilience team and colleagues across the hospital. He highlighted the importance of timely significant adverse event reviews in supporting learning and reducing the risk of recurrence and noted that the report provided evidence-based assurance to the Committee.

Mr Connor queried the increase in health and safety incidents shown in the table in section 3.5.3 and noted that that the figures appeared to have risen significantly compared with the previous two years. Mr Hardy advised that further analysis would be required to confirm the reasons for the increase and agreed to undertake further analysis and provide an update.

Action: Mr Hardy

The Committee:

1. Noted the Risk and Resilience Annual Report for 2025/26.

10 FINANCE REPORT TO 30 APRIL 2026

The Committee received the Finance Report to 30 April 2026 presented by Mr McNaught who advised that the Board had achieved its three financial targets for the previous year, including the two revenue targets and the capital target, which would be confirmed through the year-end accounts. He reported a small variance at the end of April, with ongoing discussions with directors to finalise savings plans for 2026/27. He advised that Nursing spend remained a key pressure, particularly in relation to Women's Service staffing. He noted that funding had been confirmed at the previous year's level, with assurance that any additional in-year demand would be addressed as it arose, and that regular dialogue with Scottish Government would continue.

Mr McNaught advised that confirmation of Northern Ireland charges remained outstanding, despite paperwork having been issued in March. Scottish Government support had been sought to progress this with Northern Ireland counterparts. He reported that the Scottish Government had been content with the Board's current financial position and projections for the year. Capital priorities for 2026/27 were being assessed within the available budget, and additional costs relating to remedial works following the April incident were being evaluated, with Scottish Government support expected in principle once final requirements were confirmed.

Mr McConnell thanked Mr McNaught for the update and opened for questions.

Mr Currie noted that the month one finance position provided an early indication but queried when the Committee would have a clearer understanding of the financial direction of travel, particularly in relation to major cost pressures such as overtime. He highlighted the ongoing importance of securing appropriate baseline funding for the Women's Service, noting that continued reliance on non-recurring funding could place pressure on wider hospital resources. Mr McNaught advised that a clearer view of the financial direction of travel was expected during quarter two, once savings plans were being tracked more fully and year-end work had concluded. He noted that nursing staffing plans and related pressures, including overtime and ward costs, would continue to be closely monitored. He also advised that the financial impact of the Women's Service would be tracked against the funding confirmed by Scottish Government, with any additional pressures raised with Scottish Government at the earliest opportunity.

Mr Connor queried whether the reported overspend for the Women's Service should also reflect associated staffing costs incurred across other wards, including overtime attributed to supporting the service. Mr McNaught advised that the presentation of the figures could be reviewed to ensure the position was clear and agreed to discuss the most appropriate way to show this in future reporting.

Action – Mr McNaught

Mr McConnell asked whether any income received from Northern Ireland would be expected to offset Scottish Government funding for the Women's Service. Mr Jenkins provided assurance that he continued to lead discussion with Scottish Government colleagues. He advised that further work was underway to define the operating model in more detail, with evidence of progress expected in future months. He confirmed that Northern Ireland income would be retained by the organisation and the expectation would be to use this to offset any other budget pressures including the women's service.

Mr Moore suggested circulating the letter from Scottish Government to all Non-Executive Directors for their information, and this was agreed as being helpful.

Action – Mr McNaught

The Committee:

1. Noted the Finance Report to 30 April 2026.

11 FRAUD UPDATE AND FRAUD ACTION PLAN

a) Fraud Update
b) Fraud Action Plan

The Committee received the Fraud Update and Fraud Action Plan presented by Mr McNaught who advised that Counter Fraud Services (CFS) virtual sessions continued to be reviewed and circulated as appropriate. Two matters had been notified during the reporting period, with further notifications received since the paper had been issued. These related to concerns about staff claiming time to which they may not have been entitled and were under review and the outcomes would be reported to the next meeting. Mr McNaught also confirmed that the Fraud Action Plan was in place and had been agreed with CFS.

Mr McConnell thanked Mr McNaught for the update and opened for questions.

Ms Radage asked whether workforce health dashboards provided oversight of excessive hours, including overtime following retirement, and compliance with Working Time Regulations to support earlier identification of potential issues. Mr McNaught advised that processes were in place to review excessive hours, including checks on required documentation. He explained that CFS notifications were reviewed case by case, with matters cleared, investigated locally or escalated back to CFS

depending on the seriousness of the concern. Mr Connor noted the process of reporting the Staff Governance Committee, as well as previous action by way of a local protocol which identified staff who worked in excess of an additional 23 hours per week. Mr Jenkins agreed and thought it would be helpful for to report this explicitly through the Staff Governance Committee. He added that the relevant data was being reviewed to ensure this was tracked appropriately, including instances where staff were asked to work consecutive shifts.

The Committee:

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

12 CYBER CRIME UPDATE

The Committee received the Cyber Crime Update presented by Mr McNaught who and advised that no major national or local security risks had been raised during the quarter and that the organisation continued to maintain awareness of emerging risks and had been successful in detecting and quarantining threats through existing systems. He noted the need to remain vigilant, continue working with national teams and maintain regular liaison. Mr McNaught confirmed that mandatory cyber security training continued and advised that the outcome of the internal audit review would be reported in the coming weeks.

Mr McConnell thanked Mr McNaught for the report and update.

The Committee:

1. Noted the Cyber Crime Update.

13 ANNUAL REPORTS FROM COMMITTEES

The Committee received the Annual Reports from each of the Governance Committees.

a) Clinical Governance Committee Annual Report 2025/26

b) Staff Governance Committee Annual Report 2025/26

c) Remuneration Committee Annual Report 2025/26

d) Audit and Risk Committee Annual Report 2025/26

Mr McConnell noted that each of the annual reports followed the same broad structure and format and set out the functions of each of the Committees and demonstrated their performance over the year and that they had fulfilled their remit and terms of reference.

The Committee noted that the Clinical Governance Committee Annual Report Committee demonstrated that it had fulfilled its remit and that effective clinical governance arrangements had been in place throughout the year.

The Committee noted the Staff Governance Committee Annual Report provided a comprehensive summary of the significant breadth of work undertaken during the year and reflected effective links with other standing committees, transparent communication and constructive discussion throughout the reporting period.

The Committee noted the Remuneration Committee Annual Report set out the role and work of the Committee, including its responsibilities in relation to the performance, pay and conditions of

executive and senior managers, together with details of membership, attendance, and the work and reports reviewed during the year and that the Committee had discharged its responsibilities during the reporting period.

The Committee approved the annual reports for submission to the Board as part of the wider annual report and accounts assurance process.

In relation to the Audit and Risk Committee Annual Report, the Committee reviewed and approved the content as representing its own work throughout the year. Mr McConnell thanked members for their contributions throughout the year. The Committee approved the report for submission to the Board as part of the wider annual report and accounts assurance process.

The Committee:

1. Endorsed the Clinical Governance Committee Annual Report 2025/26 for onward submission to the Board.
2. Endorsed the Staff Governance Committee Annual Report 2025/26 for onward submission to the Board.
3. Endorsed the Remuneration Committee Annual Report 2025/26 for onward submission to the Board.
4. Approved the Audit and Risk Committee Annual Report 2025/26 for onward submission to the Board.

14 STATUTORY ANNUAL ACCOUNTS

a) Statutory Annual Accounts
b) Annual Report and Accounts for the year ended 31 March 2026

The Committee received the Statutory Annual Accounts presented by Mr McNaught who explained that the report was intended to help Committee members navigate the structure and format of the accounts. The format remained largely unchanged from the previous year, with only minor amendments, and he confirmed that KPMG had reviewed the reports and accounts, and their draft unqualified audit opinion was included on pages 34 to 38.

Mr McNaught summarised the main sections of the accounts. The Performance Report confirmed that the Board had remained within its revenue and capital limits, noted that Women's service was now underway, highlighted potential pressures for the year ahead and recorded the 2025/26 KPI outcomes. The Accountability Report included the statement of Board members' responsibilities, the statutory compliance statement for the Chief Executive, and the Governance Statement, which covered internal controls, risk assessment arrangements, governance structures, principal Board activity and high risks on the Corporate Risk Register.

He advised that Annual Governance Statement within the accounts recorded the outcome of internal audit reviews, including one high-rated recommendation, for which an action plan was in place. The Remuneration and Staff Report set out senior staff remuneration and pension disclosures, wider staff cost information, workforce gender breakdown data and trade union facility time disclosures. The Parliamentary Accountability Report covered losses and special payments, and the basis for charging for services, with the relevant reports signed by the Chief Executive.

Finally, Mr McNaught noted that the principal financial statements showed the break-even revenue position and that the Finance Director and Chief Executive were required to sign the Statement of Financial Position. The accounting policies had previously been approved by the Audit and Risk Committee in March, and the remaining notes provided detailed statutory disclosures, largely unchanged from 2025, with the main additional disclosure relating to pensions. He concluded by thanking the Deputy Director of Finance, the finance team, NSS/PSD colleagues and KPMG for their work throughout the year-end process.

Mr McConnell thanked Mr McNaught for the overview and opened for comments or questions.

Mr Currie noted that the break-even position reflected significant work across the organisation, effective financial management and a strong focus on efficiencies. He highlighted that the Board had lived within its means without reliance on brokerage or sustainability support, which provided a strong starting point for the new financial year. He thanked Mr McNaught, the finance team, budget holders and wider teams for their collective contribution.

Mr McConnell also noted thanks to everyone for the work undertaken over the last year.

The Committee:

1. Agreed to recommend the Statutory Annual Accounts for 2025/26 to the Board for final approval.
2. Noted thanks to Robin McNaught, the Finance Team, relevant staff across Departments and both the internal and external auditors.

15 ANNUAL LOSSES AND SPECIAL PAYMENTS REPORT

The Committee received the Annual Losses and Special Payments Report from Mr McNaught who advised that there were no significant matters in the current year requiring specific highlight. He noted that compensation payments made during the year had been agreed and approved through the appropriate governance routes and with legal advice, and a small stock write-off had arisen following the annual stores review. He added that the recorded other losses related to historic salary overpayments which were considered unrecoverable as the person concerned had left the organisation and could not be contacted. Recovery action was not considered proportionate, since legal costs would likely exceed any potential recovery.

Mr McConnell thanked Mr McNaught for the overview.

The Committee:

1. Noted the Annual Losses and Special Payments Report.

16 WAIVERS OF SFI TENDERING REQUIREMENTS REPORT

The Committee received the Waivers of SFI Tendering Requirements Report presented by Mr McNaught who advised that formal tendering was required for items over £10k, with quotations required for items between £5k and £10k; however, exceptions could be applied in specific circumstances, including timescale pressures, specialist expertise, completion of existing projects, or supply continuity benefits. He confirmed that each waiver had been reviewed to ensure its validity and that the rationale for each case was included within the report. He explained that the main items related to security, estates, IT licensing, maintenance and service support, with the number and value of waivers remaining broadly consistent with 2025 and assured the Committee that there had been no instances during the year where the required process had not been followed and noted the report.

Mr McConnell thanked Mr McNaught for the report and overview.

The Committee:

1. Noted the Waivers of SFI Tendering Requirements Report.

17 PATIENTS' FUNDS ACCOUNTS REPORT

The Committee received the Patients' Funds Accounts Report presented by Mr McNaught who advised this this related to the separate accounting arrangements for monies held on behalf of patients. He noted that the 2026 accounts had been subject to an independent annual audit by Wylie and Bisset, which had provided an unqualified opinion. The accounts presented a summary of collective patient income and expenditure, with fluctuations in average funds held reflecting the uneven pattern of income and expenditure during the year. He added that the patient balances varied significantly and continued to be closely monitored.

Mr McNaught asked members to recommend the Patients' Funds Accounts to the Board and that the Director of Finance and e-health and the Chief Executive are given approval to sign the summary income and expenditure statement.

Mr McConnell thanked Mr McNaught for the report and there was agreement around the table to approve the Patients' Funds Account for submission to the Board.

The Committee:

1. Approved the Patients' Funds Accounts Report for onward submission to the Board.

18 ANNUAL REPORT TO THE BOARD AND THE AUDITOR GENERAL FOR SCOTLAND

The Committee received the Annual Report to the Board and the Auditor General Auditor for Scotland presented by Mr Matthew Moore who highlighted that while some audit work remained to be formally documented and finalised, there were no matters expected to alter the audit conclusions, and the audit opinion was expected to be signed before the required deadline.

Mr Moore advised that materiality had been set at £1.2m, with misstatements above £53k reported to the Committee. He confirmed that the full estate valuation had been reviewed and considered reasonable and free from bias. The presumed fraud risk around year-end expenditure had been rebutted and reclassified as a standard risk of misstatement; journal testing found no evidence of management override; and wider scope work identified no significant weaknesses. He noted one recommendation to formalise funding arrangements for the Women's Service with the Scottish Government and the service level agreement with Northern Ireland. There were no corrected or uncorrected audit misstatements above the reporting threshold, only minor presentational adjustments, one control efficiency point and no specific management representations. He confirmed KPMG's independence and advised that the final report would follow completion and signing of the unqualified audit opinion.

Action – KPMG

Mr McConnell thanked Mr Moore for the overview and opened for questions.

Mr Currie noted that Appendix 1 helpfully set out the scope and outcome of the external audit work. He welcomed confirmation that no significant difficulties had arisen and considered the clean audit opinion to provide strong assurance to the Committee and Audit Scotland. He noted that the audit recommendation would support continuous improvement and thanked Mr Moore and the finance team for their collaborative work and clear reporting.

Mr Moore acknowledged the comments and advised that, in his first year working with the Board, the external audit team had had a positive experience. He recognised the quality of the accounts, supporting evidence and assistance provided by the finance team, and noted the effective collaboration between the finance and external audit teams. He identified one area for continuous improvement, namely bringing the draft annual report to a more advanced stage earlier in the

process to reduce subsequent clarification and revision. He thanked the Finance Team and external audit colleagues for their work in completing the audit.

Mr McConnell acknowledged the positives in the report and thanked everyone for their work over the last year.

The Committee:

1. Noted the Annual Report to the Board and the Auditor General Auditor for Scotland, and that it would be submitted to the Board at its meeting later today.

19 a) ANNUAL AUDIT AND RISK COMMITTEE ASSURANCE STATEMENT TO THE BOARD
b) APPENDIX 1

The Committee received the Annual Audit and Risk Committee Assurance Statement to the Board and Appendix 1, presented by Mr McNaught who highlighted that the cover paper was intended to support the Committee in approving Appendix 1 for submission to the Board later that day. He explained that the purpose of Appendix 1 was to provide the Board with assurance that the Performance Report, Accountability Report and Annual Accounts were ready to be signed, following approval by the Audit and Risk Committee and external auditors within their respective remits. He noted that the Board was required to formally adopt the accounts and that the report confirmed that KPMG had issued an unqualified audit opinion. He further confirmed approval of the Governance Statement and the statement of Board members' responsibilities. Mr McNaught advised that the Committee was being asked to approve submission of Appendix 1 for submission to the Board for approval and signing of the accounts later that afternoon.

Mr McConnell thanked Mr McNaught for the overview and summarised that the Committee had considered the key areas required to support the Annual Assurance Statement, including assurances from internal and external audit, review of the accounts, and assurances received from the relevant governance committees. He reiterated that the Committee was being asked to confirm that Appendix 1 could be submitted to the Board, providing assurance to support approval and signing of the Annual Accounts.

There being no questions, the Committee approved the submission of the Audit and Risk Committee Assurance Statement for 2025/26 to the Board and agreed to recommend approval and signing of the accounts.

The Committee:

1. Approved the annual Audit and Risk Committee Assurance Statement for 2025/26 for submission to the Board.

20 NATIONAL SINGLE INSTANCE (NSI) & NSS SERVICE AUDITS

The Committee received the NSI and NSS Service Audits presented by Mr McNaught who informed members since the NHS in Scotland report had been presented to the Committee in January, no further relevant Audit Scotland reports had been issued for the State Hospital. He summarised the relevant National Services audit reports, noting that the National Services Scotland IT Services audit had identified no significant control issues of specific impact to the Hospital. He also noted that the annual report on the NSI Finance System, delivered through NHS Ayrshire and Arran as host board, had identified no control weaknesses.

Mr McConnell thanked Mr McNaught for the update and noted the assurance provided that copies of the reports were available on request.

The Committee:

1. Noted the NSI and NSS Service Audits.

21 SECURITY, RESILIENCE, H&S OVERSIGHT GROUP UPDATE

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

The Committee:

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

22 FINANCE, eHEALTH AND AUDIT GROUP UPDATE

The Committee received the Finance, eHealth and Audit Group Update from Mr McNaught who noted that the group continued to conduct business in line with terms of reference and there were no matters highlighted that required escalation to the Committee.

The Committee:

1. Noted the Finance, eHealth and Audit Group Update.

23 RELEVANT ISSUES ARISING TO BE SHARED WITH GOVERNANCE COMMITTEES

There were no relevant issues noted.

24 ANY OTHER BUSINESS

There was no other business raised by members.

25 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 1 October 2026 at 9.30am** via MS Teams.

The meeting ended at 11:50am.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting: 22 October 2026

Agenda Reference No: Item No: 15ii

Author(s): Head of Corporate Governance

Title of Report: Summary Report: Audit and Risk Committee

Purpose of Report: For Noting

(This report provides the Board with an update on the key points arising from the Audit and Risk Committee meeting that took place on 1 October 2026.

1	Internal Audit	The Committee welcomed the reasonable assurance provided by the finalised IT Security Review. They noted the actions agreed and acknowledged the ongoing challenges in cyber security. Assurance was provided that the timescales for actions were achievable, however, those dependent on national support could be delayed due to wider national priorities.
2	Corporate Risk Register	The Committee received reporting on the position of the Corporate Risk Register including high risks and noted that all risks were current. The Committee requested a review of the Cyber Security risk rating following the IT Security Review and noted ongoing challenges within cyber security.
3	Finance Report	The Committee noted the broadly favourable financial position, while recognising continued pressure from staffing costs, particularly within the Women's Service. Further confidence on the year-end position was expected after Q3, with further work planned to increase recurring savings and review funding for long-standing vacancies.
4	Anchors Strategy Annual Update	The Committee noted progress across procurement, workforce development and sustainability, including local apprenticeships, employability initiatives and reduced reliance on diesel vehicles. It recognised the need to balance local economic and environmental benefits with procurement legislation and best value requirements and welcomed efforts to adapt national learning and improve transparency of forthcoming contract opportunities.
5	Annual Reports: Procurement Legal Claims	The Committee took assurance from each area of reporting with no risks requiring escalation. The Committee requested future Procurement reporting identified contracts awarded to local suppliers. The legal claims report was noted for assurance.
6	Update Reports: Counter Fraud Cyber Crime	The Committee received and noted the quarterly summary of fraud allegations and notifications received from Counter Fraud Services (CFS) and the review process in place. No significant cyber incidents were reported, although national concerns about cyber-security tools, training and governance would continue to be monitored.

7	Policy Updates	Reporting provided assurance on the arrangements in place to ensure that policies are being reviewed through an appropriate review process.
9	External Audit Progress Report	Planning for the 2026/27 audit was expected to begin before the next meeting.
10	Review of Committee Effectiveness	Committee members had undertaken a review of its effectiveness, aligned to the guidance and audit checklist provided by the Audit Committee Handbook. The Committee noted the positive effectiveness review and effective cross-committee working, while recognising challenges relating to overlapping membership, independence and future quoracy. Recruitment to the forthcoming Non-Executive Director vacancy remained subject to Scottish Government confirmation.
11	Internal Updates	The Committee received updates from the Finance eHealth and Audit Group, and the Security, Resilience, Health and Safety Group, with no matters requiring escalation.

RECOMMENDATION

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