NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 23 JUNE 2022
at 1pm, held by MS Teams
A G E N D A

1.	**Apologies**		
2.	**Conflict(s) of Interest(s)** To invite Board members to declare any interest(s) in relation to the Agenda Items to be discussed.		
3.	**Minutes** To submit for approval and signature the Minutes of the Board meeting held on 28 April 2022	For Approval	TSH(M)22/03
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 22/41
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
1.15pm	**RISK AND RESILIENCE**		
7.	**Covid 19 Response and Remobilisation:**		
a.	**Resilience Update** Report by the Chief Executive	For Decision	Paper No. 22/42
b.	**Finance Update** Report by the Director of Finance & eHealth	For Noting	Verbal
8.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 22/43
1.45pm	**CLINICAL GOVERNANCE**		
9.	**Clinical Model Implementation** Report by the Medical Director	For Decision	Paper No. 22/44
10.	**Clinical Governance Committee Annual Report 2021/22** Report by the Chair of the Committee	For Decision	Paper No. 22/45
11.	**Quality Assurance and Quality Improvement** Report by the Head of Corporate Planning and Business Support+	For Noting	Paper No. 22/46

12.	**Clinical Governance Committee** Approved minutes – meeting held February 2022 Chair's Update – meeting held 12 May 2022	For Noting	CGC(M) 22/01
13.	**Clinical Forum** Approved minutes - meeting held 22 March 2022 Chair's Update – meeting held 17 May 2022	For Noting	CF(M)22/01
2.30pm	**** BREAK ****		
2.45pm	**STAFF GOVERNANCE**		
14.	**Staff Governance Committee** **Annual Report 2021/22** Report by the Chair of the Committee	For Decision	Paper No. 22/47
15.	**Remuneration Committee Annual Report 2021/22** Report by the Chair of the Committee	For Decision	Paper No. 22/48
16.	**Whistleblowing Annual Report** Report by the Director of Workforce	For Noting	Paper No. 22/49
17.	**Attendance Performance Report** Report by the Director of Workforce	For Noting	Paper No. 22/50
18.	**Staff Governance Committee** Approved minutes – meeting held February 2022 Chair's Update – meeting held 19 May 2022	For Noting	SGC(M) 22/01
3.10pm	**CORPORATE GOVERNANCE**		
19.	**Report on the Annual Accounts 2021/22** Report by the Chair of the Audit Committee	For Decision	Paper No. 22/51
20.	**Patients Funds** Report by the Director of Finance & eHealth	For Decision	Paper No. 22/52
21.	**Audit Committee Annual Report 2021/22** Report by the Chair of the Audit Committee	For Decision	Paper No. 22/53
22.	**Finance Report to 31 May 2022** Report by the Director of Finance & eHealth	For Noting	Paper No. 22/54
23.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/55
24.	**Property and Asset Management – Update** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/56
25.	**Performance Annual Report 2021/22** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 22/57

26.	**Risk and Resilience Annual Report 2021/22** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/58
27.	**Communications Update** Report by the Chief Executive	For Decision	Paper No. 22/59
28.	**Model Code of Conduct** Report by the Board Secretary	For Noting	Paper No. 22/60
29.	**Audit Committee** Minute – meeting held 17 March 2022 Chair's Update – meeting held 23 June 2022	For Noting	AC(M)22/01
30.	**Any Other Business**		Verbal
31.	**Date of next meeting** 25 August 2022		Verbal
32.	**Proposal to move into Private Session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal
33.	**Close of Session and Reflection on Meeting**		Verbal

Estimated end at 4.15pm

THE STATE HOSPITALS BOARD FOR SCOTLAND **TSH (M) 22/03**

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 28 April 2022.

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

Chair: Brian Moore

Present:

Employee Director	Allan Connor
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Medical Director	Lindsay Thomson

In attendance:

Director of Workforce	Linda Davidson
Person Centred Improvement Lead	Sandie Dickson [item 9]
Social Work Team Leader	David Hamilton
Head of Corporate Planning and Business Support	Monica Merson
Associate Chief Nursing Officer, Scottish Government	Mark Richards
Board Secretary	Margaret Smith [Minutes]
Director of Security, Estates and Resilience	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Mr David McConnell (Vice Chair). It was noted that Dr Sheila Howitt (Chair of the Clinical Forum) as well as Ms Caroline McCarron (Head of Communications) were unable to attend this meeting.

He welcomed Ms McCaffrey, newly appointed as Director of Nursing and Operations, to her first Board 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 24 February 2022 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 24 February 2022: TSH(M)22/01.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 22/20) and noted progress on the action points from the last meeting, with actions either being completed, progressed satisfactorily, or on today's agenda for discussion.

Mrs Fallon took the opportunity to query whether further clarity in respect of the requirement for savings from National Boards was available, and Mr McNaught advised this was not confirmed at this time and that clarification was being sought.

The Board:

1. Noted the updated action list.

5 CHAIR'S REPORT

Mr Moore provided an update to the Board in relation to his activities and main areas of focus since the last Board meeting.

He highlighted the release of a number of videos launched through Communications, which had provided positive views of the care provided at TSH and which were a very welcome addition to the communication approach.

He had continued to attend the System Pressures Meetings led by the Cabinet Secretary for Health and Social Care which was focused on the recovery and remobilisation of NHS Scotland. For TSH, this was an opportunity to reset and refocus in terms of long term thinking especially in terms of the continuing response to the pandemic and how to focus on strategic development in this new landscape.

Mr Moore advised he continued to attend the NHS Board Chairs Group as well as the National Board Chair's group meetings. There had been an emphasis on the development of the National Care Service and proposal to enable legislation. This could be a useful reference point for the potential introduction of structural change in the governance of forensic mental health services this year, especially around learning and the possible benefits.

He advised that the Ministerial Annual Review for TSH for 2020/21 had taken place virtually on 5 April and thanked all those involved in the preparation of the briefings for the review. An update in this respect was included on today's agenda.

Mr Moore offered thanks to Professor Thomson in relation to the Development Session which took place on 7 April, focused on forensic mental health and which had been tremendously helpful in interpreting the complexity of issues involved.

Mr Moore also advised that he welcomed the opportunity to attend the Patient Partnership Group in April where patients expressed an interest in the revised clinical model, in particular around timescale and the process of transition. This was helpful in helping to understand patients' views and in taking learning from past experience. He had also had the opportunity to attend the Clinical Forum in March and more recently, the Sportsman Awards which were focused on physical activity.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on his activities since the last meeting. This included his involvement in NHS Board Chief Executives meetings where they were discussion around the challenges facing the NHS and planning for recovery. He had also attended the System Pressures Meetings led by the Cabinet Secretary for Health and Social Care

He advised the Board that he had participated as a guest in a Joined Staff Side Development day held on 21 March 22, which had been led by an external facilitator. This had been arranged to help support The State Hospital (TSH) in being a partnership empowered organisation, and a follow up session was planned. He advised that the Corporate Management Team (CMT) were going to hold an away day on 4 May, including a review of lessons learned during the pandemic and to plan the future directional leadership of the organisation.

He asked the Board to note the work led by Ms Merson on submission of the Remobilisation Plan Quarter 4 Delivery Plan, which was due to be submitted to Scottish Government on 29 April. He emphasised two key areas as being the continued work on recruitment and on boarding of staff into the organisation as well as the improved position noted on attendance management. In addition, the importance of restarting the patient active day programme, and monitoring the impacts.

Mr Jenkins advised that he delivered a presentation to the organisation on 6 April, as part of the Seminar Series, which detailed areas of focus for TSH for the coming year across high level themes.

Further, he highlighted notification of termination of specific Covid-19 funding from Scottish Government and that financial planning analysis had commenced across directorates on post covid legacy costs and on potential savings. A Service Legal Agreement for the delivery of pharmacy services had been signed with NHS Lothian.

He continued to lead on pressures on patient flow within the forensic estate, and was in contact with senior leadership at NSH Greater Glasgow & Clyde in particular.

Mr Jenkins advised that detailed planning work was continuing on the implementation of the Clinical Model, including financial modelling, with full reporting to be brought to the next meeting of the Board in June 2022.

Alongside Professor Thomson he had participated in the Short Life Working Group into the Review of the Delivery of Forensic Mental Health Services, and the options appraisal process had completed scoring the long list options under consideration and reporting of the results was now due.

He outlined the correspondence from the Director General for NHS Scotland to all Board Chief Executives, dated 27 April 2022, which confirmed a stand down from the strategic intent confirmed by the NHS Chief Operating Officer in December 2021. There was to be a change to the emergency footing status for NHS Scotland at the end of April 2022. Mr Jenkins provided an outline of the key areas which included cross portfolio elements such as climate change and Fair Work, as well as issues relating to staff wellbeing, recruitment and retention. Further guidance had been received on the development of Annual Plans and the wider planning cycle. It was helpful to note that consideration would be given to bespoke planning being developed for National Boards

Following this update, Mr Currie noted the developments in the National Care Service, linking this to the Review of Forensic Mental Health Services and how whole system impacts may have an effect for TSH. He also noted the importance of benchmarking service delivery to pre-pandemic levels to ensure a useful comparator was taken. Mr Jenkins noted these helpful points and agreed about service delivery being benchmarked in this way.

In answer to a question from Ms Fallon on the Joint Staff Side Development Day, Mr Jenkins advised that the session had been aimed at ensuring support was provided to colleagues. Mr Connor commented that this session was helpful particularly around promoting cohesive working within Joint Staff Side and providing a platform for reflection on roles and aspirations. The external facilitator had been skilful in leading the session and feedback had been positive.

The Board:

1. Noted the update from the Chief Executive

7a COVID 19 RESPONSE AND REMOBILISATION - RESILIENCE REPORTING UPDATE

A paper was received from the Chief Executive (Paper No. 22/21) to provide the Board with an overview of the continuing response to Covid-19 by TSH and to provide key updates to the Board on actions taken since the date of its last meeting. Mr Jenkins provided an overview of the report, and highlighted that the stand down of NHS Boards from an emergency footing would impact strategic leadership and enable further focus on recovery.

He noted the information contained in the report which showed that there had been increases in cases in the patient and staff populations. This recent experience of outbreaks of Covid-19 infection had been carefully managed through very firmly established infection control guidance and practice, and governance through the Incident Management Team process for guidance and assurance. There were at the current time, no cases of Covid-19 infection within the hospital. At the same time, operational leadership through Safe to Start showed improvements in staffing capacity and delivery of services. Patient vaccination rates remained high at 88% and all new patients admitted to the hospital were being encouraged to take up this offer of vaccination.

Mr Jenkins emphasised the pressures within forensic service more widely, especially the challenges experienced in transferring patients ready to leave TSH and move to a medium secure setting. He was linking directory with senior leadership within NHS Greater Glasgow and Clyde in particular in this regard.

He advised that the Short Life Working Group (SLWG) set up to progress the structural changes required to the Family Centre to support in person visiting would report through the CMT, and that an update would be brought back to the Board. An update on digital visiting would be provided later in the meeting through the update on Digital Strategy.

In respect of reporting on key workforce issues, he noted that there had been significant development in terms of nursing recruitment, with a 7.6 variance in whole time equivalent posts to the end of March 2022, a much improved position. Considerable work had been taken forward in respect of workforce reporting to embed a strong system of monitoring. The Staff and Volunteer Strategy was included on today's agenda but it was of particular note was that the Staff Care Specialist had begun employment within the hospital and was already linking in with departments across the site. In respect of Personal Development Plan (PDPR) progress, he acknowledged that the position had remained static and that this had been impacted by the recent staffing pressures. There had been key focus on Prevention and Management of violence and Aggression (PMVA) and Soft Restraint Kit (SRK) training for patient facing staff groups to ensure their safety during this time, and there would now be a phased and planned return to ensuring the delivery of PDPR for all staff.

The Chair thanked Mr Jenkins for this report and noted the improving positions in respect to staff absence as well as recruitment and on boarding into the organisation. Ms Radage agreed on the positive nature of the report, and offered thanks to staff for their continued efforts. There was discussion around the nature of the assurance reporting the Board would need in the coming period balancing the useful nature of a high level summary report against the stabilising landscape and the need to live with Covid-19.

Ms Fallon noted that she had attended the Clinical Forum at its last meeting, in her role as Chair of the Clinical Governance Committee and there had been discussion around the timings of a phased return to re-starting workstreams and the complexities involved in doing so whilst also ensuring that staff continued to be supported. The Board discussed this aspect, and underlined the need to pause and reflect on the experience of the past two years and to sense check on the wellbeing of the organisation through its workforce. At the same time there should be opportunity for building on the achievements already made, and to take learning from this experience. This would help to inform the way forward. Mr Jenkins acknowledged this difficulty and the danger of moving forward too quickly especially given the lack of knowledge in the early stages of the pandemic about how long it would last, and how long the NHS Scotland would remain in an emergency footing as a result. Professor Thomson echoed this point, and also referred to the work underway through the Forensic Network in relation to taking lessons which would include detailed input from TSH.

Mr Moore provided a summary for the Board, in accepting assurance from this report, and also to consider the next phase of reflection and taking lessons. Future reporting to the Board in this area should include an opportunity to consider the structure of reporting.

The Board:

1. Discussed and endorsed the position outlined in the report in respect to the ongoing operational management and governance of the organisation in response to the global Covid-19 pandemic.

2. Agreed that there should be an organisational pause for reflection on learning from Covid-19, and input to the Board on this as well as the structure of reporting.

7b COVID-19 RESPONSE AND REMOBILISATION - FINANCIAL GOVERNANCE

A paper was received from the Finance and eHealth Director (Paper No. 22/22) to provide the Board with an update on financial governance to date during the Covid-19 pandemic.

Mr McNaught confirmed that a final submission for 2021/22 had been prepared for the Scottish Government Covid-19 Health Finance team. He highlighted the position for 2022/23 with notification that covid specific funding would not be provided within the 2022/23 allocation and all such costs would be considered as additional in-year pressures. A formal review had taken place with the Chief Executive officer, and budget planning would reflect this change going forward. The Board discussed the potential impacts for TSH including variance in impacts between costs and savings made during the changes in working practices during the pandemic. This was particularly evident in travel budgets where some savings had been made. Mr McNaught also highlighted the likely fluctuations and impacts from rising energy costs.

Mr Moore summed up the discussion highlighting the need for close monitoring in this area.

The Board:

1. Noted the updated advice on financial governance through the Covid-19 pandemic and potential pressures for 2022/23 costs.

8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 22/23) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register, and provided assurance that these were being addressed appropriately.

Mr Walker presented this report and highlighted the changes in respect of compliance with mandatory PMVA Level 2 Training and for SRK trained staff. He noted the proposal to remove impact

from EU Withdrawal from the Corporate Risk Register and this was discussed and agreed given the evidence that the organisation had not been adversely impacted.

Mr Moore thanked Mr Walker for reporting, and noted the continuing improvement in reporting in this area and thanked Mr Walker's team.

The Board:

1. Noted the content of this report.

2. Agreed that content represented an appropriate assessment of risk for the organisation and agreed the changes made as presented.

9 PATIENT STORY: "QUESTIONS FROM THE EXPERTS"

The Board received a presentation led by the Director of Nursing and Operations, and Ms McCaffrey introduced this by underlining the importance of hearing directly from patents, and taking on board their lived experience as experts in their own care.

Ms Sandie Dickson, Person Centred Improvement Lead joined the meeting and led the Board through a presentation on behalf of patients, in relation to their thoughts on the role of the Patient Partnership Group as well as the possibility of patients providing input to the recruitment process. This would enhance their role as experts in their own care. Ms Dickson outlined the possibility of the Patient Partnership Group providing input to this process through feedback on the type of qualities patients valued, and the type of questions they would like asked at interview.

The Board considered this as a welcome initiative although recognised that this would need to be developed carefully in that there may be some tensions in direct involvement by the patient group. Learning should be taken from across the Forensic Network, especially medium secure settings. Ms Davidson noted that work was underway with Human Resources to develop the recruitment strategy further and so this initiative could be linked, and Mr Jenkins added that this was something that the CMT would lead on.

Mr Moore compared this to initiatives to include care experienced individuals, or those with a disability in recruitment processes, and noted the Board's support for this and interest in receiving an update on progress. He thanked Ms Dickson for this presentation.

Action: Ms McCafferty/ Ms Davidson

The Board:

1. Noted the presentation delivered by the Person Centred Improvement Lead

2. Requested a progress update as this was developed.

10 NURSING REGISTRATION AND REVALIDATION REPORT

A paper was received from the Director of Nursing and Operations (Paper No. 22/24) to provide the Board with an update and assurance on registration of nursing professionals for the year 2021/22.

Ms McCaffrey summarised the requirements as well as the process involved in this, and the support that nursing staff were given throughout. She also noted the extension of three months provided by the National Midwifery Council, due to the pandemic. She advised that during this period, one nurse's registration status had lapsed.

Mr Moore asked if the staff member would be re- banded in terms of their pay if their registration had lapsed, and Ms McCaffrey confirmed that this was the case. In response to a question from Ms Fallon on the preparation required in this process, Ms McCaffrey outlined the local steps for compiling evidence and review by the line manager. She emphasised that this was firmly embedded in nursing practice and a well-used process. She was also asked to add in further detail around revalidation in future reporting. There was discussion centred on whether Covid-19 had affected the ability of nursing staff to progress continuous professional development. Ms McCaffrey advised that nursing staff were well supported to do so and the extension period of three months had also been a supportive mechanism, and was not aware of any concerns in this regard within TSH.

The Board:

1. Noted the content of the report.

2. Agreed that further detail on revalidation should be included in future reporting.

11 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A paper was received from the Head of Corporate Planning and Business Support (Paper No. 22/25) in relation to an update on progress made towards quality assurance and quality improvement activities since the last Board meeting. Ms Merson summarised the detail for the report for the Board, across the wide range of activity contained in reporting.

Ms Radage queried whether with reference to quality improvement, there had been any specific lessons learnt from the What Matters to You? and Learning into Practice programmes. Ms Merson noted that good progress was being made in embedding quality improvement initiatives and in reflecting good practice across the organisation, including these workstreams. For Learning into Practice, this was a developing process in TSH, and the intention was to provide an opportunity for staff to share experience and learning. Ms Fallon added that staff were to be commended on the improvements evidenced, especially during this period. She asked whether further update reporting could be included in respect to the Carers Clinic, and also whether there was clarity on the Forensic Network led CQUIF audit timeframe. Ms Merson agreed to ensure detailed information was included around the Carers Clinic on future reporting.

Action: Mrs Monica Merson

Professor Thomson advised that the Forensic Network were progressing work on the audit timeframe, and this had been delayed due to the impact of the pandemic and staffing capacity. The Forensic Network were taking forward work to set standards for the forthcoming audit, and the intention was to commence work in low to medium security firstly, then move to high security.

Professor Thomson also provided further advice around the shift in how to record patient activity, given that the Interim Clinical Operations Policy had included recording all types of activity. With the recovery from the pandemic, the intention would be to ensure accurate detailed recording of focused therapeutic activity programmes as this was key to care delivery.

Mr Moore asked if there was any update in respect of the Clinical Engagement Policy at a national level, and Ms McCaffrey confirmed that this was expected in June 2022 and would be taken forward to ensure learning at a local level.

Mr Moore noted that the detail provided within reporting on the Realistic Medicine Action Plan was very helpful, as well as the positive work being completed around the diabetes action plan. He underlined Professor Thomson’s remarks on the need to monitor timetabled activity carefully.

The Board:

1. Noted the content the report and update made over the previous 3-month period.

12 CLINICAL FORUM

The Board received and noted the agreed minutes of the meeting (Paper No.CF(M)21/06) of the TSH Clinical Forum which took place on 23 November 2021.

In addition, both Mr Moore and Ms Fallon advised of their attendance at the meeting on 22 March 2022, and commented on the valuable nature of the discussion within this forum and the work being progressed.

The Board:

1. Noted the content of the update CF(M) 21/06 from the Clinical Forum.

13 STAFF AND VOLUNTEER WELLBEING STRATEGY 2022-24

A paper was received from the Director of Workforce (Paper No. 22/26) in relation to the final draft of the Staff and Volunteer Wellbeing Strategy 2022-24. Ms Davidson led the Board through the key points of the strategy, emphasising the way in which staff wellbeing was central to delivering staff governance standards. She asked the Board to note that the strategy had been developed in consultation with groups and committees across the organisation to ensure that all staff groups had been able to contribute. Work had also been progressed through the Person Centred Improvement Team to include the views of volunteers.

Ms Davidson provided further background about the continuing development of the Wellbeing Centre as well as the benefit and wider support available through the Wellbeing Champions national network. She advised that the strategy focused on the eight key dimensions as outlined, linked to the work being progressed through the Healthy Working Lives Group and supported through the Action Plan included in the strategy.

Mr Moore thanked Ms Davidson for her helpful overview, and Ms Fallon echoed this noting that the strategy was structured well and placed appropriate focus on each dimension. She asked if it would be possible to incorporate that into the recruitment strategy to help demonstrate TSH as an attractive place to work. Ms Davidson confirmed that work was progressing in this regard especially around the use of digital platform and social media to help encourage young people to consider TSH as part of their future career development.

Ms Radage noted the importance of ensuring that wellbeing remained a key focus in a post pandemic landscape, and felt that the strategy offered assurance of this. She asked if there were any concerns about future funding to develop this workstreams. Ms Davidson confirmed that additional staffing had been resourced in support temporarily, and that this would require to be taken into account going forward to ensure resilience. Mr Jenkins added that this was a dynamic approach, and the changing profile around wellbeing would be key with appropriate focus placed on resourcing to it.

Mr Richards suggested that a trauma informed approach could be a helpful addition to the strategy, and it was agreed that this should be taken forward.

Actions: Mrs Linda Davidson

Mr Moore provided a summary, noting that this was a very dynamic area, and that the strategy was an evolving document. Staff Governance Committee would take detailed oversight of this workstream with reporting to the Board leading on from that. He offered thanks to Ms Davidson and her team for the work progressed.

The Board:

1. Approved the Staff & Volunteer Wellbeing Strategy 2022-2024, subject to the suggested amendments.

2. Agreed the assurance framework for reporting through the Staff Governance Committee send the Board.

14 ATTENDANCE PERFORMANCE REPORT

The Board received a paper from the Director of Workforce (Paper No. 22/27) outlining the high level position on staff attendance for the most recently reported period to 31 March 2022. Ms Davidson summarised the content including the comparator to the position in other Health Boards.

Members recognised the positive improvement in March for overall sickness absence, the increase in COVID absence, and the ongoing collaborative work between Human Resources and line managers to support staff back to the workplace.

Ms Davidson advised that work was underway with Occupational Health in respect of more detailed analysis of the pattern of sickness absence, and to develop quarterly updates.

Mr Moore noted the positive reduction demonstrated in sickness absence levels, and that this was an area that the Staff Governance Committee would take oversight of in terms of monitoring. Ms Fallon underlined the improvement made, and asked about Attendance Management training programme and whether this provided additionally to the training programme. Ms Davidson advised that this training provided support to line manager to apply the nationally adopted policy framework in this area. With new line managers coming into their roles, this was essential to help them in their development in new posts.

Mr Moore summed up for the Board, and noted that the positive direction of travel and the benefit for the workforce overall.

The Board:

1. Noted the content of the report, and continued progress in this regard.

15 WHISTLEBLOWING REPORT UPDATE

The Board received a report from the Director of Workforce (Paper No. 22/28) detailing the quarterly update, and Ms Davidson highlighted the key points with respect to the process for investigation of the two cases presented.

In terms of the position of Whistleblowing Champion, Mr Moore advised that the recruitment plan was being developed through Public Appointments team, with a view to interviews being held during the summer period.

The Board:

1. Noted the content of the report.

16 ANNUAL REVIEW OF STANDING DOCUMENTATION

A paper was submitted to the Board (Paper No. 22/29) by the Director of Finance and eHealth, which detailed the update on proposed minor changes to Standing Documentation. Mr McNaught provided a summary and confirmed that the Audit Committee met on 17 March and had provided approval.

He also confirmed that external audit work was progressing towards the end of year position for the Board.

The Board:

1. Approved the annual review of Standing Documentation

17 MINISTERIAL ANNUAL REVIEW 2020/21

A paper was submitted to the Board (Paper No. 22/30) by the Board Secretary, which provided an overview of the Annual Review of the State Hospitals Board for Scotland for the year 2020/21. This had taken place on 5 April 2022 by way of MS Teams; and was led by Mr Kevin Stewart, Minister for Mental Wellbeing and Social Care.

Mr Jenkin summarised the content of the review which had covered the initial response to the pandemic during 2020/21, as well as oversight of the more recent period during 2021/22. He asked the Board to note the content of the positive outcome letter received from the Minister and highlighted this would be communicated to staff.

Ms Fallon asked for clarity on the position for patients admitted from Northern Ireland, and Mr Jenkins confirmed that work was progressing with NHS National Services in this respect.

Mr Moore commended the preparatory work completed to ensure that the Minister was fully briefed on the progress made by the organisation during a challenging period. He confirmed that the key message from the Minister had been to thank staff for their level of commitment and work over the past two years. On behalf of the Board, Mr Moore noted that reporting would return in respect of following up the actions outlined.

The Board:

1. Noted the content of this report in respect of the Ministerial Review which took place on 5 April 2022 and, noted the letter from the Minister to the Chair to confirm the outcome.

2. Agreed that reporting should return to the Board on the action plan.

18 FINANCE REPORT AS AT 31 MARCH 2022

A paper was submitted to the Board (Paper No. 22/31) by the Finance and eHealth Director, which presented the financial position to 31 March 2022, month 12.

Mr McNaught provided a summary of the report, and advised that the draft year-end position subject to audit was £0.017m underspend, with breakeven a position anticipated for the year-end. This was currently undergoing review by the external auditors. He also advised that work was progressing on directorate budget reviews for the 2022/23 year.

Mr Moore asked whether there was any concern in reference to accruals, noting that this had been the case at the end of the 2020/21 year across all NHS Boards. Mr McNaught provided assurance that it was not anticipated that this would be a significant issue, and that any required adjustment especially around capital works which did not fall within the 2021/22 year would be discussed fully with the external auditors.

The Board was content to note this update report.

The Board:

1. Noted the content of the Finance Report, to 31 March 2022, month 12.

19 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 22/32) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project and planning for the remainder of this year.

Mr Walker noted the key elements of reporting including minor change to the terms of reference for the Project Oversight Board. Further that it was proposed that additional reporting would be made during the private session of the Board due to commercial sensitivities and security detail. The Board noted this update and agreed the changes as outlined.

The Board:

1. Noted this update in relation to the perimeter Security and Enhanced Internal Security Systems Project and that further reporting would be presented during a private session today.

2. Approved the changes to the Project Oversight Board Terms of Reference as reviewed and agreed at the Project Oversight Board on 21 April 2022.

20 DIGITAL STRATEGY UPDATE

The Board received a report from the Director of Finance and eHealth (Paper No. 22/33) which provided an overview of recent activities. Mr McNaught described the progress made in each area outlined in reporting. He highlighted the success of the projects to delivery an upgrade to RiO (the electronic patient record system) as well as to install HEPMA (electronic prescribing). He also noted that work would be taken forward in respect of a trial of a new mode of virtual visiting during May 2022.

Professor Thomson added that from a clinical perspective, the work delivered in respect of RiO and HEPMA represented a major step forward for the organisation.

Mr Moore echoed this as a significant achievement and offered thanks to the eHealth team on behalf of the Board. It was agreed that an update should be presented to the Board in respect of the virtual visiting trial.

The Board:

1. Noted the content of this report.

2. Requested an update on virtual visiting,

21 CORPORATE GOVERNANCE IMPROVEMENT PLAN – UPDATE

The Board received a report from the Board Secretary (Paper No. 22/34) which provided an update on The State Hospital (TSH) Corporate Governance Improvement Actions Plan that support the key corporate governance priorities as part of the NHS Scotland Blueprint for Good Governance. Ms Smith introduced this item by noting that this related to a previous self-assessment exercise carried out by the Board in 2018, and that alongside the national progress being made on updating the guidelines on the Blueprint for good governance, it was expected that arrangements would be made for a further self-assessment to be carried out by NHS Boards this year.

In respect of the existing plan, she outlined the progress made to date. Mr Moore added that the new guidance would include external evaluation. There was agreement round the table on the proposed amendments to the improvement plan, and that it would be helpful for Non-Executives to be included in welcoming staff to the organisation through their induction.

Action – Ms Smith

Mr Moore summed up for the Board, noting progress had been made in key areas.

The Board:

1. Noted the content of this report, in particular the key areas of development, and those actions that could be closed.
2. Welcomed the opportunity for Non-Executive Directors to welcome new staff through the induction process.
3. Noted that new national guidance would be circulated shortly to support board development.

22 AUDIT COMMITTEE

The Board received the agreed minutes of the meeting (Paper No.AC(M)21/05) of the TSH Audit Committee which took place on 7 October 2021.

The Board:

1. Noted the content of the update AC(M)21/05 from the Audit Committee.

23 ANY OTHER BUSINESS

Mr Jenkins took the opportunity to wish Mr Richards every success in his secondment to the Scottish Government in his Associate Chief Nursing Officer role. Mr Moore echoed this and thanks to Mr Richards for his substantial contribution during his time at TSH. There was warm agreement around the table from the Board.

24 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on 23 June 2022, by way of MS Teams.

25 PROPOSAL TO MOVE TO PRIVATE SESSION

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

The meeting ended at 1315 hours

ADOPTED BY THE BOARD

CHAIR

DATE

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught	Adjusted to June 22	Update August 21: Update included in Covid response report at Item 7a. Full report to be brought to October meeting Update February 22: trial of new system used in other high secure hospitals pending start date = delayed due to need for full DPIA to be completed. Update to Board in December. Update April 22 – Work progressing to pilot following completion of DPIA- update on agenda as part of digital strategy **<u>Update June 2022:</u> Update as part of Covid report on today's agenda including comparator visit to high secure unit**

2	August 2021	Covid Resilience Report (Item 7a)	To progress work on link between performance metrics and the governance structure e.g. how do individual metrics get tracked.	M Merson/ M Smith	Re-adjusted to May 2022/complete	Work in progress as part of performance metrics / active governance and update to be brought back to board. Update - Active Governance session scheduled for Jan 2022 postponed by agreement, and rescheduled for 3 May session. **<u>Update June 2022</u>– Active Governance Session took place, and follow up actions to be considered through ongoing review of reporting to committees and board. Add as standing item to next committee and board meetings, and track progress through Corporate Governance Improvement Plan, CLOSE**
3	December 2021	Patient, Carer Volunteer Story (Item 8)	Request that stories return to being presented first hand, using digital means if possible, as soon as service delivery allows.	K McCaffrey	Adjusted to August 2022	Update April 22: The use of ‘digital touchpoints’ will be a feature of the presentation the April Board. **<u>Update June 22</u>– this wasn’t possible for April Board – plan in place with PCIT/Communications to be brought back to Board.**

4	February 2022	Resilience Report – Covid-19 (Item 7a)	Updating on Family Centre infrastructure/ capital plan and progress of SLWG	D Walker	Adjusted to June 2022	**Update June 2022: Reported progress to CMT on 1 June, and included progress report in Covid report on today's agenda**
5	February 2022	Corporate Risk Reg (Item 8)	Update on directorate review of risks with Risk team – ensure added as topic to Board Seminar programme for 2022 - to agree timing/ content.	D Walker/ M Smith	August 2022	**Update June 2022: Progressed with RSMUK, with planned programme agreed and in place, session dates to be confirmed and arranged.**
6	February 2022	Performance report Q3 (Item 20)	Review presentation of data re professional attendance at CPAs to give more clarity.	M Merson	June 2022	**Update June 2022: On agenda as part of annual performance reporting.**
7	April 2022	Covid Report (Item 7a)	Board review of living with covid, going forward	M Smith	June 2022	**Update June 2022: CMT leading review – update within Covid Report on today's agenda.**
8	April 2022	Patient Story (Item 9)	PCIT proposal for patients to be part of recruitment for patient facing staff – to be considered for CMT agreement then update to Board.	K McCaffrey	August 2022	**Update June 2022: Work progressed initially through PPG to provide a number of suggested scenarios drafted by patients for use in recruitment - focus on issues important to patients and their care and treatment. To be taken**

						forward through CMT.
9	April 2022	Nurse Registration Report (Item 10)	Add revalidation into reporting for next report in 2023	K McCaffrey	Immediate	**Confirmed added to reporting for future – CLOSE**
10	April 2022	QA and QI (Item 11)	Update on Carer's clinic workstream	K McCaffrey	December 2022	**Update June 2022:** **Progress with clinic in 2 Hubs during Feb – May 2022. Given positive feedback, further clinics will be held on 3-monthly basis. Feedback Reporting to be prepared end of November, and then update back to the Board.**
11	April 2022	Staff and Volunteer Wellbeing Strategy (Item 13)	Highlight wellbeing workstream and also develop digital means e.g. podcasts to demonstrate TSH as positive place to work. Add Trauma Informed approach to strategy.	L Davidson L Davidson	August 2022 Immediate	**Update June 2022:** **Progressing as part of the roll out of the Action Plan and also for the Recruitment Strategy.** **Information was added in the final version of the document and will be included in the Actions – CLOSE**

			Add timetable of assurance reporting to staff governance committee as well as Board	L Davidson/ M Smith	Immediate	**Board Workplan adjusted. Standing Item for Staff Governance Committee – CLOSE**
12	April 2022	Ministerial Annual Review (Item 17)	Action list to respond to Minister's letter – report through CMT and Board	M Smith	August 2022	**Update June 2022:** **Report to CMT on 6 July and update to next Board in August.**
13	April 2022	Corporate Governance Action Plan	Confirm Non- Executives are added to Inductions	M Smith	August 2022	**Update June 2022:** **Confirmed with Learning Centre that this is scheduled as part of inductions – consider in-person or digital means as part of Corp Gov. improvement Plan.**

Last updated – 17.06.22 – M Smith

Author:
Margaret Smith
Board Secretary
01555 842012

Paper No. 22/42

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 7a
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	TSH Response to Covid 19 Global Pandemic – Update
Purpose of Report:	For Decision

1 SITUATION

The Board receives an update report at each of its meetings in respect of the continuing response to the global Covid-19 pandemic by The State Hospital (TSH). Within the context of the changing outlook for the pandemic, NHS Scotland ceased to operate on an emergency footing at midnight on 30 April 2022.

However, it is recognised that there continues to be a need for mitigation of this risk to minimise, as far as possible, transmission of the virus through staff and patient populations. Focus is now on what is required to enable TSH to safely deliver services whilst living with Covid-19.

Therefore, this report will provide the Board with a detailed update on the framework through which TSH has continued to manage its response to Covid-19, since the date of the last Board meeting. At the same, to present a proposed new framework for reporting to the Board at each of its meetings on the overall risk and resilience position of the hospital.

2 BACKGROUND

2.1 Board Governance

Throughout the Covid pandemic The State Hospitals Board for Scotland has been able to maintain all aspects of board governance, including its regular schedule of Board and Committee meetings, except for a short postponement of the Audit Committee originally scheduled in January 2022. There have been no further changes in the past two months, and the Board has now returned to its schedule of development sessions and a return by Non-Executive Board Members to on-site visits to participate in a range of engagement activities. The Board is scheduled to re-consider its mix of digital and in-person meeting arrangements at its next meeting in August as part of the Corporate Governance Improvement Action Plan.

2.2 Senior Leadership and Management Structure

Since the date of the last Board meeting, the organisation has continued to operate through normal governance arrangements led through the Corporate Management Team (CMT) and its wider reporting groups.

The CMT receives a full range of reporting relating to the impacts of Covid-19, including formal assessment of risk, care delivery impacts and surveillance /modelling reporting. This also includes links to NHS Lanarkshire's Horizon Scanning Group. In addition, national guidance is reviewed to ensure an appropriate TSH response, and to ensure alignment with NHS Scotland strategy. The hospital has experienced outbreaks of Covid-19 infection during this period, and oversight of these has been taken through the Problem Assessment Group/ Incident Management Team structure led by the Director of Nursing & Operations. Further detail is included in the following section.

The CMT held a development session on 4 May, and a follow up to this on 23 May. This enabled a pause by the senior leadership team to consider organisational strategy and operational priorities underpinning planning; as well as the management and governance structure through which to deliver these priorities. This is focused in particular on how to build a bridge between clinical leadership through Hub Leadership Teams, linked directly to the operational structure through the Organisational Management Team (OMT). This work is progressing and will be reviewed by the CMT at its next meeting on 6 July 2022. Establishing this new framework will be essential for the implementation of the new clinical model.

3 ASSESSMENT

This aims to provide the Board with a review of the key decisions taken and how these align with the framework outlined in the previous section.

3.1 TSH Route Map and the Interim Clinical and Support Services Operational Policy

The Board has been kept advised on decision-making for the delivery of care within TSH through adjustment of the Interim Clinical and Support Services Operational Policy. This has included scrutiny and review of the data gathered by the Clinical Quality team, focused on impacts on patients. This has been kept under review by the CMT to ensure continued focused consideration of how best to ensure that patient activity is delivered most effectively, and there was a return to the pre-pandemic model of patient activity on 9 May.

With this change, the remit of the Operational Model Monitoring Group (OMMG) which has monitored patient activity throughout the pandemic is now being reviewed. The aim is to maintain close oversight of patient activity and how performance in this area can be measured and reported through existing governance structures.

A revised terms of reference for is being developed to transition OMMG into the Activity Oversight Group.

3.2 Infection Control Committee

The Infection Control Committee meets monthly providing oversight for the management of Covid -19 within TSH, and additional support continues to be received from NHS Lanarkshire. This includes detailed review of National Guidance on infection control requirements for any impact on TSH. The programme of Covid-19 audit work is embedded as part of the wider

programme of infection control audit, and the Director of Nursing and Operations is progressing work to ensure appropriate ownership of compliance at a local level within wards and departments.

ON 16 May, the Healthcare Improvement Scotland (HIS) Infection Prevention and Control (IPC) single set of standards for use in health and adult social care were published. NHS Boards have been instructed to undertake implementation within a three-month period to embed the new standards, concluding on Monday 8 August 2022. This is in support of the Once for Scotland approach and further integration of health and social care.

The standards will underpin HIS programme of inspection of the safety and cleanliness in acute and community hospitals. The Healthcare Environment Inspectorate (HEI) will use these standards as a basis for inspection in NHS Hospitals. These standards are a revision of those issued in 2015 and the process for HEI inspection has not changed.

Within TSH, this is being led by the Director of Nursing and Operations, with reporting to the CMT. Prior to the pandemic, the Board received dedicated reporting on infection control and management of the risk of hospital acquired infections, and it is proposed that there should be a return of this reporting to the Board at each of its meetings.

3.3 Covid-19 Incidence

There are clear guidelines in place for incidence of Covid-19 in both the patient and staff cohorts following national guidance. Table 1 provides the data for testing and confirmed cases of Covid-19 within the patient population in TSH over the past six months.

Month	Dec	Jan	Feb	March	April	May
Total Tests	125	64	23	138	70	77
Positive results	10	4	22	15	0	20
Negative results	115	60	1	123	70	57

Table 1: Patient testing and results

Table 2 below provides the updated position on staff testing and incidence of Covid-19. To the end of May, this provides the total number of PCR tests reported for staff members, in numerical and percentage terms across each month as well as an indicator of the positivity rate as compared to the whole staff group numbers. However, as most testing is now conducted via LFT, the figures from February onwards represent the number of staff who reported covid infection, following either type of testing. It can be seen that the practice from May consists of notification of a positive test only, with the data indicating the lowest positivity rating for staff as a whole since the start of the pandemic.

	Total	Positive results	Negative results	% positive tests (of all tests)	% positive rate (of staff *wte n650*)
December	140	39	101	27.9%	0.06%
January	114	54	60	52.6%	0.08%
February	64	49	15	76.6%	0.08%
March	123	111	12	90.2%	0.17%
April	46	38	8	82.6%	0.06%
May	18	18	0	100%	0.03%

Table 2: Staff testing and results

3.4 Response to Outbreaks

During May, the hospital experienced covid infections in four wards, and three of these were formal outbreaks with two or more patients affected. These outbreaks were managed through the standing up of an Incident Management Team (IMT) with colleagues from NHS Lanarkshire and the Outbreak Management Team from Scottish Government. The hypothesis reached was that the outbreaks were a consequence of asymptomatic transmission.

The actions taken included patient testing and isolation of wards, reinforcement of the message regarding PPE compliance, as well as continuation of the enhanced cleaning measure in place by both housekeeping and ward staff. Ward closures were managed throughout the course of this period in line with well-established practice for infection prevention and control. The wards affected wards were able to re-open by 12 June 2022.

At the time of reporting in week beginning 13 June 2022, four patients have tested positive for Covid-19, with one ward confirmed as experiencing a formal outbreak. An update on this will be provided at today's meeting.

3.5 Covid-19 Vaccination Programme

All newly admitted patients continue to be offered vaccination, depending on their individual stage within the vaccination cycle. Uptake is monitored and patients are supported and advised on the importance of vaccination.

3.6 Test and Protect

TSH is following national guidance in line with the Test and Protect Transition Plan, including voluntary self-testing by Lateral Flow Device (LFD) and to register their test results. As part of this plan, contact tracing for staff ended on 1 May, in line with the general population.

All contractors coming on site continue to undertake LFD testing, and are required to report their test prior to coming on site, and the Estates Manager oversees auditing of this process to ensure compliance.

3.7 Clinical Care Guidance for COVID-19 patients

Throughout the pandemic, the Board has received regular reporting on the reviewed contingency planning for the delivery of enhanced care for patients on site for symptoms of Covid-19, in the context of pressures on service delivery in NHS Scotland. There has been no change to the position that NHS Lanarkshire have continued to have capacity for a model of care delivery wherein any TSH patient who requires acute medical care, will be transferred to a general hospital.

3.8 Personal Protective Equipment

TSH continues to be linked with National Services Scotland (NSS) through procurement. To date, there have been no issues with stock availability on site.

3.9 Patient Flow

The Board has received regular reporting in respect of TSH links with medium and low security care providers for contingency planning for transfer of patients between secure mental health services as part of the Forensic Network Capacity Plan. The Board is asked to note the

continued pressures due to capacity challenges within the medium secure setting in particular presently.

The following table outlines the high level position from 1 April 2022 to 31 May 2022.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	7	0	7
Discharges / Transfers	3	0	3
Average Bed Occupancy: Available beds/All beds			97.5% / 83.6%

Table 3: Patient flow 1 April 2022 to 31 May 2022

Prior to the pandemic the Board received dedicated reporting on patient flow across the forensic estate and it is proposed to return to this reporting at each meeting.

3.10 Virtual and In-Person Visiting

The current model of in-person visiting allows most visits to take place in the Family Centre, with a limited number taking place in the ward environment due to the identified need of individual patients. Volunteers continue to support those patients who do not have designated visitors. TSH follows national guidance on hospital visiting, to ensure compliance with infection control guidelines. Visitors are encouraged to undertake Lateral Flow Device (LFD) Testing, on a voluntary basis to help support infection control within the hospital.

A Short Life working Group (SLWG) has been commissioned by the CMT to consider the re-purposing of the Family Centre as the main visiting area. This re-purposing will provide a person centred approach to visiting and involves a number of security enhancements to create a safe and secure environment for patient visits. The SLWG is progressing this through consideration of the scope of recommended works and an agreed reporting timetable. This will produce a report recommending design and technical specification by mid-July so that an 'Outline Business Case' can be developed.

Indicative cost for the project are currently estimated to be in the region of £80 -100k. TSH capital funding for 2022/3 has been already been agreed and assigned to other projects across the hospital. Once detailed costings have been obtained, the TSH Capital Group will review the cost against the 2022/23 agreed spend to assess any available funding in this period. Should this not be feasible, a request for additional funding could then be made to Scottish Government; or alternatively the project timing could draw on the 2023/24 TSH capital allocation meaning the project would begin in April 2023. Procurement have advised that following project initiation, the procurement phase can proceed and is anticipated to take between three to four months to complete.

Virtual visits continuing to take place through video-conferencing and this is a valued means of keeping in contact for many patients and carers. At the same time, the eHealth Team is progressing an evaluation of virtual visiting packages to help establish the most optimal digital

platform. This includes scoping functionality and viability, and the team visited another high secure area during June to see this working at first hand.

3.11 Workforce

3.11.1 Attendance Management

The Board receives dedicated reporting separately in respect of attendance performance, including Covid-19 related absence.

3.11.2 Planning for Extreme Loss of Staff

TSH has an Extreme Loss of Staff Plan for TSH, developed in response to a significant threat to business continuity, and it has not been necessary to put this into action to date.

3.11.3 Staff Recruitment

Human Resources have continued to take forward the recruitment process for all confirmed positions with appointments made across a range of disciplines. There are currently 19 posts actively moving through the recruitment process from the following departments: Nursing, eHealth, AHP, Psychology, Housekeeping, Catering, Forensic Network and the Sky Centre. Since the date of the last Board meeting, recruitment activity has concluded for posts within Ward Based Nursing, eHealth, Catering and Housekeeping, Security, Psychology and Corporate Services.

There is particular focus on the recruitment of registered and non–registered nursing staff. This includes the prioritisation of on-boarding of new recruits into the organisation, including expediting inductions and training programmes. Nurse staffing is further supported through continued development of a system of supplementary staffing and nursing bank. The Director of Nursing and Operations is leading this programme, working in partnership, through a dedicated short life working group to monitor progress. Staff are being supported to through training to help them commence in their new role, whilst ensuring that this does not impact on their substantive role within the organisation.

The Head of Human Resources is leading development of recruitment strategy, to promote TSH as an employer through innovative means to attract applicants into the organisation from across all disciplines in what is a competitive arena.

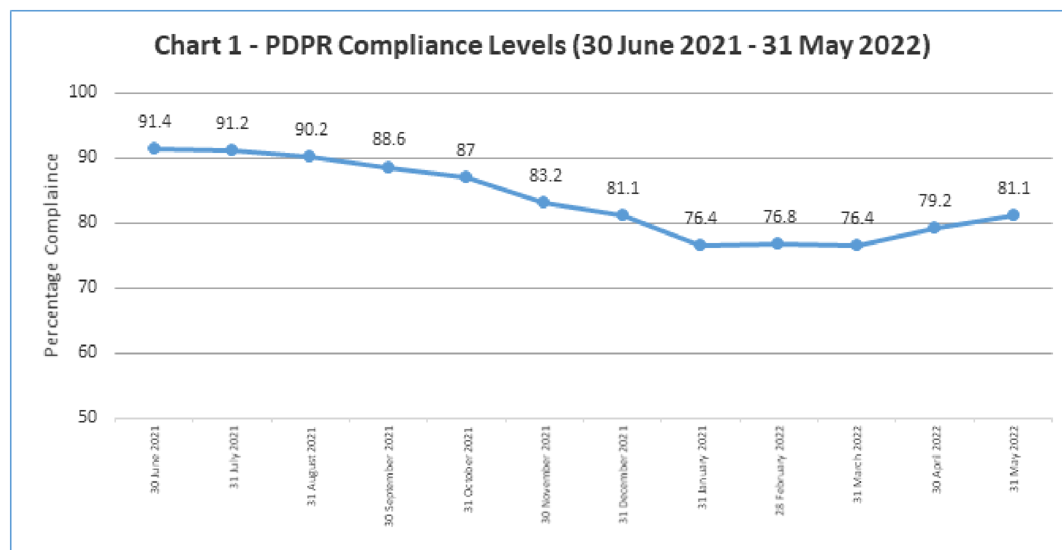
3.11.4 Staff Wellbeing

The Board approved the Staff and Volunteer Wellbeing strategy at its last meeting April 2022. This set out an agreed plan for assurance reporting to the Board and Staff Governance Committee in this respect. Therefore, the Staff Governance Committee will receive quarterly updates meaning that this will now be a standing item on the committee's agenda. In addition, the Board will receive reporting twice within each reporting year.

In the meantime, it is highlighted that alongside the range of wellbeing opportunities offered through the Staff Wellbeing Centre and the National Wellbeing Hub, the CMT has commissioned a review of delivery of these opportunities to ensure that all staff are able to access and benefit from these services regardless of the nature of their role within the organisation. This gives particular consideration to how best to provide an outreach service to staff in patient-facing roles e.g. in wards area; or staff continuing to work in a hybrid pattern of on-site and home working. This initiative will be supported through the HR and Wellbeing Group.

3.11.5 Personal Development Planning and Review (PDPR) compliance

Chart 1 shows the trend in organisational PDPR compliance levels for the 12-month period from 30 June 2021 to 31 May 2022.



As at 31 May 2022:

- The total number of current (i.e. live) reviews was 495 (81.1%).
- A total of 76 staff (12.5%) had an out-of-date PDPR (i.e. the annual review meeting is overdue)
- A further 39 staff (6.4%) had not had a PDPR meeting. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

Following the stand down of incident command in January 2022, there has been a targeted focus on the delivery of training in the Prevention and Management and Violence and aggression (PMVA) Level 2 training alongside training in the use of soft restraint kits (SRK) for front line staff to ensure their safety in fulfilling patient–facing roles. This had an impact of the delivery of individual PDPRs, however, compliance in this respect is now improving with an increase by 4.7% since the previous report in March 2022. Line managers are being supported to help them to make progress in this area for all staff.

3.12. Communication

Recognising the key importance of this area, the Board has asked for an update on work progressing in respect of service transformation, and this will be presented as part of today's Board meeting.

Staff Bulletins have continued to provide regular communication throughout the organisation, providing high level feedback to staff about national developments, as well as more local updates for TSH, including local outbreaks and helping to ensure that all staff are aware of changes in national guidance.

3.13 Digital Technology

The Board now receives regular updates on the programme of digital transformation for the hospital, and dedicated reporting in this respect is received at every second meeting.

4 REPORTING

The Board has received this report at each of is meeting since the start of the pandemic, commencing at its meeting in April 2020 to date. This has provided a detailed summary of governance and the operational response led by TSH in response to the emergency footing of NHS Scotland throughout the pandemic. Although this position has substantially changed as of 1 May 2022, it is recognised that learning can be taken from this streamlined form of reporting. Further, that there has been benefit from raising the profile of risk reporting to the Board within its agenda.

In light of this, it is proposed to retain the "Risk and Resilience" section of the Board agenda to include the following reports:

- Corporate Risk Register
- Infection Prevention and Control (including Covid Incidence/Outbreaks, Vaccination and PPE updates as presented here).
- Patent Flow/ Forensic Network Contingency Planning

In addition, there should be high level reporting within "Staff Governance" section of the Board agenda for workforce reporting including: Attendance Management, Recruitment and On-boarding and PDPR compliance. There is a framework in place for specific update reporting on the Staff and Volunteer Wellbeing Strategy.

A key area of focus in this report to date has been patient visiting, due to the changes made to the offer made throughout the pandemic, and the learning this has brought for making change and the possibility of improvements in the longer term as a result. There are two workstreams underway presently, for in-person and for virtual visiting. It is proposed that the Director for Security, Resilience and Estates should bring specific reporting to the Board at every second meeting on the project underway for the Family Centre. Further that the Digital Transformation reporting brought by the Director of Finance and eHealth should encompass reporting on the work being progressed in respect to virtual visiting.

It is also proposed that the Head of Communications will bring an update to every second meeting of the Board on the progress on service transformation of the communications function. The Board Secretary should continue to provide reporting to every second meeting in respect of the Corporate Governance blueprint including board governance and development of the senior leadership and management structure.

5 RECOMMENDATION

The Board is invited to:

1. Discuss and endorse the position outlined in this report in respect to the operational management and governance of the organisation in response to the global Covid-19 pandemic in the past two-month period.

2. Discuss and consider approval of the proposal to vary the way in which reporting is brought to the Board, given the end of NHS Scotland emergency footing and a shift in the landscape to living with Covid-19. This should take into account the move to strategic planning led locally by the Board, and senior leadership of dedicated workstreams. The Board Secretary will adjust the board workplan to ensure that this is delivered throughout the year as planned.

Author:
Margaret Smith
Board Secretary
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MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support operational management and governance structure of the NHS Board during Covid 1-19 emergency response ensuring the NHS Board received detailed reporting across directorate areas.
Workforce Implications	Considered in this report – noting staff wellbeing, staff appraisal arrangements and recruitment.
Financial Implications	Financial implications outlined within a separate dedicated Financial report related to Covid-19 presented at same Board meeting
Route to Board Which groups were involved in contributing to the paper and recommendations.	Board requested for each meeting
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Fully outlined and considered in the report: staff patients, carers, volunteers
Equality Impact Assessment	Not required for this report as monitoring summary 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).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

Paper No. 22/43

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 8
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Risk Management Facilitator
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix A.

3.2 Review Dates

All CRR Risks are currently in date

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

- Following a review of the Security Directorate Corporate Risks – **SD54 Climate change impact on The State Hospital** - is to be reviewed by the Sustainability Group to better align with DL38 - The Climate Emergency and Sustainable Development Policy. The risk assessment will look to focus on our compliance with the policy as well as the potential impact to the wider hospital should this not be implemented. Update will be provided to the Sustainability Group at the next meeting which is taking place in mid-June.

- **HR1 - The risk that the State Hospital is not complying with the nationally agreed Staff Governance Standards** – Reviewed by Head of HR and HR Director. Agreed that no requirement to include in the Corporate Risk Register as there has been no incidents of non-compliance within the Hospital and is of no concern at present.

3.4 Corporate Risk Register Updates

IT Risk Updates

Work is currently underway to update IT Corporate and Local Risk Registers.

Risk	Action
IT4 - Maintenance of System Backups	Actioned by Senior eHealth Analyst. Now on the Local Risk Register.
FD91 - IT System Failure	Due to be approved at CMT in July 2022
FD98 - Failure to Comply with Data Protection Arrangements	Due to be approved at CMT in July 2022

HRD112 – Compliance with mandatory PMVA Level 2 refresher training – Risk was reviewed at June CMT with agreement to reduce to Medium. Likelihood has been decreased to Unlikely from Almost Certain. Training plan is progressing well and continues to be monitored through hospital groups. The compliance level is now at 87% for PMVA level 2 up from 54% in February, risk of non-compliance is considerably less as a result.

ND73 – Lack of SRK Trained Staff – Risk was reviewed at June CMT with agreement to reduce to Medium. Likelihood has been decreased from Likely to Possible. There are now over 77% of staff trained within the target group, up from 42% in February 2022. Work is still ongoing to further reduce this risk by continuing to provide training to staff.

3.5 High and Very High Risk – Monthly Update

The State Hospital currently has **Four** 'High' graded risks, latest updates are below:

- **Chief Executive: CE14 - The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.**

Monthly Update: Risk was reviewed at June CMT with agreeing to remain at current level, hospital still continues to be affected by Covid related risks. Risk Assessment will be reviewed from now on at each Infection Control Committee with update passed to Chief Executive for review.

- **Director of Nursing: ND71 - Failure to assess and manage the risk of aggression and violence effectively.**

Risk is at target level and continues to be managed effectively with existing procedures and training. Violence and aggression incidents monitored by Risk & Resilience Team through Clinical Governance Group.

Monthly Update: Level 3 PPE training has been approved and is due to commence in June 2022.

- **Medical Director: MD30- Failure to prevent/mitigate obesity.**

Monthly Update: Obesity figures continue to decrease– **81.1% down from 85.8%.** The Supporting Health Choices action plan agreed in Aug 2021 has supported the ongoing action of the 'Counterweight plus' program, update of physical activity target to 150mins/week (matching national target), review of patients shopping bags, audit of patient meal preferences when colour coded for health and the commencement of some clinical pauses to focus on supporting weight management.

The appointment of a project manager for the SHC project is awaited.

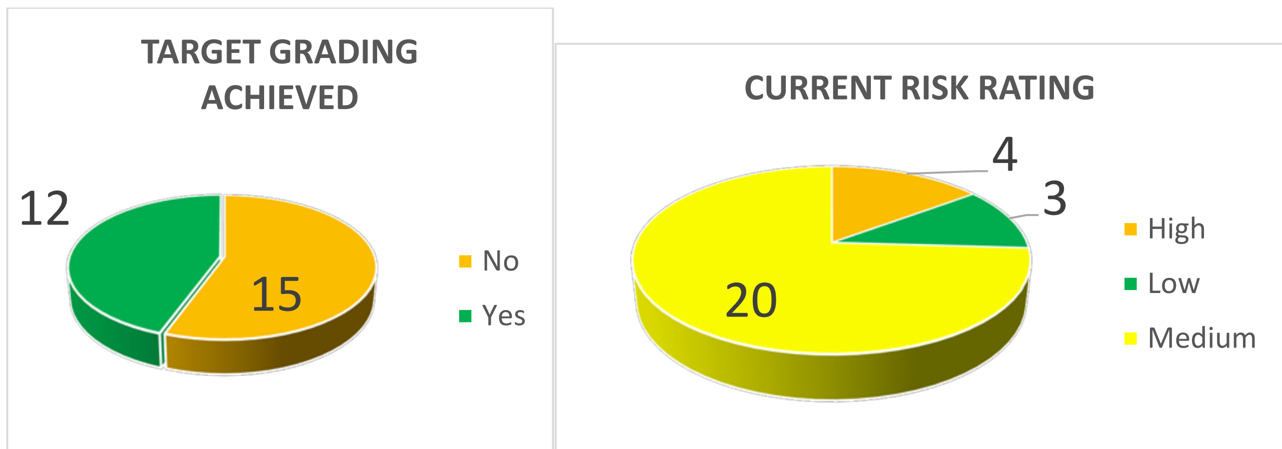
- **Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.**

Monthly Update: Staffing issues continue to affect TSH. Daily meeting takes place to monitor staff resources in real time managed through the 'Safe to Start' Process. Recruitment is ongoing.

Improvements made to escalation process and lead nurses overseeing to ensure consistent application. Training and development has been carried out to support effective rostering and again the Lead Nurses have oversight of this. DATIX reporting also under review to provide more detailed information.

There has also been progress regarding supplementary staffing. Currently focusing on the nursing pool and revising the fixed term contracts with a view to bringing all these into one supplementary staff register.

3.6 Risk Distribution



Currently 12 Corporate Risks have achieved their target grading, with 15 currently not at target level.

As per the TSH Risk Management Strategy, Low and Medium risks are tolerated within the organisations risk appetite. While some of the Corporate Risks have not met their target level, they still remain within the agreed risk parameters. Ongoing work is underway to reduce risks to target level and is being further monitored through the work plan detailed below.

A work plan is underway to focus on risks not at target level in Q1 2022/23, this will be taken forward by the Risk Management Facilitator and Head of Risk and Resilience who will liaise with risk owners. The work plan will involve working with risk owners and action officers to ensure risks are up to date and relevant, review ongoing work to reduce risk to target level and ensure appropriate grading. The aim is to meet with one directorate each month going forward with updates given to CMT and The Board through this report.

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70,	MD30	
Possible			CE12, SD54, SD57, FD91, ND73	ND71, CE14	
Unlikely			MD33, FD90, HRD110, HRD112	MD34, HR111, SD51, SD50	
Rare			FD97, CE13, SD52,	MD32, FD96, SD56,	CE10, CE11, SD53

Review Periods:

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

4 RECOMMENDATION

The Board are invited to review the current Corporate Risk Register, and approve it as an accurate statement of risk. There Board are also asked to feedback any comments and/or additional information members would like to see in future reports.

Paper No. 22/43

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report provides The Board with an update of the Corporate Risk Register.
Workforce Implications	There are 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	Board workplan/ 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)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

- Blue denotes risk that will be leaving the CRR

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/06/22	Board	Y/Y	N/A	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	01/09/22	Clinical Governance	Y/Y	N/A	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	01/09/22	Risk and Resilience Group	Y/Y	N/A	Quarterly	-
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	01/09/22	CMT	Y/Y	N/A	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Major x Possible	Minor x Possible	Chief Executive	Chief Executive	01/07/22	CMT	Y/Y		Fortnightly	Likelihood ↓
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/07/22	Clinical Governance Committee	Y/Y	Y/Y	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	01/08/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	01/08/22	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	01/08/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	01/08/22	CMT/Risk and Resilience Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/08/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	01/08/22	Infection Control Committee	Y/Y	N/A	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	01/08/22	CMT	Y/Y	N/A	Quarterly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/07/22	CMT	Y/Y	Y/Y	Quarterly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	01/07/22	CMT	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/07/22	PMVA Group and CMT	Y/Y	N/A	Monthly	Likelihood ↑
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	30/05/22	Audit Committee, RF&P Group & CMT	Y/Y	N/A	Quarterly	-

Corporate FD 91	Service/Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance & Performance Director	Head of eHealth	30/05/22	Information Governance Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/05/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/07/22	Information Governance Group & CMT	Y/Y	Y/Y	6 Monthly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Unlikely	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/05/22	H&S Committee	Y/Y	N/A	Monthly	Likelihood ↑

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 9
Sponsoring Directors:	Chief Executive & Medical Director
Author(s):	Chief Executive Head of Planning & Performance Consultant Psychiatrist
Title of Report:	Clinical Model Planning
Purpose of Report:	For Decision

1. SITUATION

Planning for implementation of the Clinical Model was at an advanced stage prior to the Coronavirus pandemic. Work was paused in March 2020. Planning restarted in June 2021 to consider: the current context, the work undertaken in 2020, the ongoing validity on the model, and any new issues worthy of consideration prior to any relaunch of the project.

A project group had reformed and initial planning took place, however, progress was limited due to the impact of the omicron variant in December 2021.

2. BACKGROUND

The clinical care model describes the way The State Hospital provides high secure services to patients with a mental disorder, many of whom have offended. The need to review the Clinical Care Model arose from issues raised through a staff engagement exercise which focused on readiness to change. The Board have received updates throughout the year on progress.

In February 2022, the Corporate Management Team (CMT) agreed the following priority actions to enable sequencing in preparation for the implementation of the Clinical Model in the financial year 2022/23:

- Description of the project management elements in the form of a Project Initiation Plan
- Assessment and review into nursing workforce requirement
- Preliminary engagement with staff, patients, carers, Clinical Forum, Forensic Network and Scottish Government
- Assurance that patient activity is a key feature within the model
- Clarity about planning assumptions and associated project elements.

3. ASSESSMENT

This paper updates the Board in two ways:

Section 1 of this report is the final draft Project Initiation Document (PID).

The PID provides a 'detail plan' of issues and elements that require focus before, during and after the clinical model project. It provides a mechanism to manage the project and judge if the project is desirable, viable and achievable.

It outlines who will work on the project, what will be developed, how it will be produced, how it will be managed and governed.

Section 2 is the outcome of the assessment and review into the nursing workforce requirements underpinning the Clinical Model. The model will not produce any savings as originally anticipated. It will, however, be cost neutral based on current costs, and fit within the current funded baseline establishment.

4. RECOMMENDATION

Board members are asked to:

- Note the contents of the attached document for due diligence prior to any further work being progressed on the Clinical Model
- Endorse the final draft Project Initiations Plan
- Acknowledge and support the review of the nursing workforce requirement

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports the implementation of the Clinical Model
Workforce Implications	Some of the actions may result in additional workforce resources being required
Financial Implications	As above
Route To The Board Which groups were involved in contributing to the paper and recommendations	Corporate Management Team and Clinical Governance Committee
Risk Assessment (Outline any significant risks and associated mitigation)	Risk that the current patient population will not fit into the clinical model
Assessment of Impact on Stakeholder Experience	Stakeholder experience may by impacted due to the new model being unable to be implemented at this time
Equality Impact Assessment	An EQIA has been completed for this project in 2020
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	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Section 1: Clinical Model - Draft Project Initiation Plan: June 2022

1. Background

The State Hospital (TSH) is a National NHS Board serving the population of Scotland and Northern Ireland. The organisation provides specialist care in conditions of high security for Mentally Disordered Offenders (MDO) with Major Mental Illness (MMI) and Intellectual Disabilities (ID).

The rationale to develop a new Clinical Model came from a safety survey carried out with staff in 2018. The survey identified that staff felt less safe, and would welcome a change in how patient care is organised. Staff highlighted the need to promote recovery for patients whilst cohorting risk factors more effectively.

This Project Initiation Document (PID) provides the details of the planning components necessary for the implementation of the Clinical Model in TSH.

It provides a mechanism to manage the project and judge if the project is desirable, viable and achievable. It outlines who will work on the project, what will be developed, how it will be produced, and how it will be managed and governed.

2. The State Hospital: The Current Context & Considerations

The Clinical Model implementation was paused in March 2020. It is necessary to consider any new factors that have arisen in the intervening timeframe and how they could impact on delivery.

There are current and residual considerations to address:

a) The Covid-19 Pandemic

TSH implemented a model of care which supported the public health advice and infection prevention and control measures throughout the pandemic. The number of contacts within wards and hubs, and between patients, were kept to a minimum.

→ *Those measures, and any new measures, can be applied within the new model should there be any resurgence of the pandemic.*

The approach taken to implement the Clinical Model will now specifically consider infection prevention and control mechanisms to limit risk from Covid-19.

→ *A phased approach to implementation is being considered; regular infection prevention and control guidance will be followed and audited.*

From the time of Board approval in October 2019, the number of patients has increased by just under one fifth. The planning assumptions are based on pre-pandemic bed occupancy, averaged over a five-year period.

→ *It is anticipated that a greater flow of patients will be achieved as the forensic system recovers overall from the impacts of the pandemic.*

If patient numbers remain above 107 when the model is fully enacted, some MMI patients will be cared for in the ID wards. Careful consideration should be given by clinical teams on how care and treatment will be provided.

→ *The current number of patients should not be considered a barrier to progressing with the new model.*

There is a need to review the risk of potential multiple moves for patients and the impact this could have on their mental health.

→ *The phasing and method of ward moves is currently under clinical consideration.*

The profile of patients in TSH recognises more patients experiencing frailty and other issues associated with ageing. This factor was considered previously by the Clinical Forum as part its work on the definitional types of wards that would most benefit patients.

→ *Clinical teams are aware of the specific complexities of each patient and will consider how clinical care is best achieved to support both physical and mental health needs. All wards have single room en-suite accommodation.*

The provision of high secure care for female patients in Scotland has been under review. Currently a small number of female patients requiring high secure forensic mental health care have this provided in Rampton in England.

→ *The Board will receive a specific update on female patients in August 2022.*

There are recruitment challenges across the system at this point in time.

→ *TSH will continue to focus all efforts in attracting and retaining its workforce. The HR team are connected to workforce planning nationally and organisational specific recruitment initiatives remain a key priority.*

There is a major upgrade to the security systems underway.

→ *The security upgrade will be completed by September 2022.*

The above issues will remain under review and be considered at each stage of the transition process to the new model.

3. PROJECT DEFINITION

The Clinical Model describes how clinical care is structured and delivered at TSH.

The new model of care is patient centred, it enables individuals to feel a sense of progress through the clinical stages of their treatment journey. The model takes cognisance of their needs, risk, physical and mental health factors.

The Clinical Model comprises of four clinical sub-specialty areas. These definitions were developed and agreed by The Clinical Forum:

- Admission and Assessment Wards
- Treatment and Recovery Wards
- Transitions Wards
- Intellectual Disabilities Wards

The Clinical Model and its definitions were approved by the Board in October 2019.

a. Project aims and desired outcomes

The overall aim of the Clinical Model Project is to safely transition from the current service model to the new Clinical Model by the end of financial year 2022/23.

The delivery aims are:

- More tailored security based on risk and clinical presentation, aligned with the least restrictive practice principles
- A sense of progression for patients through their clinical care journey in high security
- Streamlined integration between sub specialty wards and the Skye Centre, enabling best use of resources to support physical health, therapeutic activity and treatment goals
- Meeting the ID specific patient need through a more tailored and specialised environment. This involves distribution of patients across 2 wards rather than 1 to improve the therapeutic milieu.
- Improved clinical case mix, with admissions accommodated in specified wards
- The ability for staff to specialise in sub specialty areas of care and practice

Outcomes to be achieved are:

- An enhanced treatment environment with a more tailored and individualised approach
- Effective use and deployment of available resources
- Increased patient activity for the betterment of their physical health
- Feeling of progression for patients
- Management of patients with similar risks together with adequate staffing levels
- Staff feeling of improved safety within the workplace
- More positive recognition of staff and the support available to them

b. Scope, exclusion, constraints and assumptions

The principles and assumptions for the Clinical Model are as follows:

- Clinical assessment determines patient placement within the sub specialty wards
- The physical structure of the wards does not require major modification*
- All patients will be admitted to the admission wards, but can be discharged from any ward
- All ID patients should be admitted and cared for in ID wards
- If the MMI patient population exceeds bed numbers, MMI patients can be 'boarded' in the ID wards *(this may be required initially whilst the overall forensic estate re-balances post pandemic)*

*The implementation of the Clinical Model will not impact on the physical structure of the environment. It is anticipated that capital developments underway in some bedrooms, and the Modified Strong Room (MSR) suites, will be completed in advance of patient moves. Any further physical modifications required following the clinical model implementation will be considered through the capital planning process, as part of the normal business cycle.

c. Leadership, Culture and Team

Leadership, culture and team working were identified as a factor in implementing change. There will be a specific focus on:

- Ensuring the wellbeing strategy is dynamic to support staff needs

- Hub leadership integrated to the organisations management and leadership structure
- Multidisciplinary team working being optimised, ensuring effective use and inclusion of the wider team resources to support the overall patient experience
- Consistent communication across TSH, ensuring that all staff have access to the same clear and meaningful information
- Team working, culture and organisation engagement at ward level

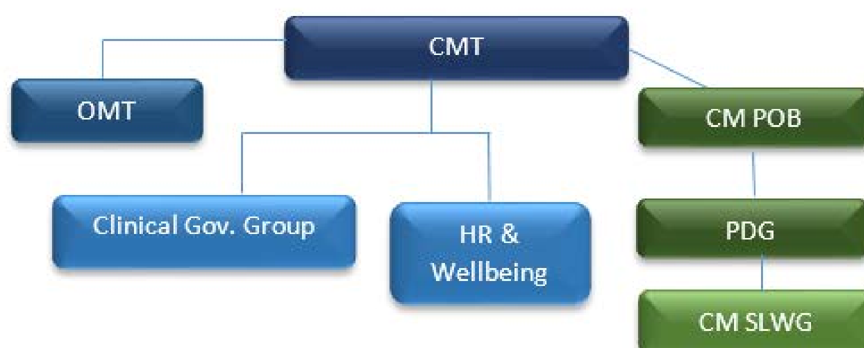
d. Project approach and structure

The move to the clinical model is a complex and involves multiple internal stakeholders. It will result in changes for staff and patients in the newly configured service environment. Staff engagement in the planning cycle, working processes, care delivery, and organisational effectiveness, are all integral to ensure the benefits of the new model are realised.

Contingency plans and risk assessments will take place prior to any moves, and once the final scheduling approach is clinically agreed. Monitoring of key data will continue throughout the process. This will provide assurance on care delivery, patient wellbeing and risk oversight.

It is likely that implementation will take place in a phased process to minimise risk of infection. This approach is currently being clinically assessed to ensure the approach is not detrimental to overall patient or staff wellbeing.

The project structure for the Clinical Model delivery is as follows:



Clinical Model Project Oversight Board (CM POB)

The CM POB has responsibility for ensuring that there is continued business justification of the project, that resources are in place for the project, and that the financial integrity and costing are within projected tolerances. It responsible for project assurance to ensure that the deliverables and project elements are reviewed, monitored and audited and meet with the quality criteria. The CM POB will ensure that the desired benefits and outcomes for staff and patients are realised and tracked post implementation.

The Chief Executive, in conjunction with Executive Directors, will provide strategic oversight and direction on the CM POB. They will connect with the project team on a regular basis across the implementation period.

Project Delivery Group (PDG)

A Project Delivery Group (PDG) will oversee and deliver the project at operational level. The PDG will manage the project risk register, project planning, implementation, monitoring and evaluation.

The PDG will be responsible for the project brief, phasing and exception plans. They will prepare regular update reports for each phase of the project. Funding and allocation of time for the project team will need to be in pace to facilitate and lead the change programme. It is envisaged that the project team will be sourced from within the hospital through secondment opportunities.

The Project Manager's prime responsibility is to ensure that the project produces the required products within the specified tolerances of time, cost, quality, scope, benefits and risk. The Project Manager is also responsible for the project producing and achieving the overall aims and benefits.

The Project Delivery Group will comprise of the following:

- Project Manager
- Clinical Lead
- Chair of CMI SLWG
- Project Administrator
- Project Officer

Clinical Model Implementation 'Short Life Working Group' (CMI SLWG)

The Clinical Model Implementation 'Short Life Working Group' (CMI SLWG) will advise and develop the necessary change approaches for the Clinical Model.

CMI SLWG will be responsible for ensuring the logistics of patient moves are planned and implemented effectively. They will ensure that clinical guidance for each ward type is developed and consulted on prior to any patient moves. They will ensure that the workforce and security guidance is developed, consulted on and agreed.

CMI SLWG will also be responsible for sequencing of activity and ensure that the interdependencies between the project are clinically understood and delivered appropriately. Membership will be drawn from all areas of business and is noted in appendix 2.

e) Oversight

The Board will be updated on progress at regular reporting intervals (appendix 1). It will be expected the governance committees will also have oversight especially in relation to clinical and staff governance. The Partnership Forum will receive regular update reports. There will be continued transparency and full partnership engagement throughout the duration of the project.

The Clinical Forum will have access to the CM POB to enable feedback and provide multi-disciplinary clinical input.

The Corporate Management Team will ensure strategic and organisational alignment across all areas of business as usual whist the project is underway.

4) ESSENTIAL PLANNING ELEMENTS

There are essential planning elements to be developed through the project structure to enable the effective transition to the new clinical model. These elements are categorised and described as follows:

- Clinical and Security Guidance
- Workforce Guidance
- Guidance for the physical movement of patients
- Patient Mapping
- Activity pathway

a) Clinical and Security Guidance

Clinical and security guidance documentation will be developed for the admission and assessment, treatment and recovery, transitions and intellectual disability wards by key clinical specialists in the relevant areas. This will include consultation with appropriate colleagues in the development and agreement of any associated clinical or security risks:

- Develop working methods for clinical teams including cross hub working
- Establish a clear bed management process
- Detail aspects of patient care specific to that sub specialty ward
- Define security standards to support clinical care in the sub specialty wards
- Identify and advise on physical, relational and procedural security issues
- Identify and advise on any specific security issues, such as patient to patient, or patient to staff disassociation, that may occur from the patient mapping process
- Detail any additional risks and indicator measures that should be monitored to ensure staff and patient safety

b) Workforce Guidance

There is a requirement to ensure that the workforce has the appropriate knowledge and skills to deliver safe and effective patient centred care within the new model:

- Ensure that a staff needs assessment is undertaken for working in the sub specialty clinical areas
- Establish an agreed partnership process which will focus on minimising disruption
- Ensure that any staff moves are clearly articulated and communicated
- Identify requirement for any structural changes, or new roles, with the development of modified job descriptions where appropriate
- Legislative requirements associated with the Health and Care (Staffing (Scotland) Act 2019 (*aka safe staffing*) is deliverable and continuously monitored with reporting to the CMT, Staff Governance Committee and the Board

c) Guidance for the physical movement of patients

The guidance for the physical movement of patients will drive the actual placement associated with the implementation. This will include the process for the potential boarding of MMI patients in the ID wards. The guidance will define:

- How and when patient moves will be carried out
- Roles and responsibilities in patient movement
- Connectivity with support services in facilities, e-health, finance and records management
- The escalation route if indicators are going out with tolerances. e.g. sharp rise in incidents of violence
- Security aspects resultant from patient movement and how these will be managed
- Specific care requirements to enable an effective care transition into new ward and routine
- ‘Go’ and ‘no-go’ checks and balances

d) Patient Mapping

There is a concern that some patient may experience multiple wards moves which could be deleterious to their health or increase their risk profile
.
- Detail and identify the number of patient moves that are envisaged with a phased movement model, versus a singular change approach model
- Clinical and security assessment required for each sub specialty ward type

e) Activity pathway

Streamlined integration between sub specialty wards and the Skye Centre, enabling best use of resources to support physical health, therapeutic activity and treatment goals.

- Detail the patient activity pathway for each sub specialty
- Outline the expectation of activity specific to each ward type: e.g. in the transition wards patients will be expected to have between xx and xx therapeutic activities and xx drop in sessions over the course of any single week
- Set monitoring and performance criteria to ensure activity and therapeutic care is delivered
- Link to the programme of work underway through the Physical Health Steering Group
- Consider the principles of reducing ill health and health inequality

5) GOVERNANCE APPROACH

The following governance areas are included to provide further detail on how the project will be managed.

- Communications and Engagement for staff, patient, carers, volunteers and stakeholders.
- Project Risk Register
- Quality: Definition and means by which the products will be fit for purpose, measurable, quality controlled and quality assured
- Change Management Process
- Benefits Management
- Project Controls

a) Communication and Engagement Approach

There has been consistent approval and support of the proposed model changes from engagement with staff, patients and carers.

Effective engagement with a range of stakeholders remains fundamental to the success of the clinical model. A range of communication tools and methods will be used depending on the needs and preferences of the audience. This will ensure timely, effective consistent information is provided, and that stakeholders have opportunity to provide feedback and shape planning.

- Ensure patients, carers, staff, volunteers, Scottish Government and external interested parties (referred to as stakeholders) are kept informed
- Ensure that where appropriate, stakeholders are engaged in shaping changes
- Ensure that scope, timescale and milestones are communicated appropriately
- Ensure consistency of messaging and transparency on progress

An engagement process will be undertaken to ensure staff, patients and stakeholders are enabled to participate and contribute. Development of the key messages will be the responsibility of the Project Team and the Head of Communications. Heads of Department, Team Leaders, Senior Charge Nurses have responsibility to share communications with colleagues.

Engagement activities:

- Engagement with key groups on the Project Initiation Document (PID) to gain buy in and explain process
- Specific engagement focus on Clinical Model with all staff groups
- Learning from experience from previous hospital moves
- Regular engagement with Partnership Forum and Clinical Forum
- The management structure of CMT/OMT/HMT will be utilised to update and inform managers and elicit feedback
- Dedicated Staff Bulletins
- Staff engagement sessions when appropriate to update, e.g. Seminar Series, Learning into Practice
- Project implementation updates and key communications available on the intranet
- Patient engagement through PPG
- Stakeholder engagement

Key issues:

- Consistent messaging: It is vital that clear consistent messaging is achieved. To support this the project team will develop regular (monthly) update reports with the Head of Communications.
- Access to information: A central space for feedback and key messages will be held by the project team to ensure that information is managed and referenced correctly. A space will be available on the intranet to hold key communications and updates.
- Impact Assessments: The Existing Clinical Model EQIA will be reviewed and if required updated. A DPIA will be developed to ensure data protection issues are considered and risks mitigated.

b) Risk Management Approach

The purpose of the risk management approach is to describe how risks will be managed in the project and to affirm TSH commitment to improve its capability to manage any type of risk.

The overall goal of Risk Management is to have an environment of 'no surprises' where we understand the risks we face and eliminate or control them to an acceptable level. We develop a culture founded upon assessment and maximum mitigation of risk. TSH has devised a Risk Management Strategy that will underpin this element of the PID.

The Project Risk Register will be used to control risks, their associated scores, with the intention to monitor these within agreed mitigation controls. The Project Administrator will request updates from risk owners and ensure the risks remain up to date and in tolerance with direction from the Project Manager.

c) Quality Management Approach

The purpose of the quality management approach is to describe how quality will be managed in the project.

The approach to quality planning and assurance will connect to TSH quality management approach. The projects approach to quality control will be through ensuring quality standards in delivery of care and services are maintained. This will be assessed through the regular pattern of audit and checks.
.
Project assurance sits independently from the project groups and is the responsibility of the CM POB to ensure quality of products adheres to organisational requirements.

d) Change Management Process

Change control is used to identify, assess, and control any potential and approved changes to the project baseline.

Changes will be flagged through an issues log and will be assessed for impact. Recommendations and actions will be produced if a change is required alongside a detail of how it will be delivered, and any impacts it has on other aspects of the project. Team members may advise the Project Manager that a change is requested. The Project Manager can authorise changes within tolerance and once the impact of the change has been fully assessed.

e) Benefits Management

This defines the management actions required to ensure the benefits are realised by analysis of key indicators and audits:

- An enhanced treatment environment with a more tailored and individualised approach
- Effective use and deployment of available resources
- Increased patient activity for the betterment of their physical health
- Feeling of progression for patients
- Management of patients with similar risks together with adequate staffing levels
- Staff feeling of improved safety within the workplace
- More positive recognition of staff and the support available to them

These benefits will be tracked and reported over time to understand if the project has delivered the desired benefits.

f) Project Control

Project tolerances for cost, time, risk, quality, scope and benefits will be detailed at the onset of the project.

Project reports will be either time driven or event driven. The event driven reports will be developed when a specific event has taken place, e.g. issues or new work packages, exception reports when an element has exceeded agreed tolerances, end of stage report and end of project report. Time driven report checkpoint reports will be reviewed on a regular basis.

6) Implementation Approach

An implementation plan will be developed, informed by clinical guidance, the mapping exercise and the elements described in this paper.

The implementation plan will detail expected timescales, sequencing of activities and interdependencies. It will provide detail and monitoring of key project milestones. There are a range of logistical issues to consider and resolve to simultaneously safely move patients from one ward environment to another.

Key issues to be resolved in the implementation approach are:

- If patient numbers remain above 107 when the model is fully enacted, some MMI patients will be cared for in the ID wards. Careful consideration of how clinical teams provide care to these individuals is required
- Consideration of how Hub Leadership Teams will operate and how key clinical services (psychology, pharmacy, social work, AHP's) will work across the new clinical model – both when TSH is in transition into the model, and once model fully established.

a) End of Project

The end of the Clinical Model Implementation will occur when all patient and staff moves have taken place. The CM POB will determine this, based on a recommendation from the PDG, including a project closure report. This will be reported to the Board for agreement that the project can be considered complete.

Post implementation, there will be a phase of evaluation of the impacts. A detailed proposal will be presented to the Board encompassing the key performance indicators and monitoring mechanisms to support assurance reporting going forward under the new model.

7) PROJECT PLAN

The sample Project Plan at appendix 3 provides high level summary of the key products, processes, governance, interdependencies and reporting timescales.

Section 2: Review of planned Clinical Model staff requirements for Nursing

This section sets out an update of the workforce planning assumptions associated with the Clinical Model. Workforce assumptions were initially presented in 2019. They and set out a reduction in recurring costs and the overall nursing workforce, informed by reasonable planning assumptions at the time.

These assumptions have been refreshed and assessed by the former Nurse Director in conjunction with the new Nurse Director and Director of Finance.

There is a shift in the overall numbers of staff required. This section sets out the rationale for this change and the financial assessment.

Key Issues

- Achieving safe staffing is a daily challenge within the State Hospital, and staff availability is currently a risk
- There are no validated workforce or workload assessment tools that are currently assessed as fit for purpose in a high secure forensic environment. As such, a blend of retrospective analysis of staff required to deliver safe care, national benchmarking, and professional judgement is a reasonable method of projecting workforce need
- There has been a sustained increase in staffing numbers required, particularly on night duty
- Average bed occupancy has increased over the past 2.5 years. While Covid-19 is a factor that has undoubtedly affected system wide flow, bed occupancy at the time of the original modelling was 103 and there was a trend of occupancy that was at or near this figure over the previous five years. Current occupancy at time of writing this report is 117
- Current rostering does not take into account the increased staffing requirement resulting in considerable workforce hours addressing unfunded staffing shortfalls
- This changed planning assumptions, specifically in relation to the 2 x ID wards and the increased likelihood of having to deliver care to ID and MMI patients in the same ward
- Previous benchmarking on staffing sourced through NHS Benchmarking suggested 33wte per 10 beds in high secure services in England
- It is best practice to regularly review workforce planning assumptions.
- Support the organisation in preparation for the enactment of the Health and Care (Staffing) (Scotland) Act 2019.

Background Information and Context

There are two main areas of variation from the 2019 planning assumptions as they relate to assessing workforce requirements.

The occupancy of The State Hospital in October 2019 was 103 patients, with a capacity for 120 patients, whilst operating on a 10 ward model. This gave an occupancy level of 86%. There was sufficient capacity overall to manage the number of patients across a ten ward operational model. Staffing was modelled on the reasonable assumption that occupancy would continue at or near this level, as bed occupancy had seen a sustained decrease in previous years.

Current occupancy is 117 patients, or 97.5%. There has been a sustained increase in occupancy since the Clinical Model planning assumptions were presented to the Board in 2019. This changes planning assumptions for staffing, specifically in relation to the 2 x Intellectual Disability (ID) wards as there is the increased likelihood of having to deliver more care to more patients where ID and mental illness patients are in the same ward. Staffing has been adjusted to take this into account.

Day and back shift staffing was previously modelled at 54, and this has been increased to 56. Analysis of 2 years of data shows that average staff requirements over this period has also been 56 staff per day and back shift.

Night duty staffing has also been reviewed. Reviewing two years of data shows that there has been a sustained increase in the staffing numbers required to deliver safe patient care. There is a need for 26 staff on duty each night, and this has now been factored into the workforce planning assumptions. This was previously modelled at 25.

The staffing model against proposed service functions is set out below. This is a 10 ward model.

Hub A = 2 x intellectual disability wards
Hub B = 2 x transition wards
Hub C +D = 1 x admission ward and 2 x treatment and recovery wards in each Hub.

2 x ID, 2 x transition, 4 x treatment and recovery, 2 x admission (10 wards)

Establishment		**am**	**pm**	**nd**	**0900-1700**
29.63	**Hub A 1**	6	6	3	0
31.47	**Hub A 2**	6	6	3	1
19.75	**Hub B 1**	4	4	2	0
21.59	**Hub B 2**	4	4	2	1
29.63	**Hub C 1**	6	6	3	0
31.47	**Hub C 2**	6	6	3	1
27.15	**Hub C 3**	6	6	2	0
31.47	**Hub D 1**	6	6	3	1
29.63	**Hub D 2**	6	6	3	0
29.00	**Hub D 3**	6	6	2	1
	Totals	**56**	**56**	**26**	**5**

280.79 WTE

2 x Lead Nurses and 12 x Senior Charge Nurses are also needed in the overall staffing model, with this taking the overall wte to **294.79**. This matches the current staffing numbers. 12 Senior Charge Nurses are needed for the 10 ward model to ensure capacity to cover night duty, as 2 Senior Charge are currently deployed on night duty.

The Board paper of October 2019 assumed an overall workforce reduction and an associated reduction in recurring revenue costs of £534,000 at 19/20 costs. This was based on a projected requirement for 283 WTE staff.

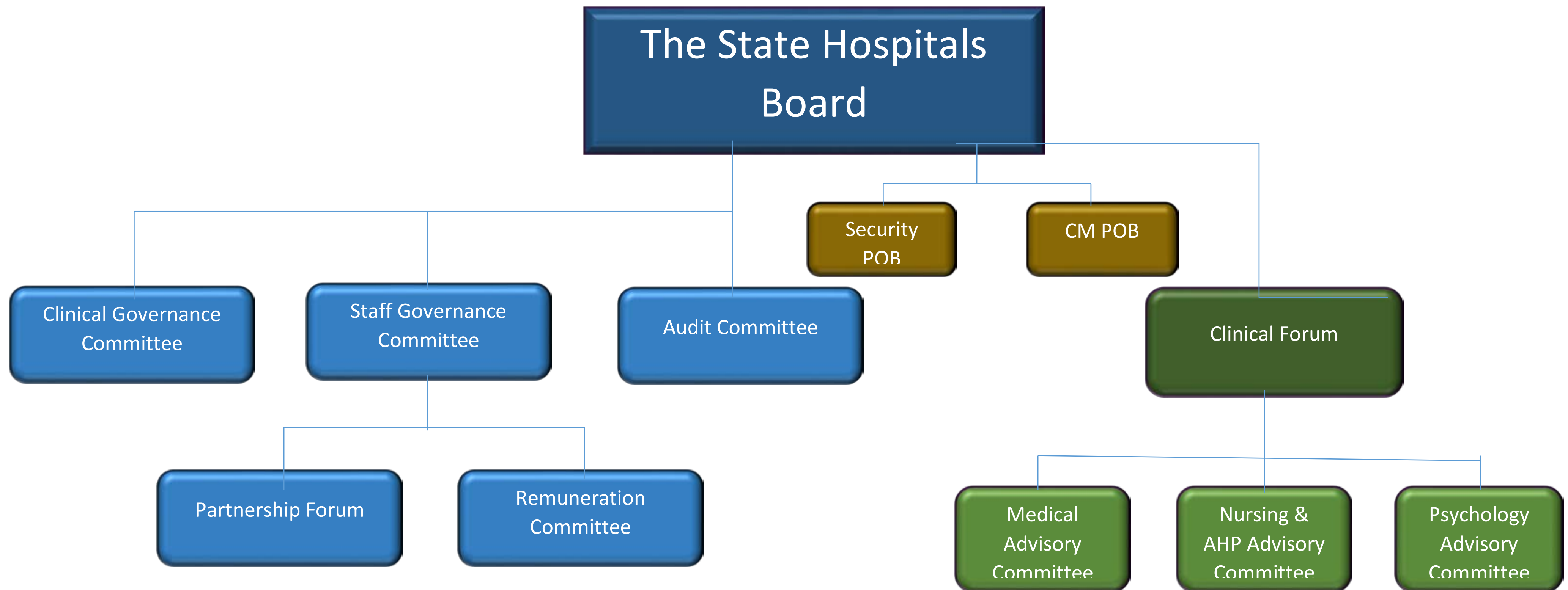
The revised workforce planning assumptions match the current 22/23 workforce number based on the current service delivery model. There is a slight variation in projected cost due to the inclusion of activity co-ordinator roles in the Hubs and the cost difference between 6 x band 3 versus band 4 posts.

Financial Assessment

There is no recurring revenue saving as was projected in 2019. Costs of the proposed model when compared to current 22/23 staff costs is £16,159,458, however, the revised model costs are within the range or close to current costs.

This is based on a current overall planning assumption of a 2.5% pay increase in 22/23 – any variation from this, once confirmed, will result in additional savings pressures for the coming year, as it would for the current staffing model.

Appendix 1 The State Hospitals Board for Scotland – Board and Sub-Committee/Advisory Committee Structure



Appendix 2

Clinical Model – Short Life Working Group Membership will include:

- Consultant Psychiatrist - Chair
- Project Manager
- Lead Nurses
- Medicine – RMO's
- Security
- HR
- Person Centered Improvement Team
- Clinical Quality
- Risk Management
- Psychology
- Pharmacy
- Finance
- e-Health
- Estates and Facilities
- Skye Centre
- Communications
- Clinical Leads for each of the four services. Hub Leadership Team representatives.
- Representation from the Clinical Forum and Partnership Forum

The group will meet regularly throughout the planning and transition process and will be stood down once transition has been achieved.

Paper No. 22/44

Appendix 3

Paper No. 22/45

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 10
Author(s):	Chair of the Clinical Governance Committee
Title of Report:	Clinical Governance Committee Annual Report
Purpose of Report:	For Decision

1 SITUATION

The attached Clinical Governance Committee Annual Report outlines the wide range of activity overseen by the Committee during 2021/22. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

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

- A review of reporting structures within the hospital.
- A review of the committee's work programme for forthcoming years.
- A review of the committee's terms of reference.
- An annual report summarising the work of the groups and departments that report to the Clinical Governance Committee.

3 ASSESSMENT

Governance Reporting Arrangements
A diagram to show how each group within the hospital reports and escalates any issues.

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

Programme of Work
The programme of work sets out the topics that will be presented to the committee over the coming months.

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

The Clinical Governance Committee approved this report at its meeting on 12 May 2022.

4 RECOMMENDATION

Board Members are asked to approve the Clinical Governance Committee Annual Report, and associated reporting as demonstrating that the committee has met its remit and terms of reference during 2021/22.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The annual report supports strategy within the hospital, and all associated assurance reporting.
Workforce Implications	The various reports throughout the year would include any issues
Financial Implications	The various reports throughout the year would include any issues
Route To Board Which groups were involved in contributing to the paper and recommendations	Clinical Governance Committee/ Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	The various reports throughout the year would include any issues
Assessment of Impact on Stakeholder Experience	All the reports are assessed as appropriate
Equality Impact Assessment	All the reports are assessed as appropriate
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	All the reports are assessed as appropriate
Data Protection Impact Assessment (DPIA) See IG 16	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT

1 April 2021 – 31 March 2022

1. Introduction

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

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

The underlying principle of effective clinical governance is that systems and processes provide the framework for patients to receive the best possible care. This report provides an overview of the work of the Clinical Governance Committee during 2020/21 and examples of good practice and matters of concern.

2. Committee Chair, Committee Members and Attendees

Committee Chair
Cathy Fallon, Non-Executive Director

Committee Members
Brian Moore (until 5th July 2021)
Stuart Currie
David McConnell (from 6th July 2021)

Attendees
David McConnell (until 5th July as interim Chair of The State Hospitals Board for Scotland)
Brian Moore, Chair of The State Hospitals Board for Scotland (from 6th July)
Gary Jenkins, Chief Executive
Prof. Lindsay Thomson, Medical Director
John Marshall, Head of Psychological Services
Monica Merson, Head of Corporate Planning and Business Support
Mark Richards, Director of Nursing, AHPs and Operations
Robin McNaught, Finance & eHealth Director
Dr Khuram Khan, Chair, Medical Advisory Committee
Sheila Smith, Head of Clinical Quality
Margaret Smith, Board Secretary

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

3. Meetings during 2021/22

During 2020/21 the Clinical Governance Committee met on 4 occasions, in line with its terms of reference. Meetings were held on:

- 6 May 2021
- 12 August 2021
- 11 November 2021
- 10 February 2022

4. Reports Considered by the Committee During the Year

4.1 12 Monthly Internal Governance Reports

Fitness to Practice
The Committee received a report in relation to Fitness to Practise at its May 2021 meeting. The reporting period covered was 1 April 2020 - 31 March 2021. The report was submitted to the Committee for information in respect of the process for monitoring professional registration status at The State Hospital thus providing assurance that all relevant staff hold current professional registration as appropriate. During 2020/21, there were no lapses in NMC registration. This is an improvement as the previous year saw 2 lapses.

Infection Control
The infection Control Committee report was received at noted at the May meeting, covering the period 1 April 2020 to 31st March 2021. The primary focus for this review period was to reduce the risk of Covid19 within the hospital through various stages of the pandemic and manage Covid19 outbreaks effectively to ensure there was no wider spread of infection across the site. In addition to this the roll out of the Covid19 vaccinations and lateral flow device testing dominated the last quarter. Government guidance/instruction with short timescales influenced the routine infection control activities, these were outlined in the full report.

The Committee commended the report and acknowledged the significant pressure placed on State Hospital staff and patients during the last 12 months. The dedication and commitment of staff has enabled the hospital to provide a safe working and living environment for all, with only a small number of Covid19 positive cases.

Research Committee/Research Governance and Funding
In May 2020 the Committee received and approved the 2020/21 Research Committee Annual Report. The reporting period covered was 1 April 2020 - 31 March 2021. The report highlighted the governance arrangements in place along with a range of areas of good work within the State Hospital and Forensic Network. One main area of work for the next 12 months will be the review of the Research Portfolio. The research portfolio review will also support the development of an updated State Hospital Research Strategy 2021-2024. The full review will commence in April, and will focus on the ongoing development of a high-quality research programme in forensic mental health, that addresses the evidence and information needs of the organisation.

Duty of Candour
The third annual report for Duty of Candour was received and noted at the November 2021 meeting. The report covered information on the policy, training that had been implemented across the site as well as the governance and monitoring arrangements. Between 1 April 2020 and 31 March 2021 the Risk Management Department forwarded 63 incidents for consideration by the Duty of Candour Group, up from 43 in the previous year. It was agreed by the group that none of these incidents fulfilled the criteria for Duty of Candour.

Patient Safety
In August 2021 the Committee received and approved the Patient Safety Report covering the period 1 July 2020 - 30 June 2021. The 4 principles remained: Communication; Leadership and Culture; Least Restrictive Practice and Physical Health. Key pieces of work included: the

movement of PMVA policies from the PMVA Review Group to the Patient Safety Group; discussion and population of the 'Safe Essentials of Care' driver diagrams received from the National Patient Safety Team with a view to populating an improvement plan for 2021/22 with any gaps or further improvements the Group would like to explore going forward; ongoing monitoring of PMVA policies with action plan being taken forward where appropriate.

Forensic Network Medium and High Secure Care Review Visit – Action Plan
At the August 2021 meeting the updated actions from the Forensic Network Peer Review Visit were tabled for information. By August 2021, of the 37 actions assigned, 2 remained outstanding; one is the clinical model and the other is communication and digital inclusion, work on which is well under way. It was agreed that the last 2 actions could be monitored through the Clinical Governance Group and no longer required to be presented at Clinical Governance Committee. The Committee thanked staff for their hard work in closing off all actions.

Medicines Committee
The Medicines Committee annual report was submitted to the Clinical Governance Committee in May, covering the period 1st July 2020 and 31st March 2021. The Committee approved the report and formally agreed removal of the EU Falsified Medicines Directive implementation from the Corporate Risk Register following UK exit from the EU 1st January 2021. Key activities included contribution to the Covid-19 vaccination programme; update of the Safe Use of Medicines Policy; delivery of the clinical audit programme; maintaining medicine supply processes to the wards during Covid-19 and moving forward with the electronic prescribing project.

Patient Learning Annual Report
At the May 2021 meeting, the Patient Learning annual report was presented, covering the period 1st January to 31st December 2020. The Committee noted the progress that had been made and acknowledged the planned future developments that are detailed within the report. A number of areas were noted including: the continuation of the curriculum framework providing access to a broad range of nationally recognised qualifications and accredited national units including a newly approved Award in Volunteering Skills; learning opportunities, although limited during the year, ranged from entry level through to further and higher education and include clear progression pathways; data to show that 71 patients engaged in formal learning programmes with 29 formal qualifications being attained within 2020.

Clinical Risk Register
At the August 2021 meeting, members received and noted the Clinical Risk Register. There were 3 high graded clinical risks: the risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff; failure to prevent/mitigate obesity and failure to assess and manage the risk of aggression and violence effectively.

CPA/MAPPA
At the November 2021 meeting the Committee noted the report covering the period 1 October 2020 - 30 September 2021 and supported the future areas of work. For the third consecutive year, 100% of transfers were managed through the CPA process during the reporting period. The report identified a number of key areas in relation to Multi-Disciplinary CPA attendance, Patient and Carer Involvement and Strategic Engagement and Representation. During the review period no patients had been identified as potentially meeting the risk of serious harm category, however all patients remain under consideration in this regard and consultation takes place with the relevant MAPPA Co-ordinators as appropriate. Future areas of work included a specific MAPPA policy and DPIA for The State Hospital to be developed and

adopted; MAPPA training materials to be reviewed and uploaded onto Learnpro and further analysis in respect of carer involvement.

Child and Adult Protection
The Committee received and noted the report in November 2021 that covered the period 1 October 2020 - 30 September 2021. The report highlighted key areas of work that included key achievements in the areas of keeping children safe and adult support and protection. A training update was given that highlighted the Keeping Children Safe Training and Adult Support and Protection Training have been adapted and recommenced via Teams or in person where appropriate. Future areas of work includes review of the Keeping Children Safe Policy; continuing to promote video visits and a means of supporting child contact; learning from 'near misses' and preparing and submitting a Corporate Parenting report to Scottish Government.

Physical Health Steering Group
In November 2021 the Committee received and noted the 12 month rolling report from the Physical Health Steering Group covering the period 1 October 2020 - 30 September 2021. The report noted the developments and progress made in the 5 key strands for which the Physical Health Steering Group had responsibility. These related to Primary Care (including long term conditions); Physical Activity; Nutrition and Weight Management; Food, Fluid and Nutrition and National Guidelines and Standards. For each of these areas, details were provided of the work undertaken and the performance against local performance management targets. Key pieces of work for the next 12 months includes to look at Physical Health data pre and post Covid and ways that we can use this data to establish a "new normal"; continue to monitor patient's physical activity and review what effect the "re-opening and new normal" will have on patient's physical activity levels; continue to monitor the timescales when patients sports induction are completed under a "new normal" and support key dietary messages, to promote good nutritional care and healthy eating within the restrictions of the current pandemic.

Rehabilitation Therapies Service
In November 2021 the Committee noted the report covering the period 1 October 2020 - 30 September 2021 and endorsed the future areas of work and service developments contained within it. The report provided a summary of the key areas of work that included: an update on the QI patient activity project; Skye Centre skills mix review; occupational formulations; RiO activity timetables and digital interventions. Future areas of work for the service includes: the introduction of planned activities onto the RiO timetable; develop approach to KPIs and outcomes; introduction of process for routine reporting of AMPS assessment data and embed the employability pathway as part of the Clinical Model. It was agreed that over the next 12 months, work will be undertaken to review the content and focus of the report to best describe rehabilitation from a person centred perspective. This will wherever possible draw upon agreed KPI and outcome data.

Clinical Governance Group
At the February 2022 meeting the Committee received and noted the 12 monthly report from the Clinical Governance Group covering the period 1 January - 31 December 2021. The report provided a summary of the work of the Clinical Governance Group over the past 12 months. As well as overseeing the reports that go to the Clinical Governance Committee other key pieces of work included: monitoring the realistic medicine action plan; receiving updates on the Improving Observation Practice Policy; receiving a demonstration of the tableau dashboards; receiving updates from the Operational Model Monitoring Group; commenting on the digital inclusion updates; agreement on actions required to implement the guidance received on the Management of Medical devices; noting the Person Centre Improvement Service 12 monthly report and oversight of the exceptional circumstances finance report. The areas of future work includes: supporting the implementation of the clinical model, including preparation of guidance for the 4 ward types, patient flow, model fidelity and development of measures to

monitor the model; oversee the implementation of the QI Activity Project to ensure activity within the patient's objectives are reflected in the activities delivered to the patient and ensure this is an ongoing focus on Quality Improvement, Realistic Medicine and TSH 3030 initiative.

Psychological Therapies
At the February 2022 meeting the Committee noted the Psychological Services report covering the period 1 January - 31 December 2021. The report acknowledged the impact that the pandemic has had on the Service with regards to providing group work to patients. The report was centred on the 6 quality dimensions from The Healthcare Quality Strategy for NHS Scotland. Key service developments during 2020 included: individual and group supervision received and provided by psychology staff; 90.5% of staff have a completed and signed off PDP; the group work and consultation activity delivered within the 18 week target , although there was an acknowledgment that group therapies had been impacted by the pandemic. Future developments include: tracking data and impact on group and one to one therapy of providing support to the wards: recruitment to consultant nurse post and consultant health psychologist; training using NES accredited model of health lifestyle and fitness motivation changes (MAP) to Skye Centre staff and development of Neurodevelopmental (NDD) pathway for patients given high likelihood of co-occurring Autism Spectrum; Foetal Alcohol, language disorder and other NDD's. The committee commended the author on the vignettes included within the report.

4.2 Standing Items Considered by the Committee during the Year

Covid-19
In March 2020 restrictions were placed on the hospital in relation to the national outbreak of Covid-19. In response to this a paper was presented at all 4 meetings during 2020/21. The paper gave updates on the number of patient tests that had been required due to symptoms or close contact with another patient testing positive; the number of patients that had tested positive; the incident command structure; the implementation of an Interim Clinical Support Policy (that had many updates as national restrictions changed); the monitoring that was ongoing through the Operational Model Monitoring Group to ensure that the patient models being used were not having a detrimental effect onthe patients mental wellbeing or their access to fresh air or physical activity; national guidance that had been received; updates from the Scientific and Technical Advisory Group (STAG); patient flow; PPE; updates on the staff and patient vaccine programme; along with updates on the communication methods being used for staff and patients to ensure they were being kept up to date with the ever changing landscape of restrictions.

Learning from Complaints
The quarterly Learning from Complaints report was considered and noted at the Clinical Governance Committee at every meeting. Actions arising from all complaints are included within the report to share the learning which enables the organisation to develop services which take cognisance of complaint outcomes. The report is based on the two stage model that enables complaints to be handled either locally, by front line staff, allowing for *Early Resolution* (Stage 1) within 5 working days, or for issues that cannot be resolved quickly or are more complex, by *Investigation* (Stage 2) within 20 working days. All responses that have been received through the Complaints Experience Feedback Forms from patients/carers are also included within the reports.

Learning from Feedback
The quarterly Learning from Feedback report was considered and noted at every Clinical Governance Committee meeting. These reports highlight the feedback received, encompassing concerns, comments and suggestions, (including evaluation forms) and any compliments/positive feedback received. The report notes the outcome from all feedback and any lessons that have been learned by the hospital. The Committee were also given assurance that, during the current pandemic situation, the Patient Centred Improvement Team are still very focussed on reaching out to wards and ensuring patient and carer voices are

heard irrespective of the situation we are in. The Committee were happy to see an increase in the number of compliments being received in relation to Family Centre visits.

Work was progressed between the Corporate Services Team and the Person Centred Improvement Team to review how best to report on the learning opportunities presented by Complaints and Learning from Feedback reporting. This included the possibility of bringing these together to provide one report that covers the whole range of patient feedback and complaints. However, the conclusion of this review was that the current practice of separate reports brings more value in allowing the full breadth of detail needed, giving the required assurance to the Clinical Governance Committee.

Patient Movement Statistical Information
The Committee received and noted 2 reports during the year at its May 2021 and November 2021 meetings. The May 2021 report covered the reporting period 1 October 2020 - 31 March 2021 and the November 2021 report covered 1 April 2021 - 30 September 2021. These reports provided an overview of bed occupancy, area and source of admission, delay between referral and admission, admissions of young people (under 18), 'exceptional circumstances' admissions, appeals against excessive security, discharges and transfers and number of patients on the transfer list.

Incident Reporting and Patient Restrictions Report
The quarterly Incident Reporting and Patient Restrictions report was considered at every Clinical Governance Committee meeting. The report showed the type and amount of incidents received through the incident reporting system DATIX, as well as all the restrictions applied to patients during the periods under review. The report provided more information of the various incidents that had occurred in relation to PAA activations; the use of handcuffs; patient seclusions; withheld mail; urinalysis results; security incidents; communication/information incidents and incidents relating to equipment, facilities and property. The Committee continue to welcome the trend graphs that are included within the report that allows them to see incidents over time.

Staffing and Care Report
The staffing and care report was presented at all the meetings during 2021/22. The reports included any challenges with staffing; including the number of times a ward had to close due to staff shortages (this would mean patients being cared for in their rooms for the duration of the shift) and the challenges the hospital has recruiting an acceptable gender mix due to the small numbers of males going into mental health nursing.

5. Discussion Items During the Year

Due to the move to the meetings taking place on MS Teams and the additional Covid-19 item being added to the agenda there were no discussion items during 2021/22.

6. Special Topics/Items for Approval

Clinical Governance Annual Stock Take
At its May 2021 meeting, the Committee received and noted: the Clinical Governance Reporting Structures for 2021-22; the Programme of Work for 2021-22 subsequent to any changes that may arise at future meetings; the Clinical Governance Committee Terms of Reference; and the Clinical Governance Annual Report 2020-21. The Annual Report summarised the work of the Committee during the financial year 1 April 2020 - 31 March 2021.

Clinical Model
At its August meeting the Committee noted an update re the Clinical Model. The update included steps taken to restart this piece of work. These included: reviewing the progress made in 2019/20 in planning for implementation of the Clinical Model and considering what aspects continue to be fit for purpose and where changes are required; identifying any

adjustments required to the model in light of the last 12 months experience and the Barron Review; reviewing current patient population to align with new clinical model and considering the financial aspects of the model and reviewing if this continues to be achievable in financial plan 2021/22

Category 1 Review Reports
Three category 1 review reports were presented to the Clinical Governance Committee for noting at their August meeting. The reports outlined the background to the incident and the recommendations that had come out of the investigation. The Committee asked for these to be included in the Board development day with a view to discussing how we review the findings and ensure the recommendations are being progressed.

7. Areas of Good Practice Identified by the Committee

- Staff flexibility and accommodating as evidenced from AHP report
- 100% LDP target for CPA
- TV example and hire purchase scheme routed through PPG
- Responsiveness of staff during Christmas for patients and carers
- OMMG Annual Report
- Infection Control Committee Annual Report / Hand Hygiene Compliance
- MAPPA Level 2 Meeting which was convened in response to a situation where there was felt to be a risk of a patient returning to the community. This meeting was well attended by staff from The State Hospital and community partners and was raised as an example of good practice at the Lanarkshire MAPPA Operational Group.
- The analysis and vignettes included in the Psychological Therapies report to keep sight of improvements keep the service outcome focussed.

8. Matters of Concern to the Committee

Matters of concern	Update
Hand hygiene compliance remains a challenge in some areas. A series of face to face meetings between Karen Burnett, Senior Charge Nurses and Lead Nurses has been included in the 2021 programme of work to move responsibility and activity locally around the infection control agenda.	This data is now presented at Hospital Management Team to ensure oversight and that actions are taken forward.
'*Clinical Waste*' incidents related to staff not adhering to Linen Segregation, Bagging and Tagging National Infection Prevention & Control Manual. Incidents have decreased from 12 to 8 in this quarter. 2 incidents occurred in Mull, 3 in Iona and 3 in Arran.	The infection control lead continues to educate ward staff and the Infection Control Committee continues to monitor if the change ideas have resulted in improvement.
Ongoing staffing pressures, which are being looked at on a daily basis.	We have seen a decrease in the number of ward staff shortages since the last Committee meeting. This is discussed daily at the huddle for planning purposes and weekly at OMMG for assurance purposes

9. Conclusion

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

NHS SCOTLAND

The State Hospital

CLINICAL GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Clinical Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that clinical governance mechanisms are in place and effective within the State Hospital.

2 COMPOSITION

2.1 Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of at least three Non-Executive Board members, one of whom shall act as Chair.

The Clinical Governance Committee will have the authority to co-opt up to two members from outwith the Board in order to carry out its remit. These members will act in an ex-officio capacity.

Members:

- Stuart Currie
- David McConnell
- C Fallon (Chair of the Clinical Governance Committee)

In Attendance

- Brian Moore, Chair of The State Hospitals Board for Scotland
- Gary Jenkins, Chief Executive
- Prof. Lindsay Thomson, Medical Director
- John Marshall, Head of Psychological Services
- Monica Merson, Head of Corporate Planning and Business Support
- Karen McCaffrey, Director of Nursing and Operations
- Robin McNaught, Finance & eHealth Director
- Dr Khuram Khan, Chair, Medical Advisory Committee
- Sheila Smith, Head of Clinical Quality
- Margaret Smith, Board Secretary

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members, the Chair of the Medical Advisory Committee and the Chair of the Research Committee, will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

If attendance at the meeting is only required on a periodic basis, this should be agreed with the Committee Chair in advance. Apologies should be tendered to the Chair of the Committee via the minute secretary at least 2 working days prior to the meeting unless an exceptional event prevents this level of notice.

Where a member who is due to present a paper is not able to attend, they should ensure that another person is suitably briefed in order to deal with this item. The arrangement made should be discussed and approved by the Committee Chair.

To fulfil its remit, the group may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings. If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

Others may attend the Committee on the approval of the Committee Chair.

3 MEETINGS

3.1 Frequency

The Clinical Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.
The Chair of the Committee may convene additional meetings as necessary.
The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance to allow time for consideration of issues.

The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Medical Director.

All papers will clearly state the agenda reference, the author, and the purpose of the paper, together with the action to be taken. Cover papers should be prepared in the format set out in Corporate Document Standards, to draw out the main issues for the Committee. Annual Reports of reporting committees should follow the format set out in Corporate Document Standards.

Documents will be watermarked as Confidential, or Draft as required. Documents which are watermarked as Confidential should not be shared outwith the Committee membership. Guidance on confidentiality and openness can be sought from the Records Services Manager.

The secretary for this Committee will maintain a master file of documents, in line with Policy for Management, Retention and Disposal of Administrative Records.

3.3 Quorum

In the event of the Committee making decisions, two members need to be in attendance to be quorate.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Board meeting. The Board Secretary is responsible for minute taking arrangements. The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive (Medical Director) prior to approval by the Committee and notification to the Board.

Following approval, minutes will be placed on the hospital's website.

4 REMIT

4.1 Objectives

The main objectives of the Clinical Governance Committee are to provide the Board with the assurance that clinical governance mechanisms are in place and effective within The State Hospital; and that the principles of clinical governance are applied to the health improvement activities of the Board.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with clinical standards, in delivery of improved services for patients, and ultimately in improved outcomes for patients as evidenced through the clinical key performance indicators reported in the Local Delivery Plan.

4.2 Systems and Accountability

- To ensure that appropriate clinical governance mechanisms are in place throughout the hospital in line with national standards.
- To ensure that clinical risks are managed in accordance with the corporate risk management strategy, policies and procedures.
- To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed through clinical governance mechanisms.
- To ensure that systems are in place to meet information governance standards.
- To ensure that systems are in place to meet research governance standards.

4.3 Safe and Effective Care

To provide assurance to the Board in respect of clinical risk management arrangements, that:

- Structures are in place to minimise potential problems such as effective risk assessment and management, incident reporting, critical incident reviews, and complaint procedures.
- Lessons are being learned from adverse events and near misses.
- Systems are in place to measure and monitor duty of candour and any lessons to be learned.
- Complaints are handled in accordance with national guidance and lessons will be learned from their investigation and resolution (including reports of the Scottish Public Services Ombudsman and the Mental Welfare Commission).
- Arrangements are in place to support child and adult protection obligations.

4.4 Health, Wellbeing and Care Experience

- To ensure that the environment supports delivery of high-quality care with a culture and appropriate mechanism to allow staff and others to raise concerns on the standard of care provided, including the performance of clinical colleagues, in the knowledge they will be addressed without detriment to themselves or prejudice to the principles of confidentiality.
- To ensure systems are in place to monitor and measure the mental health and physical health requirements of our patient population, including medicine management, psychological therapies, and rehabilitation services.
- To ensure that arrangements are in place to embed Person Centred Improvement activities, including equality and diversity issues pertinent to clinical governance.
- To ensure that care is provided by appropriately trained and skilled professionals with the competencies required to deliver the required care.
- To ensure that clinical policies and procedures are developed, implemented, and reviewed.
- To ensure that poor performance of clinical care will be identified, and remedial action taken.

4.5 Control Assurance

- To ensure that quality of clinical care drives decision making and that clinicians are involved in planning, organising, and managing services.
- To ensure that the planning and delivery of services has taken full account of the perspective of patients and the general public.
- To ensure that systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.
- To ensure that research and development programmes are initiated, monitored, and reviewed.
- To ensure a comprehensive information governance framework is in place which ensures the Codes of Practice on Openness and on Confidentiality of Personal Health Information are fully applied.

The Committee will manage its business through a workplan, agreed by the Chair of the Committee. This will ensure that the full remit is covered on a rolling basis.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance, effectiveness, and the level of input of members to the Committee relative to added value achieved.
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Clinical Governance Committee, by presenting the minutes of the Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will ensure that relevant issues are shared with the Staff Governance Committee.

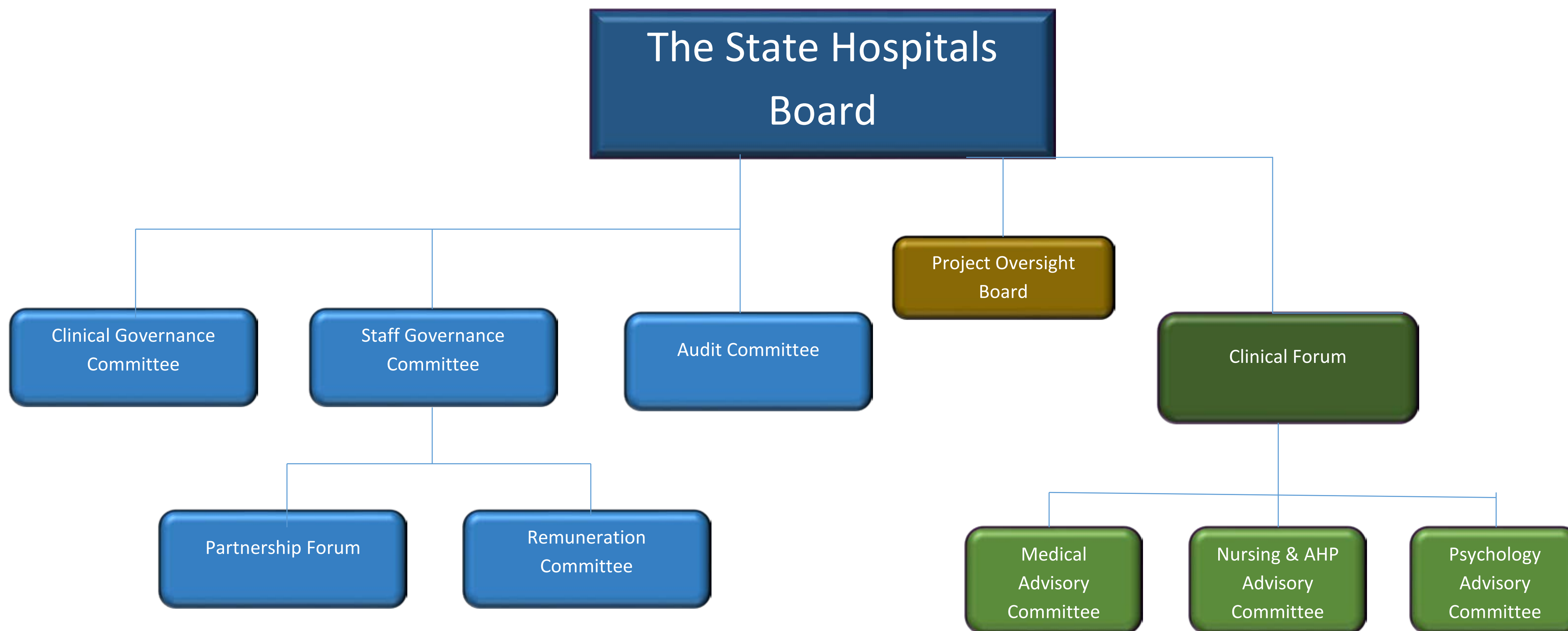
The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

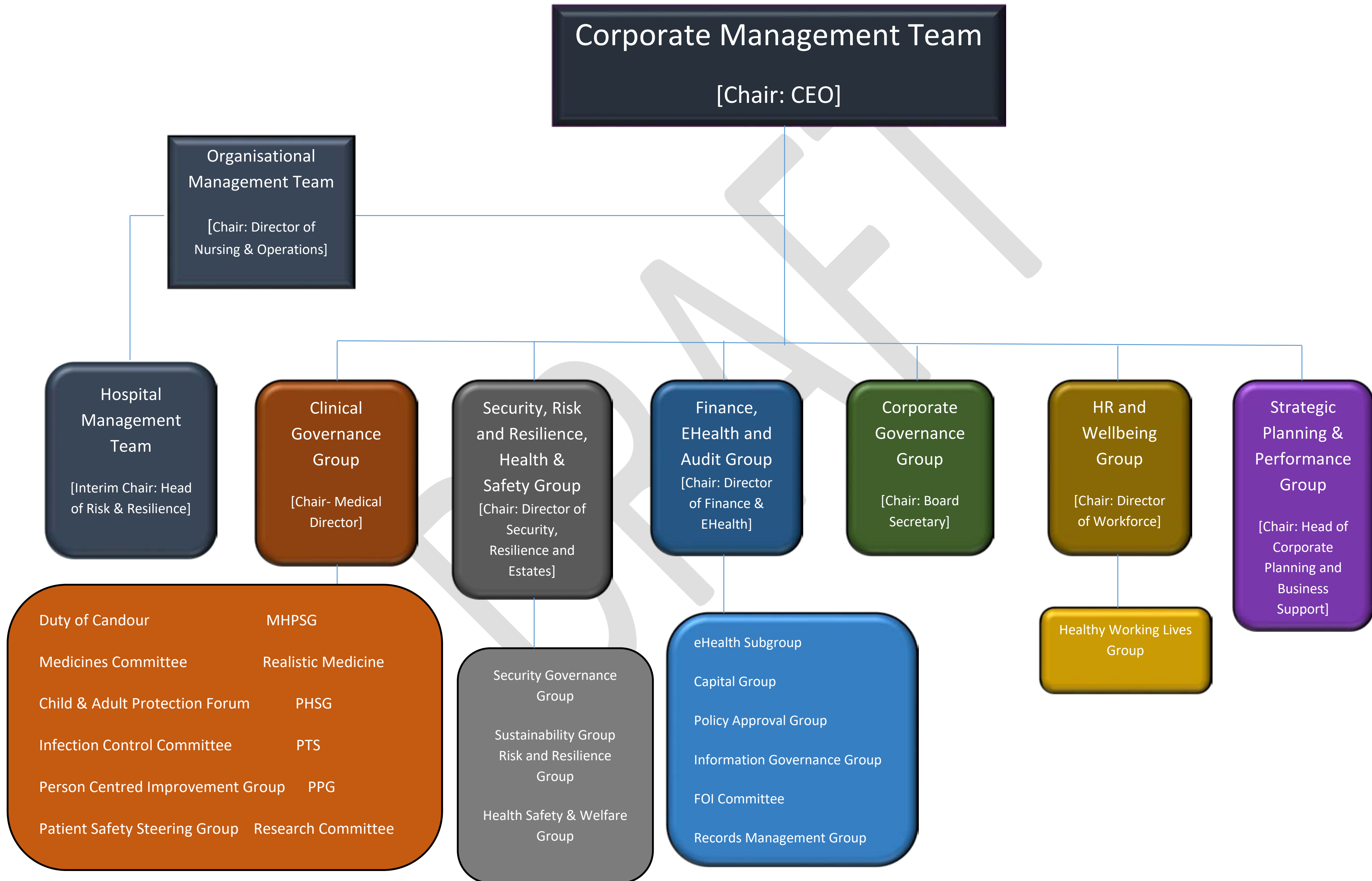
Subject to annual review.
Next revision: May 2023.

NHS SCOTLAND

The State Hospitals Board for Scotland – Board and Sub-Committee/Advisory Committee Structure



Draft: The State Hospitals Board for Scotland – Organisational Group Structure



DRAFT

Clinical Governance Committee Programme of Work 2022/23

Area of review	10th February 2022	12th May 2022	11th August 2022	10th November 2022	February 2023	May 2023	August 2023	November 2023
Standing items (20 minutes)	• Minutes of last meeting • Matters arising update • NHS HIS reports as available • CAT 1/Adverse Event report as available • Learning from feedback • Learning from complaints • Clinical Model • Incident reporting and patient restrictions • Agreement of item for discussion at next meeting				• Minutes of last meeting • Matters arising update • NHS HIS reports as available • CAT 1/Adverse Event report as available • Learning from feedback • Learning from complaints • Clinical Model • Incident reporting and patient restrictions • Agreement of item for discussion at next meeting			
12 month Monitoring Reports (70 minutes)	• Psychological Therapies • Clinical Governance Group • Staffing and Care Report	• Medicines Committee/ Pharmacy • Research Committee / Research Governance and Funding • Fitness to Practice • Patient Movement – Statistical Report • Infection Control • Staffing and Care Report • Patient Learning Report	• Rehabilitation Therapies Services • Risk Register • Patient Safety Programme • Duty of Candour • Staffing and Care Report • Mental Health Practice Steering Group	• Physical Health Steering Group • Patient Movement – Statistical Report • Adult & Child Protection • CPA/MAPPA • Staffing and Care Report	• Psychological Therapies • Clinical Governance Group • Staffing and Care Report	• Medicines Committee/ Pharmacy • Research Committee / Research Governance and Funding • Fitness to Practice • Patient Movement – Statistical Report • Infection Control • Staffing and Care Report • Patient Learning Report	• Rehabilitation Therapies Services • Risk Register • Patient Safety Programme • Duty of Candour • Staffing and Care Report • Mental Health Practice Steering Group	• Physical Health Steering Group • Patient Movement – Statistical Report • Adult & Child Protection • CPA/MAPPA • Staffing and Care Report
Interim Reports (as required) (15 minutes)	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19	Covid 19
Special topics / items for approval (15 minutes)		Clinical Governance Stock take: • Annual Report • Terms of Reference • Reporting Structures				Clinical Governance Stock take: • Annual Report • Terms of Reference • Reporting Structures		
Longer discussion items (30 minutes)	TBA	TBA	Activity	TBA	TBA	TBA	TBA	TBA

March 2022

Paper No. 22/46

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
	Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

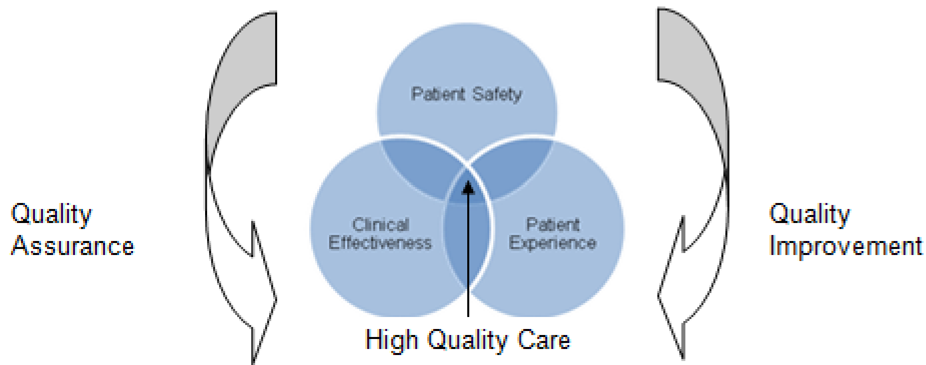
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in April 2022. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational learning and development. It contributes to the strategic intention of The State Hospital to embed quality assurance and improvement as part of how care and services are planned and delivered

2 BACKGROUND

Quality Assurance and Improvement in The State Hospital links to the Clinical Quality Strategy 2017 – 2020. The State Hospital will work towards updating and revising the Clinical Quality Strategy in 2022. The current Clinical Quality Strategy sets out the direction, aims and ambitions for the continuous improvement of clinical care. It outlines the following 7 goals to ensure the organisation remains focussed on delivering our quality vision:

- Setting and delivering ambitious quality goals to support the provision of high quality care and services to our patients and carers;
- Engaging staff, patients, carers, volunteers and other stakeholders in improving our quality of care;
- Ensuring that everyone in the organisation understands their accountability for quality and are clear about the standards expected of them;
- Gaining insight and assurance on the quality of our care;
- Ensuring access to and understanding of improvement data to build a positive momentum in relation to quality improvement;
- Evaluating and disseminating our results;
- Building improvement knowledge, skills and capacity.

The State Hospital's quality vision is to deliver and continuously improve the quality of care through the provision of safe, effective and person-centred care for our patients and to be confident that this standard will be delivered.



3 ASSESSMENT

The paper outlines key areas of activity in relation to:

- Quality Assurance through:
    - Clinical audits and variance analysis tools
    - Clinical and Support Services Operating Procedure Indicators Report
- Quality Improvement through the work of the QI Forum
- Capacity Building for Quality Improvement
- Realistic Medicine
- 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 are asked to note the content of this paper

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Quality Improvement and Assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QI and QA
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Covid monies have been approved to continue with the Daily Indicator Report due to CQ staff workload/ weekend working
Route to Board	Route to the Board is via the CMT
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 weekly indicator report will have a positive impact on stakeholder experience as they will be getting more fresh air, physical activity and 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 team work for any of the QI projects within the report
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN THE STATE HOSPITAL

JUNE 2022

ASSURANCE OF QUALITY

Clinical Audit

The Clinical Effectiveness Team carry out a range of planned audits. Over the course of a year there are usually 25 – 28 audits carried out. These aim to provide feedback and assurance to a range of stakeholders that clinical policies are being adhered to. All clinical audit reports contain recommendations to ensure continuous quality improvement and action plans are discussed at the commissioning group.

The audit reports that have been approved since the last Board Meeting in April 2022 are:

- PMVA Post Physical Intervention Audit
- Record Keeping Audit

PMVA Post Physical Intervention Audit

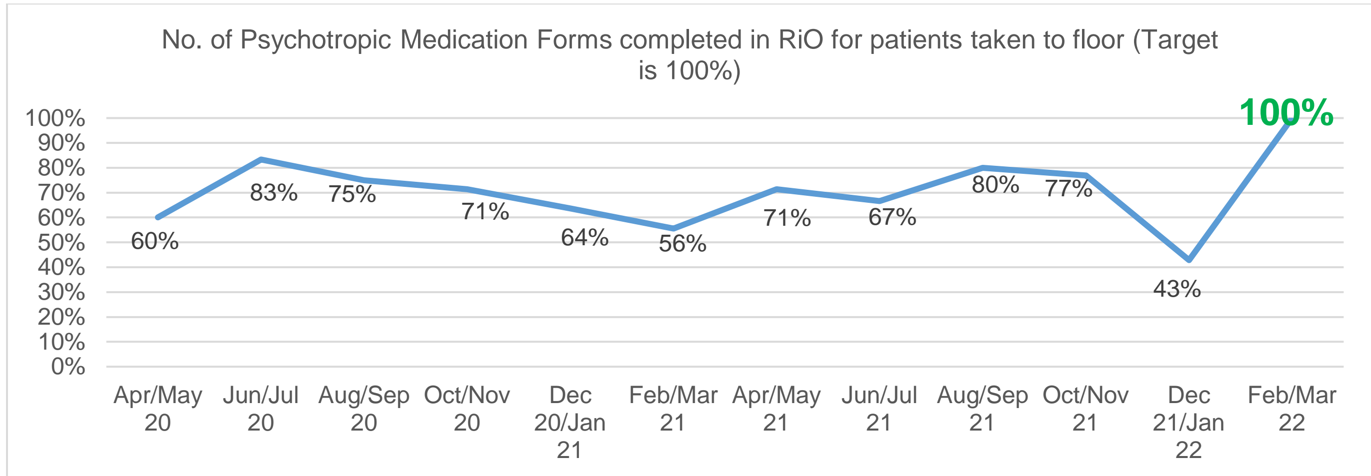
Areas of Good Practice

- Of 13 occasions where secure holds were applied, there were Post Physical Intervention Assessment (PPIA) forms completed by Senior Clinical Cover on RiO available for 11 (85%) occasions.
- Of the 11 completed PPIA forms all (100%) had been closed off in RiO
- For the 3 occasions on Datix where injuries were reported, a PPIA form was available for all 3 (100%)
- There were 8 (80%) occasions following physical intervention where a PRN was administered, all (100%) of these were recorded on Psychotropic Medication Forms within RiO.

Areas for improvement:

- Of the 11 PPIA forms completed, the incident time on the PPIA form matched with the incident time recorded in Datix on 6 (55%) occasions.
- For the 3 instances where injuries were recorded on Datix, the information matched with the injury site details recorded on the PPIA form on 1 (33%) occasion
- For the 3 instances where injuries were recorded, entries in the progress notes, Datix and the PPIA forms cross matched on no (0%) occasions.
- Of the 10 occasions where a patient had been taken to the floor and observations should have been recorded within the NEWS, there were 3 (30%) completed NEWS available within RiO.
- It was observed that on one occasion, from the incident time recorded in DATIX it was a further 5 hours and 28 minutes before the relevant progress note was entered.

Chart 1: Number of PRN forms complete on RiO for patients taken to the floor



Record Keeping Audit
There are a few components to this audit:

- *There is evidence of an RMO entry indicating the patient was seen/attempted to be seen within the last* month – In the April audit we could find evidence that 102 out of 117 patients had either been seen or there was an attempt to see them within the last month. The Associate Medical Director is provided with the details for those we could not find evidence for to support discussions as to why this may have been. On further investigation sick leave and a change in the RMO were the main reasons for this.
- *Progress notes within RiO have been validated* – In May, there were 139 progress notes from April still unvalidated. The note is not seen as a legal entry until it is validated. On further investigation there were a number of reasons found for the higher than usual number: Medic had locked themselves out of RiO (this has now been resolved) and Psychology notes that were entered prior to RiO 21 could not be validated (a solution has been found for this with Psychology and E-Health working together to resolve).

Variance Analysis Tool – Annual Reports
The annual VAT trend reports were presented to the Clinical Governance Group at the end of May. Below is an excerpt from the Treatment and Rehabilitation report to give a flavour of the year's data.

Areas of Good Practice

- All professions with the exception of Medical and Psychology had completion rates above 90%.
- Provision of reports was above 90% for Nursing, Social Work, Occupational Therapy, Pharmacy, Skye Activity Centre and Security
- Increases in professions discussing reports with patients prior to review for all professions with the exception of Nursing and Psychology. It should be noted, that Medical, Nursing and Psychology are still below pre-Covid levels.

Areas for Improvement

- Medical and Psychology completion of the VAT form continued to be low and due to this, we do not have evidence that Medical and Psychology interventions were carried out. During the year new processes were put in place to ensure completion of the VAT data.
- KW/AW attendance decreased from 67.5% in 20/21 to 58.5% in 21/22. Although we should be striving for the KW/AW to be at the case review as they will be closer to the care of the patient we can see that there was a nurse present 97% of the time but they were not the KW or AW. Suggest changes to the VAT form in order to collect data around KW attendance.
- Overall attendance was below set attendance KPI's, with the exception of Pharmacy and Social Work. In addition, 6 out of 8 professions are still below their pre-Covid attendance figures – the exception to this are Pharmacy and Social Work.
- Medical, Nursing and Psychology are still below pre-Covid levels for discussion of report with patient prior to case review.

The reports were discussed in full at the Clinical Governance Group with actions agreed.

Clinical Governance Committee
At the meeting in May 2022, the following papers were presented with a number of quality assurance and improvement activities contained within them:

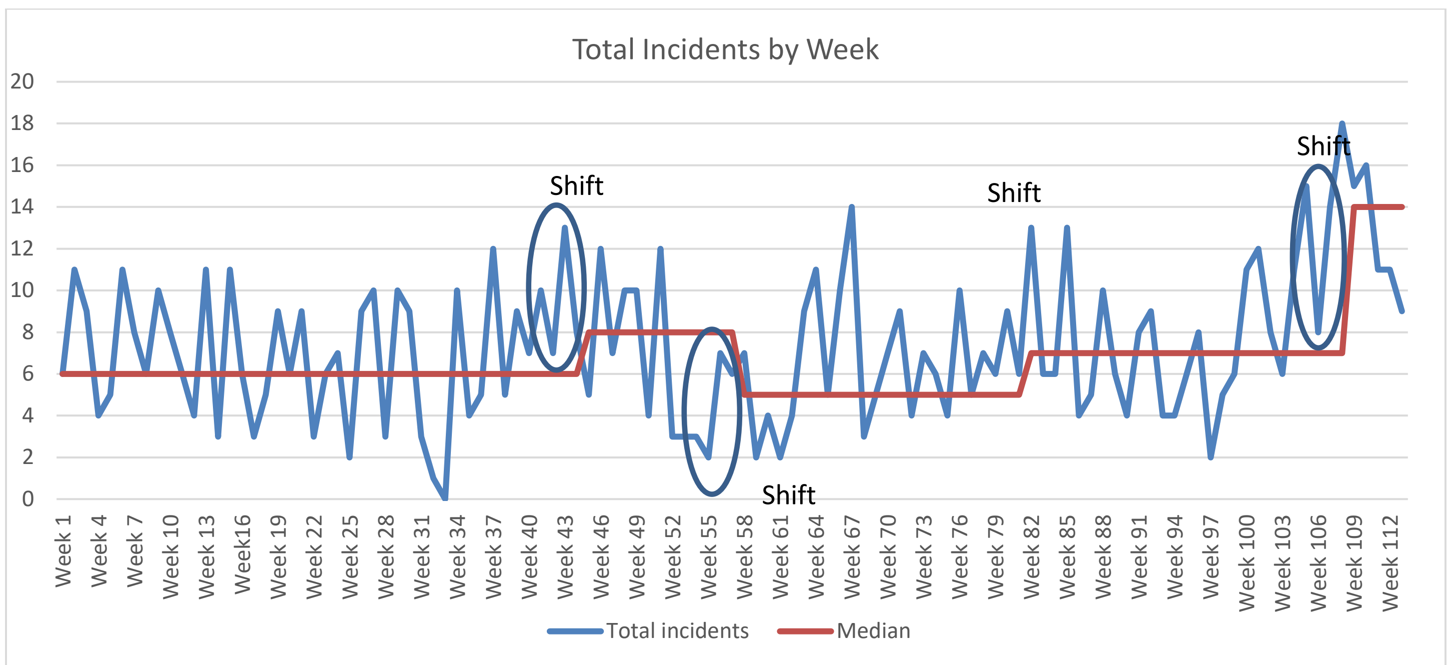
- Medicines Committee/Pharmacy 12 monthly report
- Research Committee 12 monthly report
- Infection Control Committee 12 monthly report
- Patient Movement report
- Staffing and Care report

- Fitness to Practice 12 monthly report
- Patient Learning 12 monthly report
- Learning from Feedback report
- Learning from Complaints report
- Incident Reporting and Patient Restrictions report
- Covid 19 Update
- Clinical Governance Stock-Take which included their annual report and review of their terms of reference

Daily and Weekly Indicator Reports
Clinical Quality continue to collate and present the data that gives the Corporate Management Team the assurance that it is safe to continue with the Interim Operational Policy. A sample of the most recent data is below, with week 113 representing data from 27th May to 2nd June 2022. The full report can be provided on request.

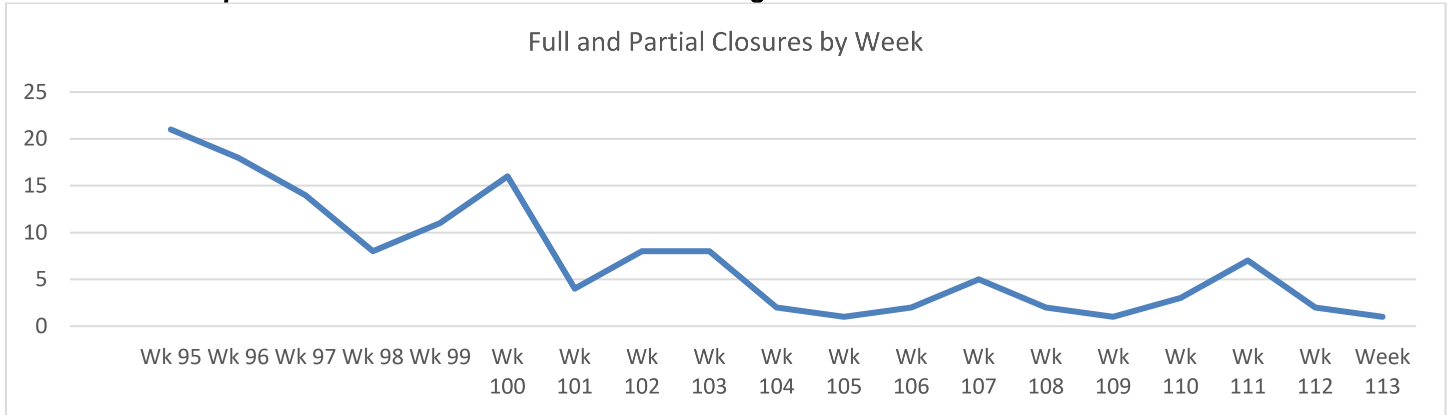
Datix assaults, attempted assaults and behaviour
We saw another increase to the median at the end of April due to the data remaining above the median. The median was moved from 7 to 14 at this time. In recent weeks, we have seen the number of incidents decrease but this will continue to be monitored through the Operating Model Monitoring Group to ensure there are no areas for improvement that should be addressed.

Chart 2: Total Incidents by Week



Ward Staff Shortages
Whilst ward staff shortages continue to be a challenge, we are not seeing the number we were at the start of the year. In addition to this, the number of times we have had to close wards has decreased (please see chart below).

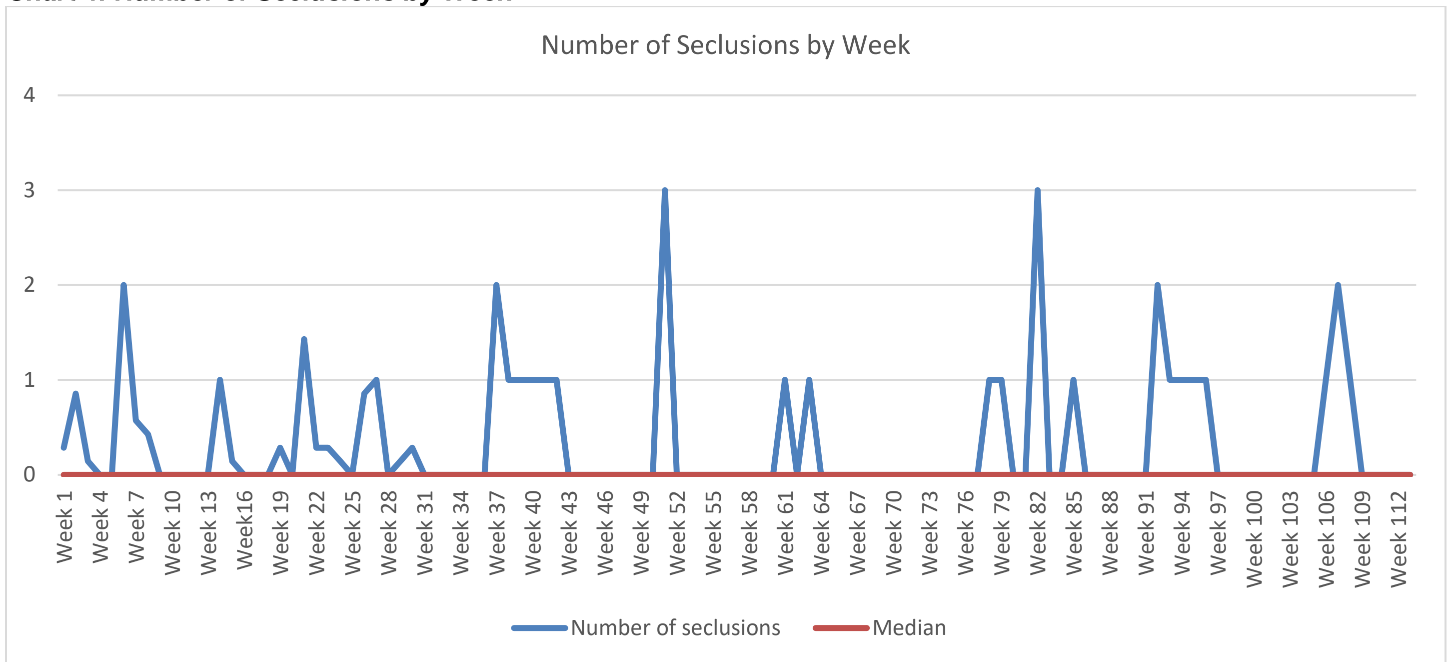
Chart 3: Full and partial ward closures as a result of staffing



Seclusions

In recent weeks we have seen very few seclusions, with the data showing random variation.

Chart 4: Number of Seclusions by Week

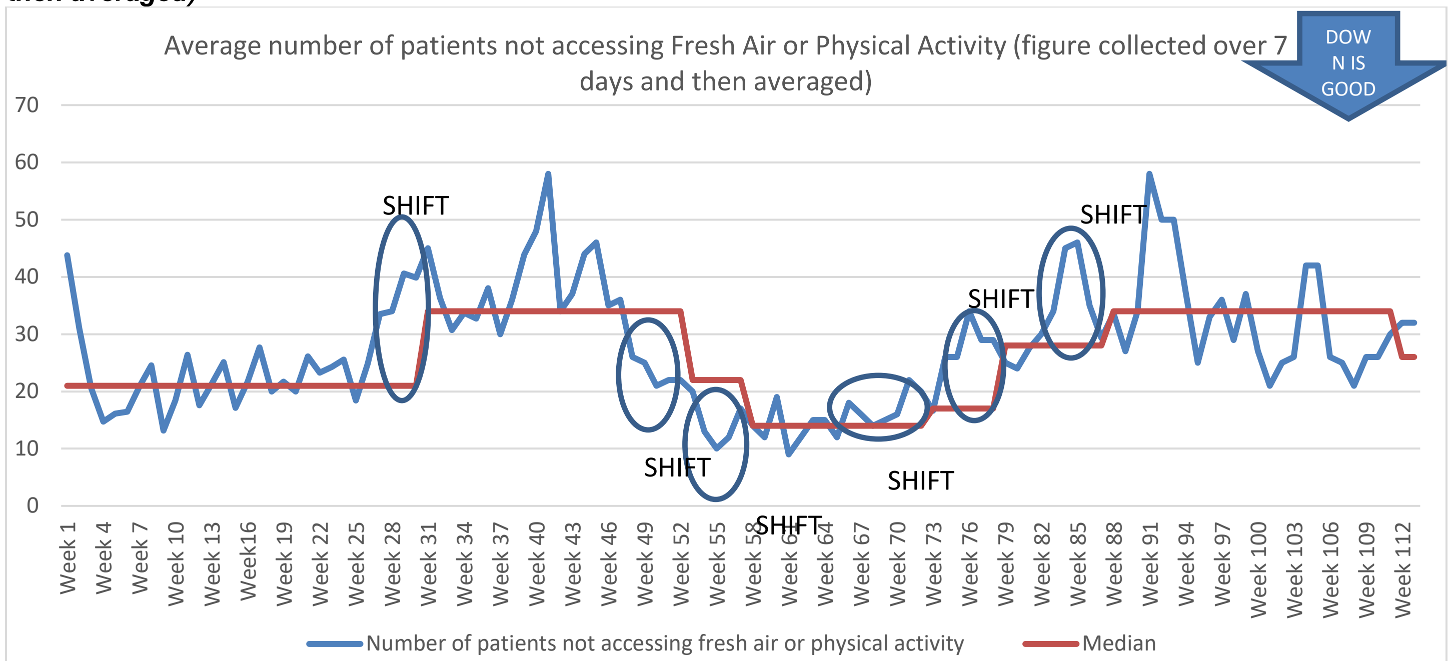


Patients not accessing Fresh air or Physical Activity (this is an average daily figure)

This indicator looks at both the fresh air data from PMTS and timetables and the physical activity data from RiO and highlights the patients that have had no fresh air or physical activity.

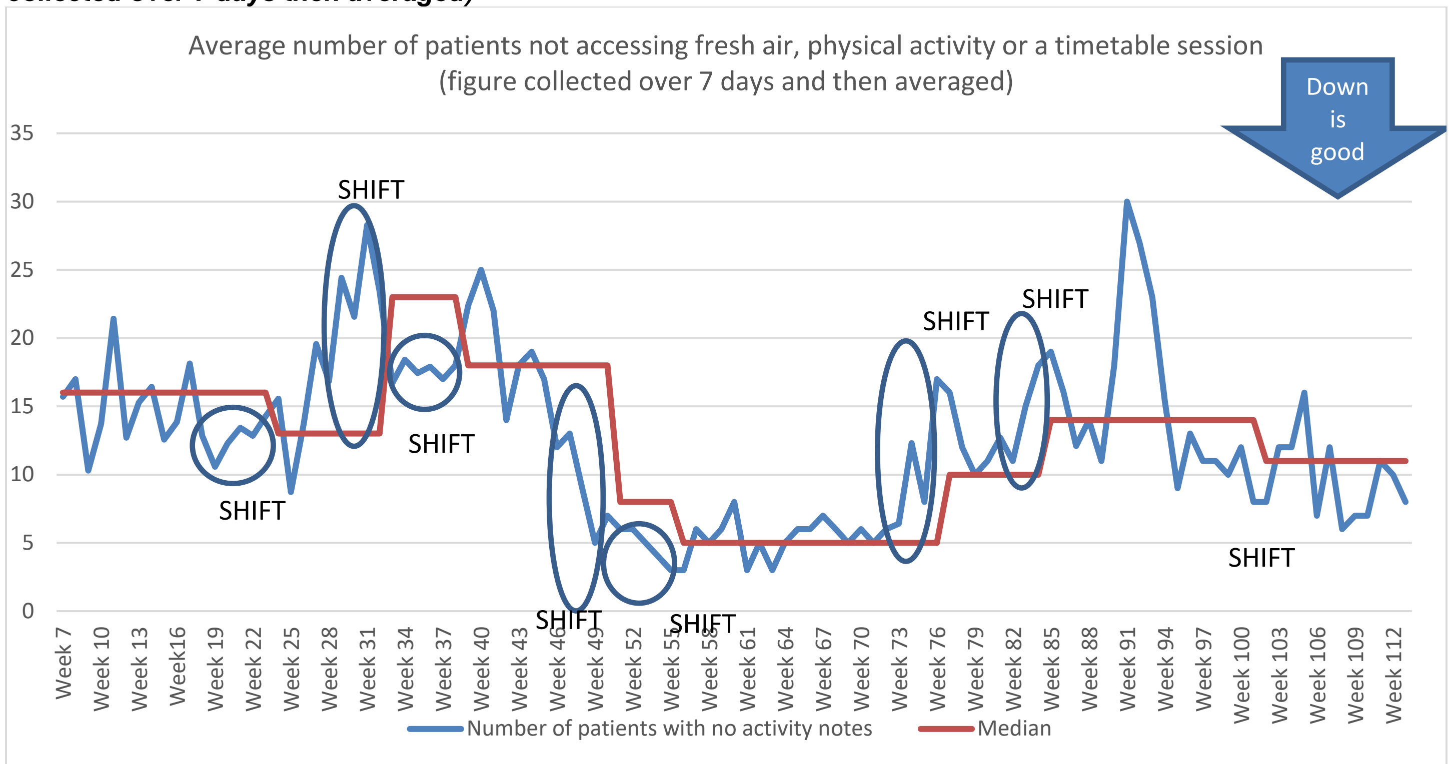
We have seen one recent positive shift in this data, with the median moving from 34 to 26.

Chart 5: Average Number of Patients Not Accessing Fresh Air or Physical Activity (figure collected over 7 days then averaged)



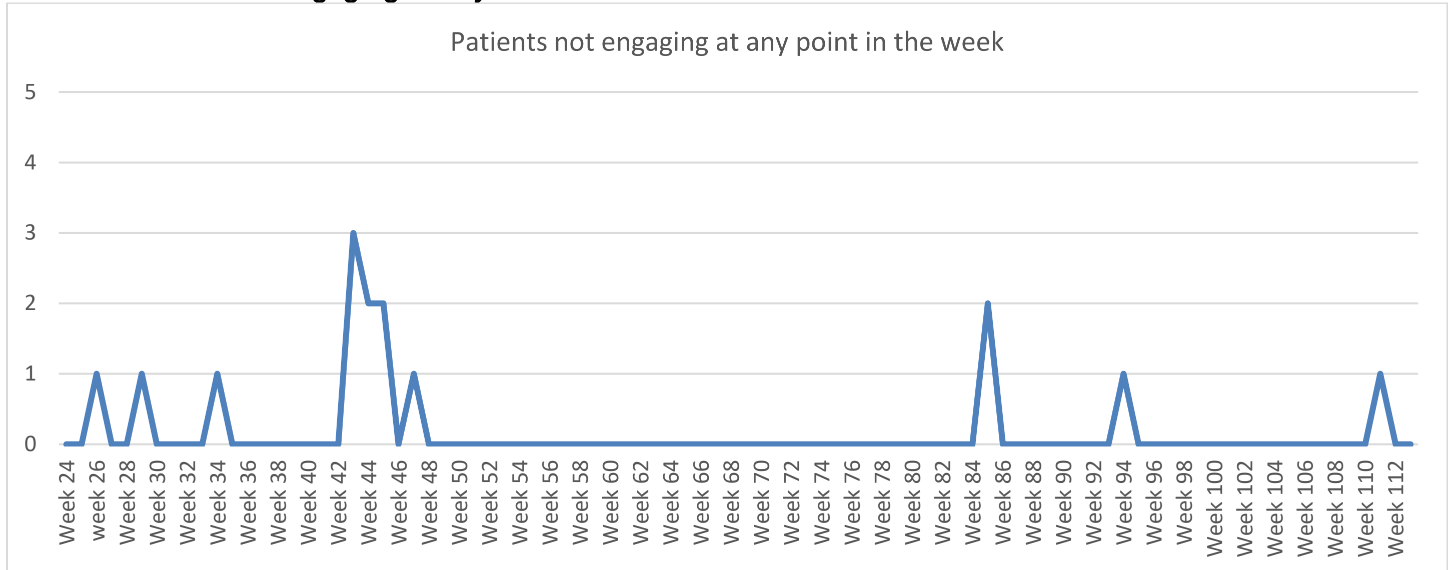
Patients not engaging with fresh air, physical activity or timetable sessions (this is an average daily figure)
One of the main purposes of collecting the daily indicator data was to ensure that there were limited patients that were not engaging with some form of activity i.e. fresh air, physical activity or a timetable session on a daily basis. Since the 1st January 2022, we have seen one positive shift in the data with the median moving from 14 to 11. This is an achievement that should be highlighted due to the number of ward staff shortages the hospital has been experiencing and the number of wards and patients in isolation in the first quarter of the year.

Chart 6: Average Number of Patients Not Accessing Fresh Air, Physical Activity or a Timetable Session (figure collected over 7 days then averaged)



Patient not engaging with fresh air, physical activity or a timetable session at any point in the week
When we look to see how many patients have had either fresh air, physical activity or a timetable session at any point in the week the data shows that the majority of the time, all patients are accessing fresh air, physical activity or a timetable activity at some point in the week. As can be seen in the chart below it is very uncommon for any of our patients not to get some form of fresh air, physical activity or a timetable activity (this includes when they are isolating due to being Covid positive).

Chart 7: Patients Not Engaging at Any Point in the Week



Planned Timetable Activity

In February 2022, the much anticipated planned timetable went live on RIO. This allows staff to programme in planned activities for our patients, linked to their recovery objectives. A report is issued weekly to show the number of these planned activities that have gone ahead and the reasons when they haven't. An excerpt from the most recent report (3rd June 2022) is below:

Table 2: Planned sessions v actual sessions provided

	Week 106	Week 107	Week 108	Week 109	Week 110	Week 111	Week 112	Week 113
Planned sessions that went ahead	350	287	350	407	428	377	340	342
Planned sessions that did not go ahead	245	95	152	163	243	313	351	339
% planned that went ahead	59%	75%	70%	71%	64%	55%	49.2%	50.2%

Monitoring of feedback regarding the reasons for activities not going ahead as planned revealed that departmental closures and Covid 19 were key issues in changes to the delivery of planned activity. The department closures were as a result of Skye Centre staff being deployed to wards to support ward routines and absences within Skye Centre Departments.

QUALITY IMPROVEMENT

QI Forum

The QI Forum meets regularly to champion, support and lead the quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum continues to support and embed QI approaches to innovation and learning using the model for improvement as a guiding approach.

The QI Forum continue to champion building capacity and skills in QI. Internal planning is underway for QI essential training later in the year. TSH have been allocated one place on a future cohort for ScLIP, this is available only for those involved in delivering Excellence in Care. Shortlisting is currently underway for this position. Initial planning is underway to offer another round of TSH3030. Aim of this would be to support new teams in QI activity following the implementation of the Clinical Model.

Realistic Medicine
Realistic Medicine (RM) is the Chief Medical Officer (CMO)'s strategy for sustaining and improving the NHS in Scotland. It is the CMO's vision that, by 2025, all healthcare professionals in Scotland will demonstrate their professionalism through the approaches of RM.

The six key themes of RM are:

- Building a personalised approach to care
- Changing our style to shared decision making
- Reducing harm and waste
- Becoming improvers and innovators
- Reducing unwarranted variation in practice and outcomes
- Managing risk better

The Realistic Medicine updated action plan has been submitted to Scottish Government alongside an interim implementation update for 2021/22. Scottish Government have extended their offer for this year of continued funding for part time Project Manager which TSH have accept. There has been movement towards focusing on a Values Based Healthcare system (theoretical movement of ensuring the best use of resources and treatments) and workshops and networking have been held over May and June.

Two Quality and Safety visits were held in Lewis 1 and Arran 1 wards over this period. Patients and Staff have engaged well in these visits and themes have emerged around time for staff to access staff support resources.

Evidence for Quality
National and local evidence based guidelines and standards
The State Hospital has a robust process in place for ensuring that all guidance published and received by the hospital is checked for relevancy. If the guidance is deemed relevant this is then taken to the appropriate multi-disciplinary Steering Group within the hospital for an evaluation matrix to be completed. The evaluation matrix is the tool used within the hospital to measure compliance with the recommendations.

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies can be reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 April to 31 May 2022, 28 guidance documents have been reviewed. Five were recorded for information and awareness purposes, 2 required completion of an evaluation matrix whilst the decision regarding relevancy for 3 documents are still pending. The remaining 18 documents were considered to be either not relevant to The State Hospital or were overridden by Scottish guidance.

Table 3: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
SIGN	1	1	0
Healthcare Improvement Scotland (HIS)	3	1	1 (1 pending)
Mental Welfare Commission (MWC)	6	3	1 (2 pending)
National Institute for Health & Care Excellence (NICE)	18	0	0

As at the date of this report, there are currently an additional 5 Evaluation matrices nearing the end of the review process.

Please see the table below for further information:

Table4: Evaluation Matrix Current Situation

Body	Title	Allocated Steering Group	Current Situation	Publication Date
SIGN	Eating Disorders	MHPSG	Evaluation matrix completed with 100% compliance achieved. Tabled at PHSG on 08/06/2022 for agreement before tabling at MHPSG for final sign off on 16/06/2022.	January 2022
HIS	Sexual Health Standards	PHSG	Review group rescheduled to meet 08/06/2022 and complete Evaluation matrix.	January 2022
HIS	Infection prevention and control standards for health and adult social care settings	ICC	Evaluation matrix currently being completed by Karen Burnett, Senior Nurse Infection Control.	May 2022
MWC	Social Circumstances Reports (SCR) – Good practice guidance on the preparation of SCRs for MHOs and managers	CGG	Following discussion at CGG on 25/05/2022, Evaluation matrix will be reviewed by Social Work on 17/05/2022	April 2022
Scottish Gov	Guidance on storage for medicines (including controlled drugs) in clinical areas	Medicines Committee	Clinical Quality were requested to assist in the review process for this letter. The Evaluation matrix was tabled on 01/06/2022 for final agreement. 91% compliance achieved with 2 outstanding recommendations to be taken forward and 5 accepted variances.	October 2021

There are currently 5 additional evaluation matrices which have been outstanding for a prolonged period of time and await review by their allocated Steering Group. The progress of the first 2 evaluations from HIS and the MWC was temporarily paused due to The State Hospital adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group which recommenced meetings in September 2020. Work is progressing with both. The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. At the date of this report, a date for the next SHC meeting to review the document is still awaited. Although the Clinical Quality Department were approached to in order to complete an evaluation matrix for the Kings Fund document entitled Courage of Compassion, this has now been placed on hold due to the retirement of the lead for this. This will be revisited once the new person is in post. The matrix in relation to the final NICE guideline was delayed due to prioritizing of guidance review upon appointment of the Practice Nurse within Tinto Health Centre. This matrix is currently tabled for the next meeting of the PHSG in early June 2022 for agreement and final sign off.

Table 5: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care	MHPSG (via Patient Safety)	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix to be revisited upon creation of updated draft Clinical Engagement Policy.	January 2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Engagement Policy currently being drafted with seclusion tier 1 and 2 being incorporated. Both to be launched together.	October 2019
PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. Awaiting next SHC meeting in order to take document forward.	February 2021
The Kings Fund	Courage of compassion – Supporting nurses and midwives to deliver high quality care	HR and Wellbeing Group	CQ were asked to assist in review of document in October 2021. Now on hold due to change in lead role (Dec 2021). Awaiting guidance once new post holder is in place.	September 2020
NICE	Acne vulgaris: Management	PHSG	Evaluation matrix completed with 100% compliance achieved. Tabled at PHSG on 08/06/2022 for agreement and final sign off.	June 2021

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 10 February 2022 at 9.45am via MS Teams **CGC(M) 22/01**

CHAIR:

Non Executive Director	David McConnell

PRESENT:

Non Executive Director	Stuart Currie

IN ATTENDANCE:

Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist	Khuram Khan
Head of Psychology	John Marshall
Head of Corporate Planning and Business Support	Monica Merson
Board Chair	Brian Moore
Director of Nursing, AHPs and Operations	Mark Richards
Board Secretary	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Lindsay Thomson
PA to Director of Nursing, AHPs and Operations	Sharon Bruce (minutes)

1 APOLOGIES AND INTRODUCTORY REMARKS

Apologies were noted from Non Executive Director, Cathy Fallon; Director of Finance and e-Health, Robin McNaught; PA to Medical & Associate Medical Directors, Jacqueline McDade.

David McConnell welcomed those present to the meeting.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted in respect of the business to be discussed.

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 11 NOVEMBER 2021

The Minutes of the previous meeting held on 11 November 2021 were approved as an accurate record.

4 PROGRESS ON ACTION NOTES

4.1 Health Psychologist Post

It was reported that work is being progressed in terms of developing a job description for a Health Psychologist post. Funding has been secured. The Human Resources department have advised that the job description has been benchmarked with a national template and therefore the post should be advertised indicative of banding.

4.2 Learning from Complaints

In terms of communicating with the Patient Partnership Group it was noted that there has been a delay. Monica Merson and Sandie Dickson highlighted however that a plan is in place and this will be reported at item 9 on the agenda.

4.3 Duty of Candour Report
It was noted that there was a data error within this report which has been rectified.

All actions were noted with these being closed from the action log.

5 MATTERS ARISING

There were no matters arising at this time.

6 PSYCHOLOGICAL THERAPIES SERVICE 12 MONTHLY REPORT

The Committee **received** and **noted** the Psychological Therapies Service 12 Monthly Report which was presented by John Marshall. It was highlighted that the report is centred on the *six quality dimensions* from The Healthcare Quality Strategy for NHS Scotland:

- *Safe* – VAT completion has been a challenge in PTS compared to pre pandemic levels but a plan to complete all VAT's and other data at every hub end of month meeting in situ for each member of staff by admin staff in the monthly hub meeting has been implemented and will be reviewed month to month.
- *Safe* – psychology service staff receives and provides regular individual and group supervision.
- *Safe* – 90.5% of staff have completed signed off PDP's on Turas as of January 2022
- *Safe* – The report highlights individual, group work and consultation activity which is lower than pre pandemic levels. Group therapies have been impacted.
- *Effective* - processes such as engagement in therapy may explain up to 60% of outcomes in the forensic field. 87% of patients were engaged in psychological therapies.
- *Effective* – for the first time in this report comparisons to the three other high secure hospitals in England have been made available and the level of engagement is joint second highest when considering all four hospitals.
- *The service is about to advertise for a Consultant Health psychologist aimed at improving physical health and lifestyle issues.* It is the first post of its kind in the UK.
- *Efficient* – VAT reporting has become problematic in some areas.
- *Efficient* – the service is on budget.
- *Equitable* – All patients have formulations which are co-constructed.
- *Timely* – Zero patients waited longer than 18 weeks for therapy as per HEAT target.

- *Developments* include tracking data and impact on group and one to one therapy of providing support to the wards: recruitment to consultant nurse post and consultant health psychologist; training using NES accredited model of health lifestyle and fitness motivation changes (MAP) to Skye Centre staff; development of Neurodevelopmental (NDD) pathway for patients given high likelihood of co-occurring Autism Spectrum; Foetal Alcohol, language disorder and other NDD's; contributing to shaping design of national sex offender treatment programme; ongoing work regarding outcome methodology and measures in Scotland (Forensic Matrix subgroup) and UK level (UK heads of psychology in High Secure).

- *Challenges – deploying staff to wards and possible adverse impacts on morale and psychological therapies; loss of two long term highly skilled staff plus one retirement due; VAT completion rates reduced.*

In terms of providing therapies it was noted that it has proved challenging to deliver via existing video conference system however it was reported that the 'Near Me' platform is being considered to alleviate those issues.

The use of stories and vignettes in the report was welcomed. These provide reference to lived

experiences and the variables which can impact outcomes.

It was noted that, outwith 1:1 sessions, patients' wellbeing was checked on a daily basis by asking them how they were feeling with the various changes. Although this was not recorded as therapy it was felt to have made a difference. However there was uncertainty around how best to capture this practice.

The Committee **noted** the report.

7 COVID-19 REPORT

The Committee **received** and **noted** the report on The State Hospital Clinical Response to Covid-19 Global Pandemic presented by Professor Lindsay Thomson. It was reported that since the last report that has been a Covid-19 outbreak in four wards. It was noted that although the Omicron variant is more infectious, evidence suggests that it is less virulent than the Delta variant.

Professor Lindsay Thomson reported that the changes to the interim clinical model took effect on 24 December 2021. This meant wards were subject to the bubble model of 6+6 patients. This was kept under regular review through the Incident Command structure and the impact of the policy was being monitored through the Operational Model Monitoring Group. More recently the model has changed to household model of 12 patients.

It was highlighted also that this reporting period presented challenges in terms of staffing with the most recent data showing a slight increase in the number of ward staff shortages from 53 to 57. These shortages resulted in 5 amendments of ward routines; 19 closures; 19 partial closures and 9 occasions when the responder model could not be met. Although there had been more ward staff shortages there was an improvement in the number of times a ward had to partially or fully close.

As of 9 February no live cases were being reported. There has been a new admission to the hospital therefore that patient is being tested. One other patient has reported symptoms and is also being tested. Should a test return positive for Covid-19, Iona 3 will be subject to closure.

Gary Jenkins reported that he liaises with Lanarkshire Resilience Partnership Group and he highlighted that The State Hospital appeared to have peaked earlier in terms of the Omicron variant than other areas in Lanarkshire. It was highlighted that absence related to Omicron was higher over the festive period and although other Board areas were able to draw on mutual aid, this was not available to The State Hospital. However staff were commended on containing the outbreaks well and were thanked for their efforts in managing to control the transmission of infection.

The Committee **noted** the report.

8 STAFFING AND CARE REPORT

The Committee **received** and **noted** the Safe Staffing and Care Report from October to December presented by Mark Richards, Director of Nursing, AHPs and Operations.

It was reported that there were a number of factors affecting delivery of adequate staffing levels such as clinical activity, sickness/absence, vacancies and health restrictions/planned leave. Additional absence due to Covid-19 was also a significant factor. The report highlighted staffing deficits and business continuity measures. As of 31 December 2021 it was noted that there were 16.92 vacancies and that currently this is sitting slightly higher at 20.4%. There is a significant focus on recruitment to bridge the gap and to ensure the position does not further deteriorate as a consequence of planned retirements. Recruitment has been extended to include student nurses and there has been temporary variation to the registered/unregistered skills mix to recruit more nursing assistants.

Absence is still a significant factor which affects day to day staffing availability. The highest sickness level was seen in November at 12.6%. Over and above this, there is a further impact due to special leave, which is expressed as a loss of hours, and is significantly affected by Covid-19 related absence. The highest numbers of hours lost was in December at 2,579 hours. In summary, the loss of staff due to unplanned leave, which is expressed as a WTE and a percentage of workforce, showed its highest level in December at 46.2 WTE (16.7%).

In terms of business continuity, which is the response to situations of significant risk and specifically significant loss of staff, it was reported that a number of full ward closures and partial ward closures took place between October and December. Improved specific monitoring of full and partial ward closures and patient access to activity was introduced from 18 November 2021. Data are now collated to show the date of closure, the affected ward, details of when the ward was fully or partially closed and the number of patients who had at least one timetabled activity. This report is scrutinised on a fortnightly basis at the Operating Model Monitoring Group.

In December 2021, a new 'Safe to Start', model was introduced through which there is a multi professional approach to achieving safe staffing, and which is also intended to support multi professional planning to ensure safe staffing at ward level. It is intended to significantly mitigate against risk of ward closures for full shifts. This is the main component of the real time staffing approach aligned to safe staffing legislation.

To assist with staffing it was highlighted that a short life working group has been established to look at a nursing bank for The State Hospital to create more resilience going forward.

The Committee **noted** the report.

9 LEARNING FROM FEEDBACK

The Committee **received** and **noted** the Learning from Feedback Report which was presented by Mark Richards, Director of Nursing, AHPs and Operations. In Quarter 3 it was reported that the Person Centred Improvement Team responded to 83 pieces of feedback which was similar in number to Quarter 2. In summary the feedback included:

- Meal service feedback remains consistent, including the sharing of 7 compliments, however there were significantly fewer concerns, with 4 this quarter compared to 11 in the previous quarter.
- 14 individual carers shared feedback this quarter, in addition to 2 pieces of feedback discussed by the Carers' Support Group.
- The majority of patient feedback shared is via the Patient Partnership Group (PPG), however there has been an increase in 1:1 patient feedback shared via the telephone this quarter.
- Increase in the number of compliments shared, the majority relating to Family Centre visiting.
- Increased concerns raised overall, primarily relating to changes to service delivery directly relating to the impact of Covid-19

Members noted in particular the initiative around the clothing bank for patients which involves patients donating to the bank which their peers can access. There has been a positive response to this initiative from the patient group.

It was also highlighted that 25 concerns were raised due to a lack of access to activities/ therapies which was the result of service constraints.

It was reported that in response to a number of complaints and concerns raised by patients in relation to the impact of resourcing challenges on patient care, the Chief Executive attended PPG

in December 2021. PPG were assured that resourcing has been and will continue to be a priority for the organisation to ensure that patient care is not impacted by staffing levels. Members noted the draft of PPG 'Traffic Lights' process to support the bedroom access process.

Going forward it was agreed to be useful to compare trend data by themes highlighting those related to covid and those due to staffing etc.

ACTION: SHEILA SMITH

The Committee **noted** the report.

10 LEARNING FROM COMPLAINTS

The Committee **received** and **noted** the Learning from Complaints Report for Quarter 3 summarised by Margaret Smith. It was reported that during this quarter, 15 new complaints were received and 17 complaints were closed.

Detailed assessment of the main issues of focus in complaints during this quarter, as well as whether they were upheld and if any learning has been taken, is included in the main report. In relation to complaints closed, the report highlights that during this quarter the majority of complains received related to ward closures in the context of staff shortages within nursing. This situation first became apparent in complaints reporting during Quarter 1 of this year, and it is clear that patients continue to feel that they have been adversely affected.

Quarter three includes the autumn and winter months and grounds access times had reduced significantly. However, the majority of the security refresh works have now been completed in the central grounds access routes and restrictions during permitted hours have been resolved.

The consideration of complaints managed during this quarter has helped to underline the way in which learning from complaints can help to highlight the views of patients and carers, so that the organisation can actively listen and respond. Whilst this report shows that there have been increased levesl of complaints and patient dissatisfaction, it also demonstrates the work progressed to try to improve our patients' experience of care.

The Patients Advocacy Service (PAS) which is independent of TSH, provided support to patients in seven cases. The report highlights the positive relationship between the complaints service and PAS and the work progressing to help support patients to access the complaints process effectively.

It was also reported that as part of the complaints handling process the organisation is required to ask people their views about the complaints process. A local feedback pro-forma is currently used with a view to seeking the feedback of those using the complaints process. These are sent out to complainants once the complaint is closed. They are returned to the Head of Clinical Quality. However, there is generally a low uptake of this opportunity and no forms were returned in this quarter. Further feedback options will be considered e.g. seeking views through the Patient Partnership Group, and a further update will be provided in the next quarterly report. [Is this an action for someone??]

The Committee **noted** the report.

11 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members **received** and **noted** the Incident Reporting and Patient Restrictions report presented by Lindsay Thomson, Medical Director. In summary it was noted that PAA activations decreased this quarter from 21 to 14. It was reported that there were 2 positive oral fluid tests with 2 patients from different hubs testing positive for Gabapentin. Handcuffs were used on 20 occasions reflecting an

increase in the number of clinical appointments. 1 patient was nursed using SRK. 2 incidents occurred in relation to withheld mail.

In terms of incidents, it was reported that there were 565 reported in Datix which is an increase from 467 the previous quarter. There were 8 ‘very high’ incidents, all of which involved staffing issues, specifically relating to the closure of wards. 177 ‘high’ category incidents were reported with 166 of those being reported under staff resource issues. The ‘high’ rating comes from an increased frequency of reporting of this issue across the hospital and the impact this has.

129 incidents were reported to be related to health and safety, an increase of 14 on the previous quarter. Behaviour had the highest number of incidents at 63, 54 were recorded as threatening/intimidating behaviour, 6 as other and 1 as incitement.

Members also noted 253 staff resource incidents which is an increase of 18 since the last quarter. 166 of those incidents had a ‘high’ rating which comes from an increased frequency of reporting staffing issues across the hospital and an increase in the impact that these issues are causing the hospital and its patients. There were also 8 ‘very high’ incidents recorded, all involved staffing issues relating to ward closures.

The Committee **noted** the report.

12 CLINICAL GOVERNANCE GROUP 12 MONTHLY REPORT

Members **received** and **noted** the Clinical Governance Group 12 Monthly Report presented by Lindsay Thomson, Medical Director. This report provides a summary of the work of the Clinical Governance Group over its fifth year.

It includes a summary of core activity including reports that were tabled at the meetings for discussion/comment prior to them coming to this Committee for approval.

The report highlights comparisons with last years planned quality assurance and quality improvement activity although much if this was impacted due to covid-19 restrictions.

Quality assurance activity and quality improvement activity is also provided in the report for 2021. The efforts of the Clinical Quality team was noted with thanks being passed to the team.

The core activities for the coming year were noted to include:

- Implementation of the Clinical Model including preparation of guidance on the 4 ward types, patient flow, model fidelity and development of measures to monitor the model.
- Oversee the implementation of the QI Activity Project to ensure activity within the patients’ objectives are reflected in the activities delivered to the patient.
- Ongoing focus on Quality Improvement, Realistic Medicine and TSH 3030 initiative.

The Committee **noted** the report.

13 DISCUSSION ITEM

No items were put forward for discussion however suggestions for next meeting included the Barron report; Clinical Model; Improving Observation Practice. It was agreed that one should be selected and added to the May agenda.

14 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee **received** and **noted** paper on Areas of Good Practice and Areas of Concern. A number of areas of good practice was acknowledged. It was noted that the value of overall analysis and vignettes included in the Psychological Therapies report should be added as an area of good practice to keep sight of improvements and outcome focus.

It was highlighted that this paper covers 2020/2021 and members were asked for their view on whether this should be refreshed. It was agreed that update should be provided on each item as to whether they have been progressed and whether they should be closed off. Lindsay Thomson to liaise with the Chair to agree best format going forward.

ACTION: LINDSAY THOMSON

15 WORKPLAN

The Committee **noted** the Clinical Governance Committee Workplan. It was highlighted that a number of reports were deferred due to suspension of meetings during a period of staffing challenges. Discussion took place as to whether some reports should be postponed to a less heavy agenda. It was agreed that discussion re the workplan would take place offline with Chair and Medical Director with liaison with other non-executive members.

ACTION: CATHY FALLON / LINDSAY THOMSON

16 ANY OTHER BUSINESS

No other business was raised at this time.

17 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on Thursday 12 May 2022 at 9.45am via MS Teams

The meeting concluded at 11.50am

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM

Draft Minutes of the Clinical Forum held at 10.00am on Tuesday 22 March 2022 via Microsoft Teams **CF(M) 22/01**

Chair:
Dr Sheila Howitt — *Consultant Forensic Psychiatrist*

Present:
Dr Aileen Burnett — *Consultant Clinical Psychologist*
Dr Jana De Villiers — *Consultant Psychiatrist*

Apologies:
Alan Blackwood — *Senior Charge Nurse*
Josie Clark — *Lead Professional Nurse Advisor*
Carly Doolan — *Allied Health Professional*
Ben Green — *Clinical Liaison Security Manager*
Sheila Smith — *Head of Clinical Quality*
Marcus Topping — *Practice Nurse*
Fiona Warrington — *Clinical Pharmacist*

In Attendance:
Sandie Dickson — *Person Centred Improvement Lead*
Cathy Fallon — *Chair of Clinical Governance Committee (Item 11)*
David Hamilton — *Social Work Team Leader*
David McCafferty — *PA to Chair / CEO, Corporate Services (Minutes)*
Julie McGee — *Clinical Quality Facilitator*
Monica Merson — *Head of Planning & Business (Item 12)*
Brian Moore — *Board Chair (Item 10)*
Margaret Smith — *Board Secretary*

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Clinical Forum Chair, Dr Sheila Howitt, welcomed everyone to the meeting. Apologies were noted as detailed above.

NOTED.

2 CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED.

3 ELECTION OF NEW VICE CHAIR

The question was raised as to whether there were any nominations for this role, and unfortunately none were forthcoming. Discussion took place around attendance at the meeting and the difficulties posed due to service pressures. There was focus on the potential to increase nursing group attendance at this meeting. The Clinical Forum Chair agreed to make contact with colleagues, especially within nursing, outwith this group. The Clinical Forum would review this item again at its next meeting.

Action: Sheila Howitt/ add to next agenda

AGREED.

4 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meeting held on 23 November 2021 **were approved** as an accurate record.

APPROVED.

5 URGENT MATTERS ARISING

There were no urgent matters which have arisen over the preceding seven days. It was highlighted that although groups were now beginning to restart following a pause due to the pandemic and also service pressures, staffing remained a challenge.

NOTED.

6 REVIEW OF ROLLING ACTIONS LIST

The Rolling Actions List was reviewed, and would be updated following today's meeting.

NOTED.

7 UPDATE FROM AREA CLINICAL FORUM CHAIR'S GROUP FOR SCOTLAND

The Clinical Forum Chair advised members that she had not been able to attend the last meeting which had taken place in March, but that the minute would be shared when available.

NOTED.

8 FORUM WORKPLAN 2022 – FOR APPROVAL

Members were provided and noted the Forum Workplan 2022. There was discussion on how to focus on the key areas that the Clinical Forum should plan to review during the coming year to build a comprehensive workplan. As part of this, it was hoped that following review of the wider Advisory Committee structure, would provide more clarity around reporting necessity and drivers for the group. Ms Smith was leading on a review of this area of governance and would bring reporting back to the Clinical Forum. It was agreed that consideration in this area should be dynamic and continually developing to ensure that the Clinical Forum could fulfil its remit.

AGREED.

9 UPDATES FROM EACH ADVISORY COMMITTEE ON SALIENT BUSINESS POINTS / APPROVED MINUTES TO NOTE

(a) Nursing and Allied Health Professions Advisory Committee

Members were advised and noted that February 2022 meeting was postponed. Current service pressures and the recent period of incident command were noted.

NOTED.

(b) Medical Advisory Committee

Members were presented with the minute from the Medical Advisory Committee which took place on 13 December 2021. Items of discussion included the Barron review on the delivery of forensic

mental health services and the national work being taken forward: as well as the Scott review looking at current Mental Health Act and development of this and the possible implications for the State Hospital and how care and treatment is provided.

NOTED.

(c) Psychology Professional Practice Meeting
Members were advised that this meeting had been stood back up as of 7 March 2022 and the draft minute had just been made available and would be shared in due course. Meta-analysis around psychological therapies and how treatment was evaluated was a key topic of discussion. Work was currently underway around neurodevelopment disorders and neurodevelopment pathways.

NOTED.

(d) Update Report from Dentist, GP and Optometric
An update report from Dentist, GP and Optometric had been received from the Practice Nurse dated 22 March 2022 and was noted. Of particular note, the GP service would switch to a new provider from 1st April 2022.

NOTED.

10 CHAIR UPDATE

Mr Brian Moore, Board Chair, joined the meeting and provided members with an update on key topics of discussion at the Board meeting on 24 February 2022 and other areas of focus.

Key topics of focus for the Board had included service pressures and the recent period of incident command arrangements in the hospital, and the learning that could be achieved from this including adapting to significant changes. The Board had welcomed the work progressed on recruitment as well as the importance of supporting staff wellbeing. There had been reporting on the implementation of the Clinical Model with planning underway, which would include engagement with key stakeholders including patients and staff. An update had been reviewed on Supporting Healthy Choices initiatives with a Project Manager having now been appointed. Mr Moore advised that an update on iMatter was provided and feedback noted to have been mainly positive.

Mr Moore advised that both the CEO and Medical Director were involved with the national Short Life Working Group which had been set up looking into recommendations from Barron report; an options appraisal had commenced to provide a shortlist in April 2022 further to this being presented to Ministers around June 2022.

Mr Moore finalised his update advising members that he had attended the Patient Partnership Group and that Patient Safety Programme walkrounds had resumed with involvement from Non-Executive Directors.

The group welcomed this detailed update from the Chair and discussed the potential for learning following the hospital's experience of incident command and how this compared to that of other Boards. In general, it was felt to have worked well, though there would be areas for learning and refinement around risk management. There was reflection on how clinical teams had been impacted, and what incident command arrangements had meant in terms hub and ward level leadership especially on taking forward tests of change at a local level. Alternatively, it was also felt that communication links from the centre through Bronze Command had been very good and enabled the ability for staff to provide feedback and influence decision-making. It was felt that the Operational Model Monitoring Group had been particularly effective in linking teams into the incident command structure, and ensuring that range of experience and views was being reported and considered. There was further discussion on the balance of being to do that against the need for rapid decision-making and rapidly changing events.

NOTED.

11 UPDATE FROM CHAIR OF CLINICAL GOVERNANCE COMMITTEE

Ms Cathy Fallon, Chair of the Clinical Governance Committee was in attendance at today's meeting to provide and update from the last Clinical Governance Committee meeting which took place in February.

Ms Fallon provided a summary to the Clinical Forum on key areas of interests and review by the Committee, as well as key areas of clinical governance considered by the Board. She underlined that key focus had been on the continuing response to Covid-19, and the wider impacts of service delivery especially round staffing capacity and patient activity. The Committee had received quarterly reporting on complaint handling as well as feedback, and on incident reporting and patient restrictions. There had been 12 monthly reporting from the Psychological Therapies Service, as well as annual reporting from the Clinical Governance Group.

Arising from this the Clinical Forum discussed the impacts experienced by services, and the balance between the need to re-start services and how to support that during periods of pressures. There were varying views around the table with some reflection on whether the re-start of some workstreams had been too soon, or whether there had been benefit in doing so nonetheless. It was underlined in discussion that the organisation had come in and out of incident command arrangements and periods of service pressures over time, and that it was important to remember the challenges in doing so.

NOTED.

12 UPDATE ON CLINICAL MODEL

Members received and noted a Clinical Model Planning update report provided by Ms Monica Merson, Head of Corporate Planning and Business Support. The report provided oversight of where the process currently was and the next steps for development which had been agreed by the Board at its meeting in February. This would centre around engagement, financial analysis, revision and development of clinical guidance documents, clarity around planning assumptions and management model description to support implementation of the new model.

There was discussion on the key points and the report was received positively. The continuing focus on a separate ID service was considered to be helpful, as well as the work being taken forward on stakeholder engagement. Ms Smith noted that it would be helpful for future updates on progress to be fed through the full advisory structure, to allow each professional group to consider implementation of the model from their own clinical perspective. It was agreed by the Clinical Forum that this would be a helpful way forward.

Mr Merson was thanked for her update and continuing work in this respect.

NOTED.

13 MWC GOOD PRACTICE GUIDE DOCUMENT – RIGHT TO TREAT GUIDE – FOR NOTING

Members received and noted the MWC Good Practice Guide Document. No change to legislation was confirmed. Guidance was noted to apply to the small number of patients within the hospital who are not able to provide consent. Document was noted to have been tabled at the last Mental Health Practice Steering Group and reassurance was given to this group that this item was discussed in detail there.

NOTED.

14 TERMS OF REFERENCE REVIEW/TSH PROFESSIONAL ADVISORY COMMITTEES (PACS)

Members received and noted a Terms of Reference Review/TSH Professional Advisory Committees (PACS) update provided by Ms Margaret Smith, Board Secretary. She provided an overview of its content. Previous discussion had taken place around the Clinical Forum membership and that this guidance linked into this. She advised that she was taking forward a review of governance within the advisory structure to strengthen and support this structure within the hospital. She would ensure these structures are benchmarked with wider NHS Scotland Boards.

The Clinical Forum discussed this and linked it to its previous discussion on membership and attendance and it was felt that this would be a helpful way forward. Ms Smith agreed to bring an update to the next Clinical Forum meeting.

Action: Ms (Margaret) Smith/ add to agenda

NOTED.

15 AOCB

Members noted this year's 'What Matters to You' initiative will take place on 6th June 2022. Bulletin communication would be produced notifying all staff of this event.

NOTED.

16 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 24 May 2022 via Microsoft Teams.

Meeting concluded at 1205 hours

Paper No: 22/47

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 14
Author(s):	Chair of Staff Governance Committee
Title of Report:	Staff Governance Committee Annual Report
Purpose of Report:	For Decision

1 SITUATION

The attached Staff Governance Committee Annual Report outlines the key achievements and key developments overseen by the Committee during 2021/22. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

2 BACKGROUND

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

3 ASSESSMENT

In the performance year 2021/22, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership.

The Staff Governance Committee approved this report at its meeting on 19 May 2022.

4 RECOMMENDATION

Board Members are asked to approve the Staff Governance Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2021/22.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To demonstraste that the committee has carried out its remit.
Workforce Implications	N/A
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	Staff Governance Committee Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One **X There are no privacy implications.** ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE ANNUAL REPORT

1 April 2021 – 31 March 2022

1. INTRODUCTION

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'** The Staff Governance Standard (4th Edition) sets out what each NHS Scotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2020/21, The State Hospitals Board for Scotland's Staff Governance Committee continued to focus its monitoring activities in respect of the above. The Committee members recognised their obligations to support a culture within The State Hospitals Board for Scotland where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the organisation and is built upon the principles of partnership. Members of the Staff Governance Committee are appointed annually by the NHS Board. Membership details of the Committee during 2020/21 are detailed below.

2. COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
Pam Radage (Chair of Committee, Non Executive Director)

Committee Members:
Allan Connor (part) (Employee Director) (from 1 September 2021)
Stuart Currie (Non-Executive Director)
Cathy Fallon (Non-Executive Director)
Tom Hair (part) (Employee Director) (to 31 August 2021)
Brian Moore (Non-Executive Director) (to 5 July 2021),

In attendance:
Alan Blackwood (part) (lay member, Prison Office Association)
Linda Davidson (part) (Director of Workforce)
Gary Jenkins (Chief Executive)
David McConnell (part) (Interim Board Chair) [to 5 July 2021]
Michelle McKinlay (part) (lay member, UNISON)
Jacqueline McQueen (lay member, Royal College of Nursing)
Monica Merson (Head of Corporate Planning and Business Support)
Brian Moore (Board Chair from 6 July 2021)
Richard Nelson (part) (lay member, Prison Office Association)
Margaret Smith (Board Secretary)
John White (part) (Director of HR & Wellbeing)

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

Where required by the Chair or by other members of the Committee, appropriate members of staff were invited to be in attendance for the purposes of verbal updates, information sharing, presentations etc.

3. MEETINGS DURING 2021/22

During 2021/22 the Staff Governance Committee met on four occasions, in line with its terms of reference (Appendix 1). Meetings were held on:

20 May 2021
19 August 2021
18 November 2021
17 February 2022

4. REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

The Committee received reports and monitored areas as follows:

- Monitoring of Personal Development Planning & Review (PDPR) performance
- Monitoring of Attendance Management performance
- Monitoring HR Performance – Employee Relations Activity
- Monitor the update of iMatter, the NHS Scotland Staff Engagement Tool
- Healthy Working Lives (HWL)
- Workforce Planning
- Whistleblowing
- Statutory and Mandatory Training Compliance
- Fitness to Practice
- Recruitment
- NHSScotland Staff Governance Standard Monitoring Framework
- Wellbeing
- Occupational Health
- Practice Development

4.1 ANNUAL REPORTS

Staff Governance Monitoring 2020/21

Staff Governance Monitoring was resumed for 2020/21 and the return was sent to the Scottish Government by the deadline date of 24th September 2021. This was approved via email with formal Staff Government Committee approval taking place at the November 2021 meeting.

Positive feedback has been received from the Scottish Government in relation to this return and work will continue to improve the outcomes for Staff (Appendix 2).

iMatter

Members of the committee received an update at the November 2021 meeting and received the iMatter End of Year Report (2021-2022) at the February 2022 meeting. They were advised that the response rate was lower than in previous years, but higher than for the Everyone Matters Pulse Survey. It was thought this was due to pressures of staff time and availability due to the Pandemic. Work continues to ensure the response rate rises for the forthcoming cycle.

Key challenges were shared and discussed.

Occupational Health Service Annual Report

The annual report was presented to the August 2021 meeting by the Occupational Health Clinical Team from SALUS, the current provider of the OHS service level. Key priorities were highlighted and discussed at length, including:

- Service Provision – an overview of all services provided
- Key Priorities
- Quality systems, processes and advice
- Key Performance Indicators
- Measures of performance
- Reducing Absence
- Service Level Agreement Extension and Renewal

4.2 PROGRESS UPDATES

The committee received regular updated reports and monitored issues relating to the following:

- Personal Development Planning & Review (PDPR)
- Attendance Management
- HR Performance – Employee Relations Activity
- Healthy Working Lives / Wellbeing

PDPR, Personal Development Plan

Monitoring of completion rates for the Personal Development Planning & Review process was kept under scrutiny throughout the year and reported regularly to the Corporate Management Team and Partnership Forum. The average monthly completion rate for 2021/22 was 85.24% - an increase of 5% when compared to the previous year. The PDPR process and associated compliance has continued to be affected as a result of the pandemic together with staff absence and homeworking which has made it difficult in some cases to progress appraisals that were due or overdue. The compliance level at 31 March 2022 was 76.4%.

Attendance Management

The attendance target set for The State Hospitals Board for Scotland in 2021/22 is 5%. This was not reached, with an end of year average monthly absence percentage of 7.30%. The long/short term split is 5.84% and 1.46% retrospectively.

The principal reasons for absence remained consistent with the previous year, with the two most common reasons for absence being anxiety/stress/depression, accounting for 28.5% of absence, and musculoskeletal (injury/fracture, back problems and other MSK), accounting for 23.11% of absence.

HR Performance – Employee Relations Activity

These reports continue to be presented for information and discussion due to the historic time delays experienced with HR cases, however the Committee recognised improvement in this area.

The Committee discuss the improvements made from previous years, particularly around compliance with policies. This continues to be a focus for the Committee.

Healthy Working Lives / Wellbeing / Staff & Volunteer Wellbeing Strategy 2022-2024

HWL is a multi-disciplinary group which continues to support work around health and wellbeing across the organisation through the delivery of a varied programme of events and initiatives.

The HWL Group's mission is to provide a forum where health, safety and wellbeing issues can be identified, and strategies put in place to create improvements that result in a happier, healthier and more highly engaged workforce. The group's aim is to improve the health, safety and wellbeing of all our employees, particularly in the following areas: supporting mental health awareness and education, improving physical health and promoting links / networking within and outside of the organisation

Updates from Healthy Working Lives were presented to the May and November meetings.

Members were advised that the submission for the Gold HWL Award was on pause as we wait advice from Public Health Scotland on what criteria might be applicable, recognising the impact of COVID-19. At the moment, recent advice received details there is no requirement to submit a formal report. The group are however hopeful to maintain the award at Gold level when this resumes and the HWL group will be ready for submission.

A HR and Wellbeing Group led by the Director of Workforce, established in December 2020, was formed to provide a Forum to review HR and Wellbeing performance, approve TSH implementation of national terms and conditions and programmes of work to enhance Employee Wellbeing.

Through this Group, a Staff & Volunteer Wellbeing Strategy 2022-25 was developed and widely consulted on, including Staff Governance Members. Approval is expected at the April meeting of the Board, with the final version being presented to Staff Governance in May 2022.

4.3 STANDING ITEMS CONSIDERED BY THE COMMITTEE DURING THE YEAR

Fitness to Practise

A report was provided to assure the Staff Governance Committee that all professional staff were registered and fit to practise.

Whistleblowing Quarterly updates

Following the implementation from The Scottish Public Services Ombudsman (SPSO) who previously advised that the role of the Independent National Whistleblowing Officer (INWO) would commence with effect from the 1 of April 2021. The Whistleblowing Standards that SPSO have developed as a model procedure for handling whistleblowing concerns raised by staff and others delivering NHS services, was formally published on 1 April 2021. For NHS Scotland staff, these form the 'Once for Scotland' Whistleblowing Policy.

The Committee received reports at the May, August, November and February meetings advising of cases raised and any relevant updates.

Statutory and Mandatory Training

The Committee reviewed the arrangements for completing Statutory and Mandatory training in order to ensure that these were robust, compliant with legislative requirements, and supported the Staff Governance Strand of the workforce being “Appropriately trained and developed”.

Notes of Minutes from other meetings

The Committee received and noted minutes/reports from the following:

- Partnership Forum
- Human Resources and Wellbeing Group
- Clinical Governance papers (as appropriate and where related to a Staff Governance issue)

5. CONCLUSION

The performance year 2021/22 has underlined the continuing need to focus our attention on key Staff Governance issues.

The main priority area in terms of Staff Governance performance management continues to be the pursuit of the Attendance Management target of 5% absence. Another key priority however is the emerging wellbeing agenda for Staff and Volunteers and work will continue in this area to ensure support and guidance is readily available.

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

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee’s behalf during 2021/22**.**

Pam Radage
STAFF GOVERNANCE COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Staff Governance Committee

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

STAFF GOVERNANCE COMMITTEE
TERMS OF REFERENCE

1 PURPOSE

The Staff Governance Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital.

2 COMPOSITION

2.1 Membership

The Staff Governance Committee is appointed by the Board and shall be composed of the Employee Director and three other Non Executive Board Members one of whom shall act as Chair.

The Committee can invite the Board Chair to be a member of the committee for the purposes of a meeting, should it be the case that the committee would otherwise be inquorate.

There will be three lay representatives identified by the staff side organisations and nominated by the Partnership Forum. The lay representatives will not act in an ex officio capacity. An ex-officio member is a member of a body who is part of it by virtue of holding another office. Such members shall have the power to vote in the Committee's decisions.

Membership will be reviewed annually.

The Staff Governance Committee will have the authority to co-opt other attendees from outwith the Board in order to carry out its remit.

2.2 Appointment of Chair

The Chair of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Members shall normally attend meetings and receive all relevant papers. All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive) and Human Resources Director shall be invited to attend meetings and receive all relevant papers. Other Directors and staff may also be invited by the Chair of the Committee to attend meetings as required.

3 MEETINGS

3.1 Frequency

The Staff Governance Committee will meet quarterly to fulfil its remit and shall report to the Board following each meeting.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken. The format of agendas and papers will be in line with corporate document standards. The lead Executive for co-ordinating agendas and papers is the Human Resources Director.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and, once approved, submitted at the next Board meeting. The Chief Executive's personal assistant is responsible for minute taking arrangements.

The minutes and action list of the Staff Governance Committee will be presented to the next Staff Governance Committee meeting to ensure actions have been followed up.

3.5 Other

In order to fulfil its remit, the Staff Governance Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

4 REMIT

4.1 Objectives

The main objectives of the Staff Governance Committee are to provide the Board with the assurance that staff governance mechanisms are in place and effective within The State Hospital; and that the principles of the national Staff Governance Standards and The State Hospital's Staff Charter are applied equitably and fairly to all staff.

Existence and effective operation of this committee will be demonstrated in continuous improvement and compliance with staff governance standards, in delivery of improved working arrangements for staff, and ultimately in achievement of outcome targets as evidenced through the staff related key performance indicators reported in the Local Delivery Plan.

4.2 Systems and accountability

4.2.1 To ensure that appropriate staff governance mechanisms are in place throughout the hospital in line with national standards.

4.2.2 To ensure that people management risks are managed in accordance with the corporate risk management strategy, policies and procedures.

4.2.3 To ensure that staff governance issues which impact on service delivery and quality of service are appropriately managed.

4.2.4 To review the Staff Governance Action Plan and ensure that the Partnership Forum is performance managing the action plan.

4.3 People management

To provide assurance to the Board in respect of people management arrangements, that:

4.3.1 Culture is maintained within the hospital where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within the hospital and is built upon partnership and collaboration.

4.3.2 Structures are in place to monitor the outcome of strategies and implementation plans relating to people management.

4.3.3 Structures are in place to monitor the outcome of strategies and implementation plans relating to knowledge management.

4.3.4 Propose policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.5 Support is given for any policy amendment, funding or resource submission to achieve the Staff Governance Standards.

4.3.6 There is timely submission of all staff governance data required by the Scottish Government Health Department and in respect of the Local Delivery Plan.

4.3.7 Pay modernisation processes are monitored and that the Boards Pay Benefits Realisation Plans are signed off.

4.3.8 Workforce planning and development is monitored and to sign off the Boards Workforce Plan and the Boards Development Plan and ensure they support the Local Delivery Plan.

4.3.9 Policies and procedures are developed, implemented and reviewed.

4.4 Controls assurance

To ensure that:

4.4.1 The information governance framework provides appropriate mechanisms for Codes of Practice on Data Protection and Freedom of Information to be applied to all staff.

4.4.2 The planning and delivery of services has fully involved partnership working.

4.4.3 Systems are in place to measure and monitor performance to foster a culture of quality and continuous improvement.

4.4.4 Staff governance information is provided to support the statement of internal control.

5 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised to establish a Remuneration Committee to cover staff under executive and senior manager pay arrangements and to validate the work of that committee. The Remuneration Committee must include, as a minimum, three non executive Directors of the Board. The Remuneration Committee will be a closed committee and shall sign off its own minutes. The Staff Governance Committee will require to be provided with assurance that systems and procedures are in place to appropriately manage the pay of this group of staff. This will not include detailed confidential employment issues that are considered by the

Remuneration Committee: these can only be considered by non executive Directors of the Board.

6 PERFORMANCE OF THE COMMITTEE

The Committee shall annually review and report on:

- Its own performance and effectiveness in meeting the terms of reference; including its running costs, and level of input of members relative to the added value achieved
- Proposed changes, if any, to the terms of reference.

7 REPORTING FORMAT AND FREQUENCY

The Chair of the Committee will report to the Board following each meeting of the Staff Governance Committee.

The Chair of the Committee shall submit an Annual Report on the work of the Committee to the Board.

8 COMMUNICATION AND LINKS

The Chair of the Committee will be available to the Board as required to answer questions about its work.

The Chair of the Committee will ensure arrangements are in place to provide information to the Scottish Government as required to meet their reporting requirements.

Appendix 2

10 - Appendix 2 Staff Governance Monitorir

THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 15
Author:	Remuneration Committee Chair
Title of Report:	Remuneration Committee Annual Report – 2021/22
Purpose of Report:	For Decision

1 SITUATION

The attached Remuneration Committee Annual Report outlines the workplan overseen by the committee during 2021/22.

2 BACKGROUND

Staff Governance is defined as 'a system of corporate accountability for the fair and effective management of all staff. The State Hospitals Board for Scotland's Remuneration Committee fulfils this remit with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

3 ASSESSMENT

In the performance year 2021/22, the Remuneration Committee continued to focus its monitoring activities in respect of the above responsibilities and provided reporting to the National Performance Monitoring Committee in this regard. The committee also considered the award of Consultant Discretionary Points.

During this year, the Remuneration Committee Chair changed to the NHS Board Vice-Chair to align with practice throughout NHS Scotland. This ensures that the committee chair does not play a role in the Executive and Senior Manager Appraisals process, avoiding potential conflict of interest.

This report has been circulated electronically to the Remuneration Committee, confirming their approval of it.

4 RECOMMENDATION

Board Members are asked to approve the Remuneration Committee Annual Report, as demonstrating that the committee has met its remit and terms of reference during 2021/22.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Reporting to demonstrate that committee has met its remit
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route To Audit Committee Which groups were involved in contributing to the paper and recommendations.	Submitted for noting, as part of year end reporting, and prior to submission to the Board
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

REMUNERATION COMMITTEE ANNUAL REPORT

1 April 2021 – 31 March 2022

1 INTRODUCTION

Staff Governance is defined as **'a system of corporate accountability for the fair and effective management of all staff.'**

The Staff Governance Standard (4th Edition) sets out what each NHSScotland employer must achieve in order to improve continuously in relation to the fair and effective management of staff. Implicit in the Standard is that all legal obligations are met, and that all policies and agreements are implemented. In addition to this, the Standard specifies that staff are entitled to be:

- well informed;
- appropriately trained and developed;
- involved in decisions;
- treated fairly and consistently; with dignity and respect, in an environment where diversity is valued;
- provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

In the performance year 2021/22, The State Hospitals Board for Scotland's Remuneration Committee continued to focus its monitoring activities in respect of the above, with particular regard to the performance, pay and terms and conditions of Executive and Senior Managers.

During this year, the Remuneration Committee Chair changed to the NHS Board Vice-Chair to align with practice throughout NHS Scotland. This ensures that the committee chair does not play a role in the Executive and Senior Manager Appraisals process, avoiding potential conflict of interest.

2 COMMITTEE CHAIR MEMBERS AND ATTENDEES

Committee Chair:
David McConnell, NHS Board Vice-Chair:
(To 5 July 2021, then from 1 February 2022)

Brian Moore, NHS Board Chair
(From 6 July to 31 January 2022)

Committee Members:
Allan Connor, Employee Director (from 1 September 2021)
Stuart Currie, Non-Executive Director
Cathy Fallon, Non-Executive Director
Tom Hair, Employee Director (to 31 August 2021)
David McConnell, NHS Board Vice-Chair (From 6 July to 31 January 2022)
Brian Moore, NHS Board Chair (To 5 July, then from 1 February 2022)
Pam Radage, Non-Executive Director

In Attendance:
Gary Jenkins, Chief Executive
John White, Interim HR Director (part year)
Linda Davidson, Director of Workforce (part year)
Margaret Smith, Board Secretary

3 MEETINGS DURING 2020/21

During 2021/22 the Remuneration Committee met on three occasions.

Meetings were held on:

- 29 June 2021
- 13 October 2021
- 15 February 2022

4 REPORTS CONSIDERED BY THE COMMITTEE DURING THE YEAR

- Approval of the Performance Management arrangements and Performance Appraisals for Executive Directors for the performance year 2020-21.
- Agreement that the Appraisal outcomes for Executive Directors be submitted to the National Performance Management Committee.
- Consideration of the National Performance Management Committee's appraisal analysis.
- Agreement of the Executive Directors Performance Planning and Review (Objectives) for the year 2021/22.
- Consultants discretionary points were reported on and approved.
- Approval of Executive and Senior Managers Pay for 2021-22.

The Remuneration Committee will also review other issues related to its remit. During this year the committee considered recruitment to Executive and Senior Management positions in the organisation to ensure resilience in the Executive Team.

5 CONCLUSION

The Remuneration Committee discharged its responsibilities with regard to the oversight of Executive and Senior Managers' performance management and remuneration.

I would like to thank the Committee members for their contribution to the meetings in 2021/22.

David McConnell
REMUNERATION COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Remuneration Committee

THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1 The Committee shall be known as the Remuneration Committee of The State Hospitals Board for Scotland. It will be a standing Committee of The State Hospitals Board for Scotland and will make decisions on behalf of The State Hospitals Board for Scotland.

COMPOSITION

2 The Remuneration Committee members will be appointed by The State Hospitals Board for Scotland and will consist of:

- The Vice-Chair of The State Hospitals Board for Scotland, who will be the Committee Chair
- All other Non-Executive Directors of the Board, including the Employee Director and the Board Chair.

In addition, there will be in attendance (in full or part):

- Chief Executive
- Director of Workforce
- Board Secretary

No employee of the Board shall be present when any issue relating to their employment is being discussed.

3 The Human Resources Director will be the Executive Director Lead and will attend meetings of the Remuneration Committee as Advisor. The Human Resources Director will not be present during discussion of Executive colleagues' appraisals.

Executive Director Lead
Generally, the designated Executive Lead will support the Chair of the Committee in ensuring that the Committee operates according to / in fulfilment of its agreed Terms of Reference. Specifically, they will:

- support the Chair in ensuring that the Committee Remit is based on the latest guidance and relevant legislation;

- liaise with the Chair in agreeing a programme of meetings for the business year, as required by its remit;

- oversee the development of an Annual Workplan for the Committee which is congruent with its remit and the need to provide appropriate assurance at the year-end, for endorsement by the Committee and approval by the Board;

- agree with the Chair an agenda for each meeting, having regard to the Committee's Remit and Workplan;

- oversee the production of an Annual Report, informed by self-assessment of performance against the Remuneration Committee Self-Assessment Handbook, on the delivery of the Committee's Remit and Workplan for endorsement by the Committee and submission to the Board.

4 Where issues with financial implications are to be discussed at the Remuneration Committee the implications will first have been discussed with the Finance Director and, where appropriate, the Finance and Performance Management Director may be invited to attend meetings of the Remuneration Committee.

5 The quorum for the Remuneration Committee will be attendance by 3 Non-Executive Directors, inclusive of the Chair.

FUNCTIONS

6 To oversee and agree the remuneration arrangements and terms and conditions of employment of Executive Directors and Senior Managers of The State Hospitals Board for Scotland, to include:

- content and format of job descriptions
- terms of employment including tenure
- remuneration
- benefits including pension or superannuation arrangements
- annual salary review

7 To ensure arrangements are in place for the assessment of the performance of The State Hospitals Board for Scotland and to monitor the performance of The State Hospitals Board for Scotland against pre-determined performance criteria to inform oversight of objective setting and support for decisions on individual performance appraisal.

8 To agree The State Hospitals Board for Scotland's arrangements for performance management and to ensure that the performance of the Executive Directors is rigorously assessed against agreed objectives within the terms of the performance management arrangements referred to above.

9 To ensure that clear objectives are established for Executive Directors of The State Hospitals Board for Scotland before the start of the year in which performance is assessed by

- receiving a report from the Chair on the agreed Objectives for the Chief Executive
- receiving a report from the Chief Executive on the agreed Objectives for the other Executive Directors of the Board.

10 To monitor arrangements for the pay and conditions of service of other Senior Managers on Executive Pay arrangements and on Professional/Management Transitional pay arrangements in accordance with appropriate guidance and to implement annual pay uplifts and pay progression in accordance with national guidance.

11 To approve The State Hospitals Board for Scotland's arrangements for the grading of Senior Manager and Executive Director posts and to oversee these arrangements by receiving regular reports from the Director of Human Resources.

12 To ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for staff employed under the Executive and Senior Management Pay arrangements. To receive formal reports (at least annually) providing evidence of the effective operation of these arrangements.

13 To consider any redundancy, early retiral or termination arrangement in respect of all State Hospital staff, excluding early retirals on grounds of ill health, and approve these or refer to the Board as the Committee sees fit. In addition, the Committee will oversee the award of discretionary points to medical staff.

14 To fulfil its functions, the Remuneration Committee will take into account a range of factors which will include

- regular reports from the Director of Workforce
- the Remuneration Committee Self-Assessment Handbook
- guidance issued by the Scottish Government Health Department
- an annual report on the application of pay awards and pay movements
- the need to recruit and retain appropriately qualified and skilled Directors and Senior Managers
- equitable pay and benefits for the level of work performed

CONDUCT OF BUSINESS

15 Meetings of the Committee will be called by the Chair of the Committee with items of business circulated to members one week before the date of the meeting.

16 The Committee will seek specialist guidance and advice as appropriate.

17 All business of the Committee will be conducted in strict confidence.

REGULARITY OF MEETINGS

18 Meetings of the Remuneration Committee will be held as necessary to conduct its business. At a minimum, the Committee should meet twice per annum, once to approve the performance assessments and annual Objectives of the Executive Directors and once to approve the annual application of pay awards and pay progression.

REPORTING ARRANGEMENTS

19 The Remuneration Committee will report to the Board.

Membership of the Remuneration Committee will be reported to and agreed by the Board. Appropriate details of Executive Members remuneration will be published in The State Hospitals Board for Scotland's Annual Report.

Annual Report
In accordance with Board and Committee Working, the Committee will submit to the Board each year an Annual Report, encompassing : the name of the Committee; the Committee Chair; members; the Executive Lead and officer supports / attendees; frequency and dates of meetings; the activities of the Committee during the year, including confirmation of delivery of the Annual Workplan and review of the Committee Terms of Reference; improvements overseen by the Committee; matters of concern to the Committee.

Where the review by the Committee of its Terms of Reference results in amendment the revised Terms of Reference must be submitted to the Board for approval. The Committee Annual Report will inform the submission of any appropriate assurance to the Chief Executive at the year-end, as part of the Statement of Internal Control.

20 Details of the business conducted by the Committee will be made available to the Scottish Government Health Department, the form and content being determined by the latter.

21 Reporting, marked as 'official sensitive', on each meeting of the Remuneration Committee will be issued to the Non-Executive Directors of the Board.

Paper No. 22/49

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 16
Sponsoring Director:	Director of Workforce
Author(s):	Director of Workforce
Title of Report:	Whistleblowing Standard Annual Report for the year ended 31 March 2022
Purpose of Report:	Detail of implementation, cases and developments during 2021/22

1 SITUATION

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

As part of the Standard, each Health Board is required to produce an Annual Report which should detail the work undertaken in the implementation of the Standard.

2 BACKGROUND

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

3 ASSESSMENT

In the performance year 2021/22, the State Hospitals Board for Scotland had two cases raised under Whistleblowing and information on these are contained in the attached Report. This also details the work undertaken to develop the processes within the Board and the Actions following the investigations into the two complaints.

4 RECOMMENDATION

Board Members are asked to note and agree the draft Whistleblowing Annual Report for 2021-22 which will be published on both the internet and intranet sites.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	This Annual Report updates the Board on the performance and uptake of this Policy and Standard.
Workforce Implications	To ensure staff feel able to raise any concerns without fear of retribution.
Financial Implications	N/A
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One **X There are no privacy implications.** ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

WHISTLEBLOWING ANNUAL REPORT

1 April 2021 – 31 March 2022

1. INTRODUCTION

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

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

In addition to this, the Scottish Government revised and promoted the role of the Whistleblowing Champion as a formal Non-Executive member of each NHS Board. Their role is to ensure that the systems are in place to enable staff to raise concerns, and that the culture of the organisation supports the full application of these systems, by valuing staff concerns. Brian Moore, (Chair) held the position of the Non-Executive Whistleblowing Champion until his appointment as Chair in July 2021. Unfortunately, this post remains vacant whilst we await the conclusion to the formal recruitment process conducted by the Scottish Government. Until this position is formally in place, it has been agreed that staff will be able to raise concerns with any of the Non-Executive Directors.

The Executive Lead remains the Director of Workforce. However once the Non-Executive position has been filled, this will be reviewed in line with the Standards recommendations.

2. IMPLEMENTATION AND REVIEWS

The State Hospital fully launched the Whistleblowing Standards and the National Policy in April 2021. A soft launch had also been undertaken in February 2021.

In advance of the formal launch of the Standards, a special Staff Bulletin was made available to all staff providing details of the new Standards, the role of the INWO, how to raise any concerns, and information relating to the Training available.

In terms of the Training, to date the current levels of training as at:

Introduction for all Staff – 448
Managers Training – 28

This information is provided to Operational Management Team, Corporate Management Team, Staff Governance and the Board. Ongoing work will continue to improve these figures with a dedicated communication plan to ensure that information is regularly sent to all Staff regarding their access to this Policy and Standard.

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

Currently the Board has two Confidential Contacts, however, work is taking place with the other National Boards on a possible shared resource to ensure complete confidentiality is in place for anyone raising a concern. It is hoped that more Staff will come forward to undertake the Confidential Contact training and therefore strengthen the pool of resource. However, it should be noted that as a small Board whilst this remains a challenge, we have been able to source and resource additional provision as and when required with support from other Health Boards.

Work continues on the development of a culture which fully promotes openness and transparency in its daily reporting. A development session has taken place with the Joint Staff Side with a full Partnership session to take place later in the year. Developing and building relationships with the Trade Unions has had significant improvements in joint working and this will continue to be undertaken – in full partnership. There is certainly has been a strengthening of the work over the past several months and the Partnership Forum and HR and Wellbeing Groups will continue with the excellent progress made to date.

The Corporate Management Team leads development of leadership throughout the organisation, and has undertaken a comprehensive review of organisational governance to support this. This has included re-visiting the learning from the Sturrock and Strang reports (published in 2019) and how this may apply to the hospital as we enter a new landscape of learning to live with Covid-19. In addition, the Workforce Directorate are developing Leadership Programmes and a Developing Manager Programme which will help support new and future and leaders in the organisation. Our Induction Programme is also under review with a view to ensuring that all staff feel fully included from their first day in the organisation, with a proposed follow up to this to “check-in” with them three months after they commence employment.

To ensure the Board are completely updated on the Standard and roll out, the INWO will attend a Board Development day in September 2022. This will ensure they are fully aware of the Standard and Policy.

3. WHISTLEBLOWING REPORTING

A key requirement of the revised standards is notification of case incidence to the Board and Staff Governance Committee.

Throughout 2021/22 a report updating the position on Whistleblowing has been produced and presented to the Board on the following dates:

15 April 2021 - Introduction to Standard and Process
26 August 2021 - Quarter 1 Update
23 December 2021 - Quarter 2 Update
24 February 2022 - Quarter 3 Update

The report has also been presented to the Staff Governance Committee and the dates this was on the agenda were:

20 May 2021
19 August 2021
18 November 2021
17 February 2022

4. WHISTLEBLOWING CASES 2021/22

In 2021/22 there was a total of two cases raised within The State Hospital under Whistleblowing.

Case 1 - investigated internally at Stage 2 and the individual who raised the concern has had formal feedback, with a follow up in writing.
Unfortunately, this case was concluded outwith the 20-day target which was due to sick leave. However, this was rectified and feedback was given as quickly as possible thereafter.

Case 2 – due to the complex nature of this complaint the investigation was conducted by a Team external to the Board. This again, was completed at Stage 2 level and feedback has been given to the individual who raised the concern along with a follow up in writing. Unfortunately, this case was not concluded within the 20-day target and was due to a number of factors outwith the control of the Investigation Team. The reasons for the delay included the complex nature of the investigation, the number of witnesses to be interviewed and sickness.

The next stage for both cases is they have the opportunity to request a review via the INWO. To date, no notification has been received that this has been requested.

5. LEARNING AND ACTIONS

As well as the outcomes, recommendations have been made in each of the cases and these are being actioned, with updates being provided at Board and Staff Governance. These include:

- Review of Recruitment Processes;
- Work on building key relationships to ensure openness and transparency;
- Further communications on the Whistleblowing Standards and Training;
- Development of more Confidential Contacts;
- Recruitment to the Non-Executive Whistleblowing Lead;
- Development of an internal Operating Procedure providing clarity on the process followed when dealing with any concerns;
- Additional support sources, not only for those who are raising the concerns but for anyone who may become involved (i.e. witnesses)
- Development of a Communication Plan aimed at raising awareness of the Standards;
- Development of a Culture where complaints and concerns are encouraged and welcomed.

6. QUALITY AND PATIENT CARE

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

7. CONCLUSION

During 2021/22 there were two Cases raised under Whistleblowing, both of which were investigated and feedback given to the Complainants.

Action which have come out of this will continue to be worked on and updates will be given at Corporate Management Team, Staff Governance Committee and the Board.

Work continues to improve the support given to Staff and development will take place on the systems and processes used to encourage feedback on any issues.

Brian Moore
Chair
On behalf of the State Hospitals Board for Scotland

Paper No. 22/50

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 17
Sponsoring Director:	Director of Workforce
Author(s):	Head of HR
Title of Report:	Attendance Performance Report
Purpose of Report:	For Noting

1 SITUATION

This report provides the Board with an update on overall attendance performance to 31st May 2022.

Detailed information and analysis is provided quarterly to the Staff Governance Committee. Monthly reviews also take place at Corporate Management Team and HR & Wellbeing Group.

2 BACKGROUND

The State Hospital use a dashboard system called Tableau, which to date has not been utilised fully to provide staffing information. Work has been done to develop this information to provide fuller and more up to date information relating to absence levels, sickness absence information and additional staffing levels. The reports are still within the test phase, however, once agreed the reports will be available to all Tableau users, who can then review the information relating to their own areas of work.

The Tableau dashboards are updated on a daily basis using information from the SSTS system, meaning that the information available is live and as accurate and up to date as the information input by managers.

In addition to the information provided through Tableau, this report contains information on the national statistics information, providing information for 2021/22 through Turas data using SWISS information, as well as the following:

- EASY compliance
- Employee Relations casework
- Workforce information including establishment

- Vacancy levels
- Recruitment information
- Workforce turnover

It is intended that over the coming months, the majority of this information will also move onto the Tableau dashboard.

All information is provided to the end of May 2022, with the exception of the national statistics information, which is for the year 2021/22. The workforce establishment provided is for April 2022.

3 ASSESSMENT

- The information available shows that the absence rate for May 2022 is 5.34%. The rolling year average is 7.21%.

- 43 staff were being managed through the formal stages of the Attendance Policy and 12 staff were off on long term absence.

- The key reasons for short term absence were unknown causes, gastro-intestinal and anxiety/stress/depression and for long term absence were anxiety/stress/depression, injury/fracture and unknown causes. Managers have been asked to review the information input to SSTS to reduce the number of entries with an unknown reason.

- Covid related absence accounted for 2.07% of all absence and there are 4 long Covid cases.

- 9 posts were within the recruitment process. The national KPI for completion of the recruitment process from post approval to start date is 75 days and for individuals who started within May, The State Hospital average was 76.

- 53.36 WTE supplementary staffing was required through overtime or excess hours.

- One new employee relations cases were identified in May 2022. There were 5 ongoing cases, including one grievance requiring input from MSG.

- 12 staff within this financial year have ended their employment with The State Hospital. The reason provided for the majority of these is ‘other’.

Full details can be found in the attached Appendix 1.

4 RECOMMENDATION

The Board is invited to note this report.

Paper No. 22/50

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target locally. The national target is currently 4%.
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team Staff Governance Committee Partnership Forum, HR and Wellbeing Group
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
Equality Impact Assessment	Not required for this report as monitoring summary 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).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

Workforce Report – June 2022

The information contained in this report comes from the following data sources:
SSTS
SWISS
EESS
Cohort Occupational Health System
NHS Scotland annual workforce report. The full report is available here: NHSScotland workforce | Turas Data Intelligence

SSTS is a live and dynamic system which means that information can be updated on it at any point. Managers are asked to update systems in real time, however, depending on when this is done, there can be variations to reports depending on when they are run.

The attendance, recruitment and turnover information contained on this report will be available on Tableau. Managers will be able to filter the reports to look at information for individual departments.

Absence and Sickness Absence - All Staff

Month
May, 2022

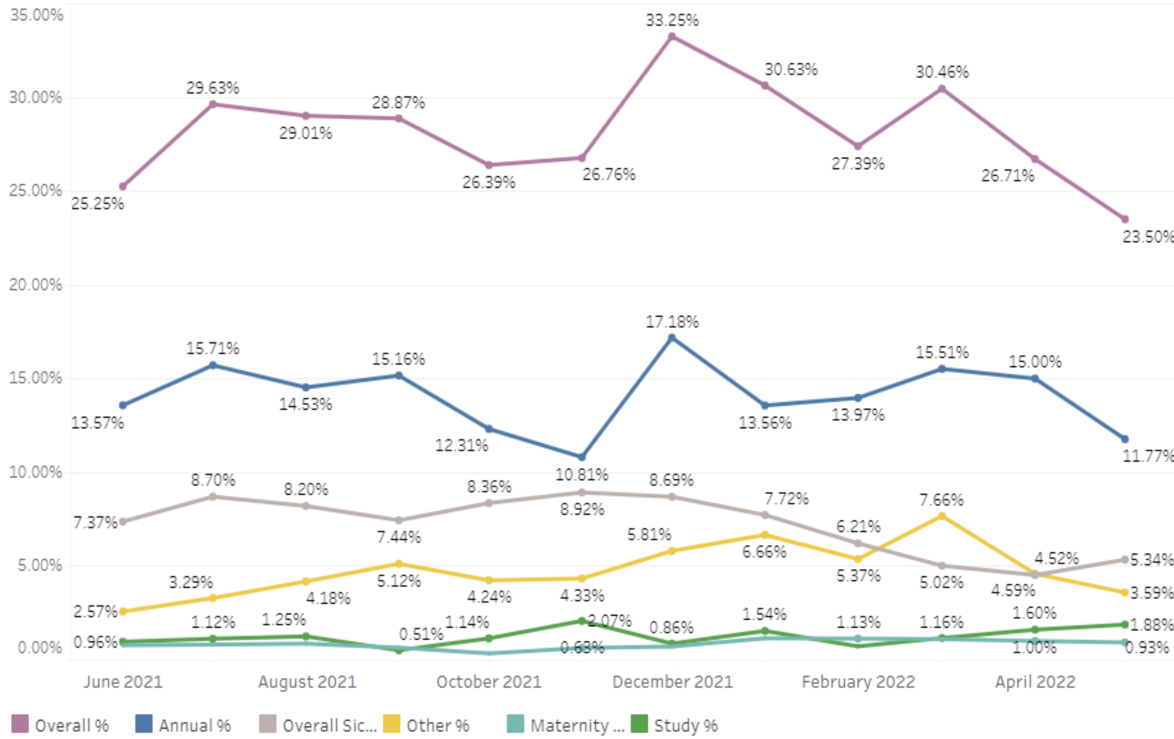
Roster Location
(All)

Absence and Sickness Absence

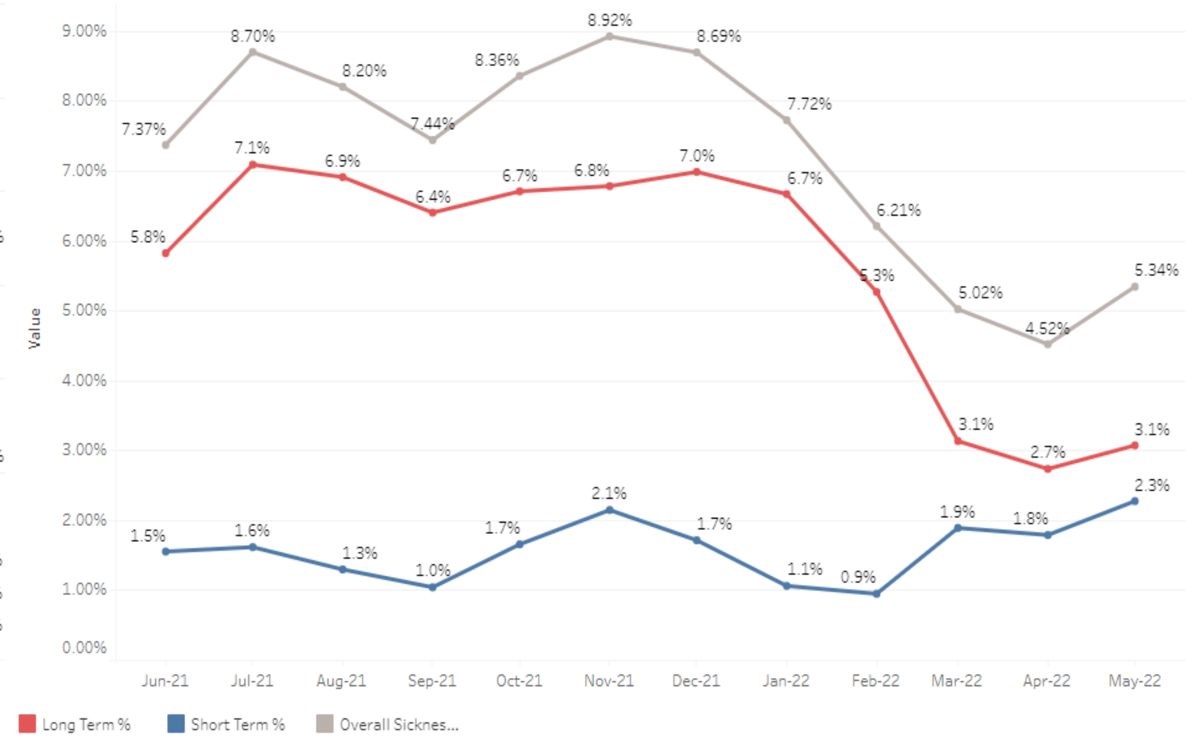
May 2022

Overall Absence	Overall WTE Lost	Overall Hours Lost	Sickness Absence	Sickness WTE Lost	Sickness Hours Lost	Long Term Sick	Short Term Sick
23.50%	137.0	22,744	5.34%	31.13	5,169	3.07%	2.27%

Overall Absence 12 Month Rolling To: May 2022



Sickness Absence 12 Month Rolling To: May 2022



Absence and Sickness Absence - Hub Nursing Staff

Month
May, 2022

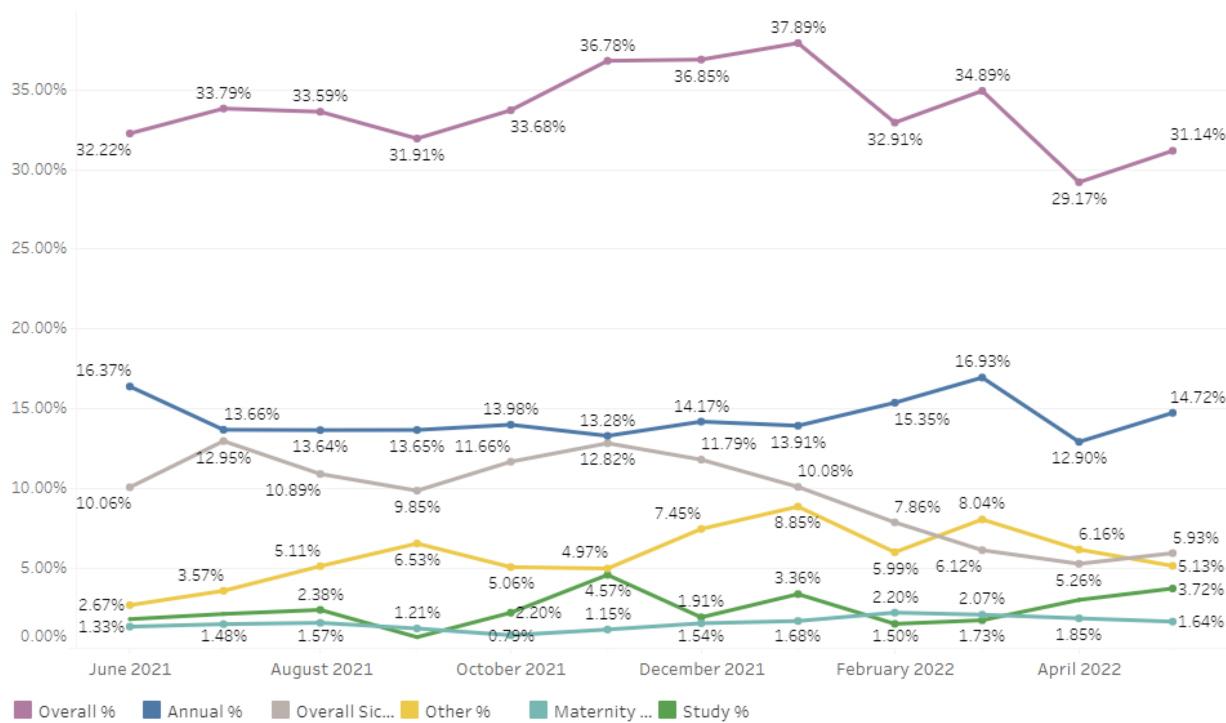
Roster Location
(Multiple values)

Absence and Sickness Absence

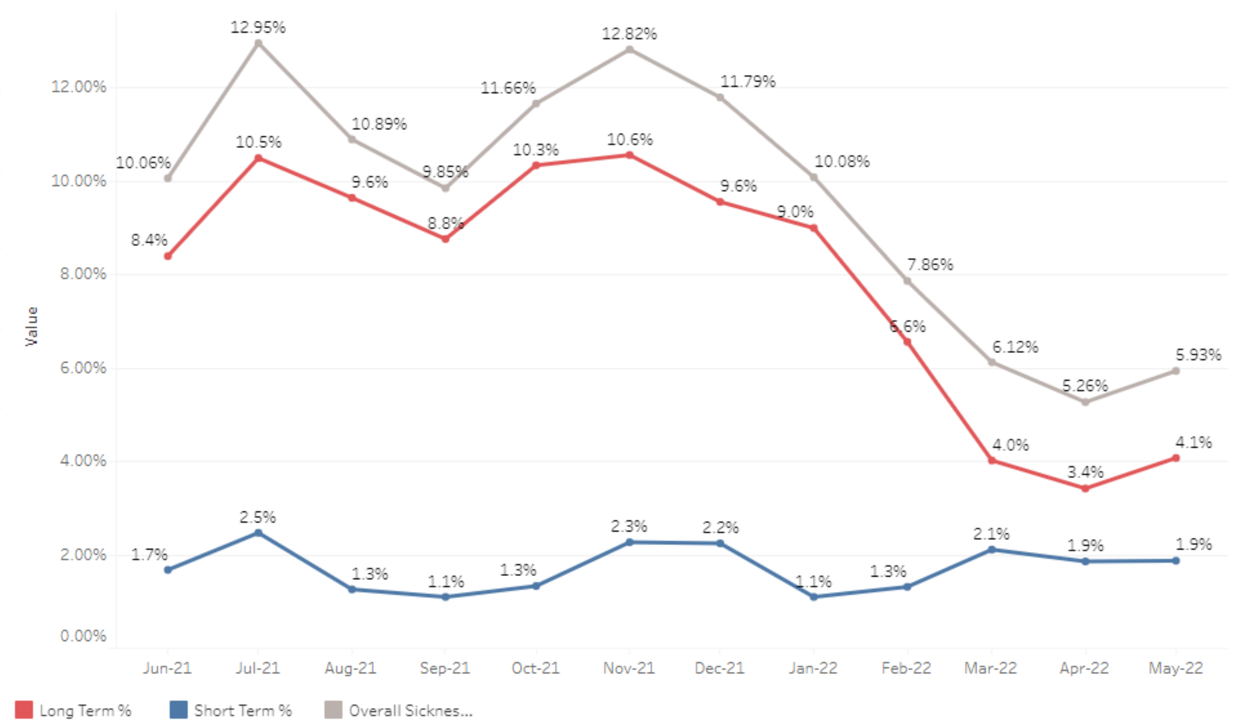
May 2022

Overall Absence	Overall WTE Lost	Overall Hours Lost	Sickness Absence	Sickness WTE Lost	Sickness Hours Lost	Long Term Sick	Short Term Sick
31.14%	80.42	13,355	5.93%	15.32	2,544	4.07%	1.86%

Overall Absence 12 Month Rolling To: May 2022



Sickness Absence 12 Month Rolling To: May 2022



Reasons for Absence, Trigger points and Compliance

Month: May, 2022

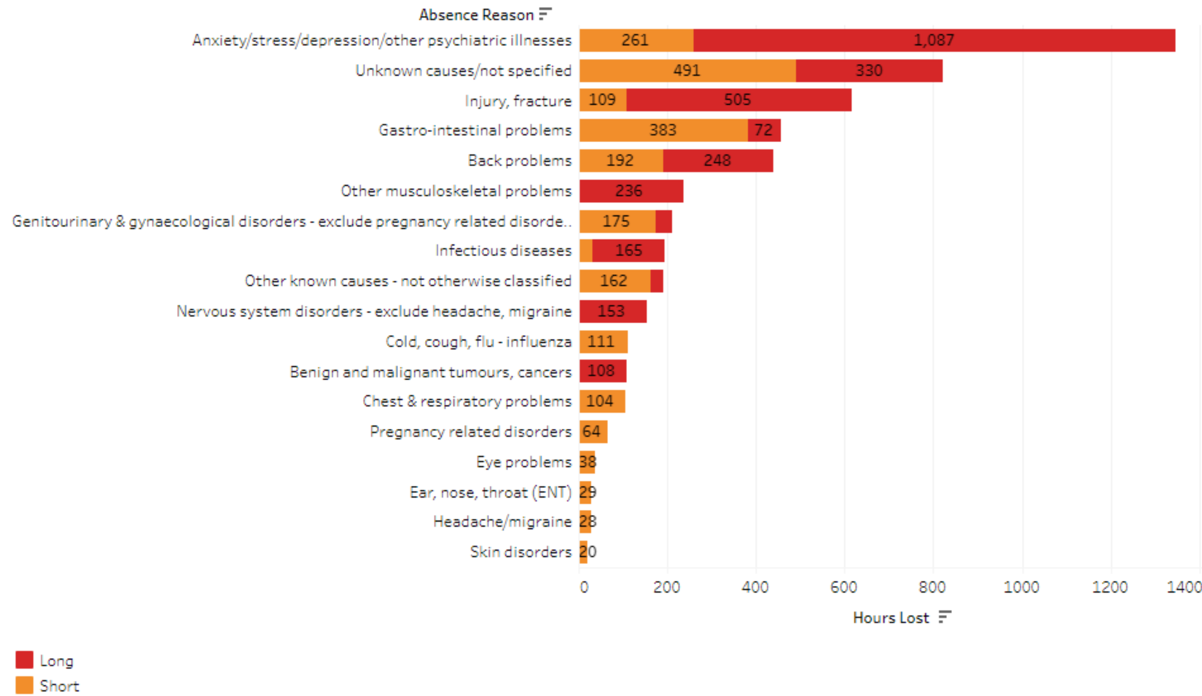
Roster Loc...: (All)

Reasons for Absence, Trigger points and Compliance

May 2022

Staff Off Sick	Returning Staff	OH Referral Made	RTW < 2 Days	RTW > 2 Days	No RTW Held
102	72	1	8	18	44

Absence Reasons



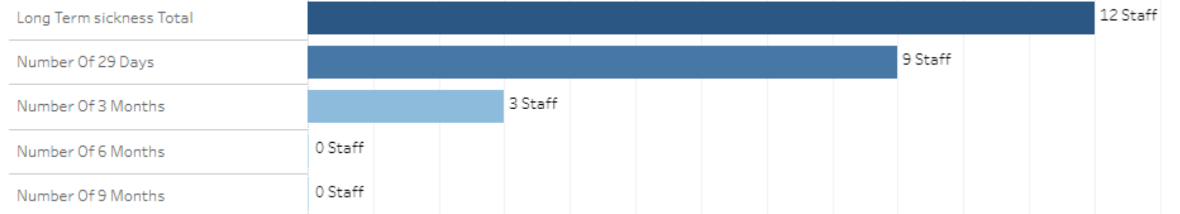
Highest Absence %- May 2022

Roster Location	
SH - Nursing Practice Development / (SM)	20.96%
SH - Hub Iona - Iona Ward 3	17.39%
SH - Housekeepers	14.40%
SH - Temporary Re-Deployment	12.89%
SH - Skye Centre - Administration	9.57%

Lowest Absence % -May 2022

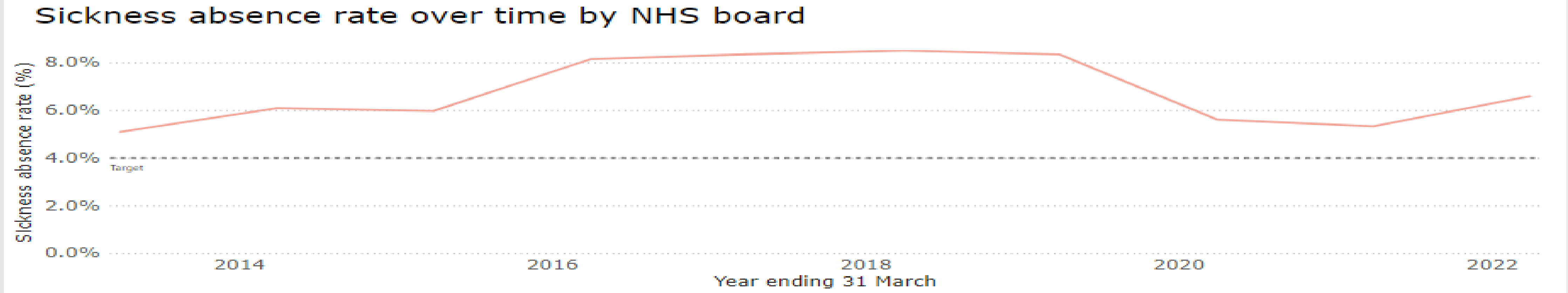
Roster Location	
SH - Allied Health Professional Service	2.11%
SH - Hub Arran - Arran Ward 1	1.84%
SH - Supplies	1.27%
SH - Clinical Admin	0.87%
SH - Human Resources	0.78%

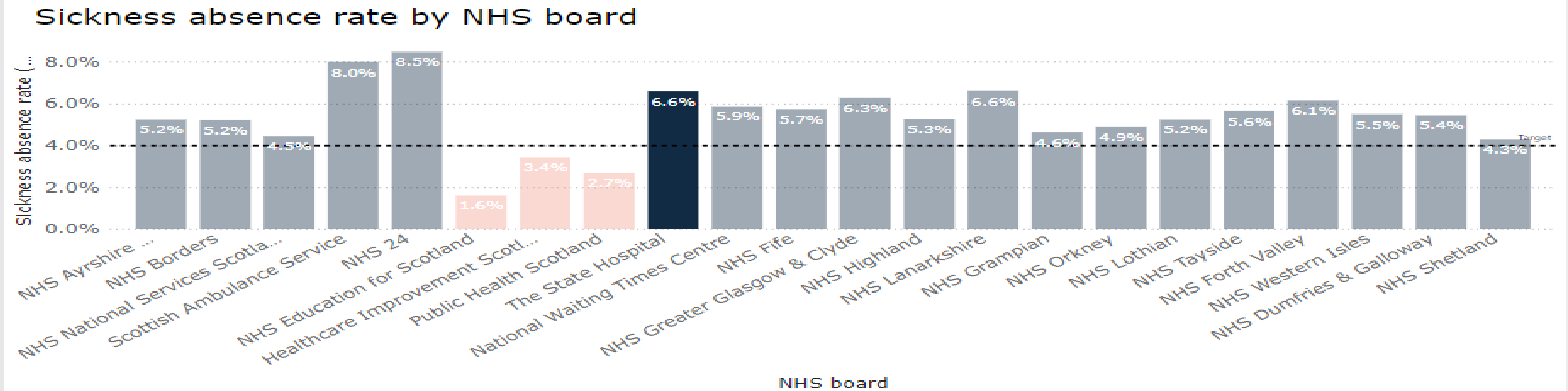
4+ Episodes	8+ Days	28+ Days
7	10	9



Sickness Absence Comparison –
Nationally Reported Figures at 31st March 2022

Sickness absence





Covid Absence

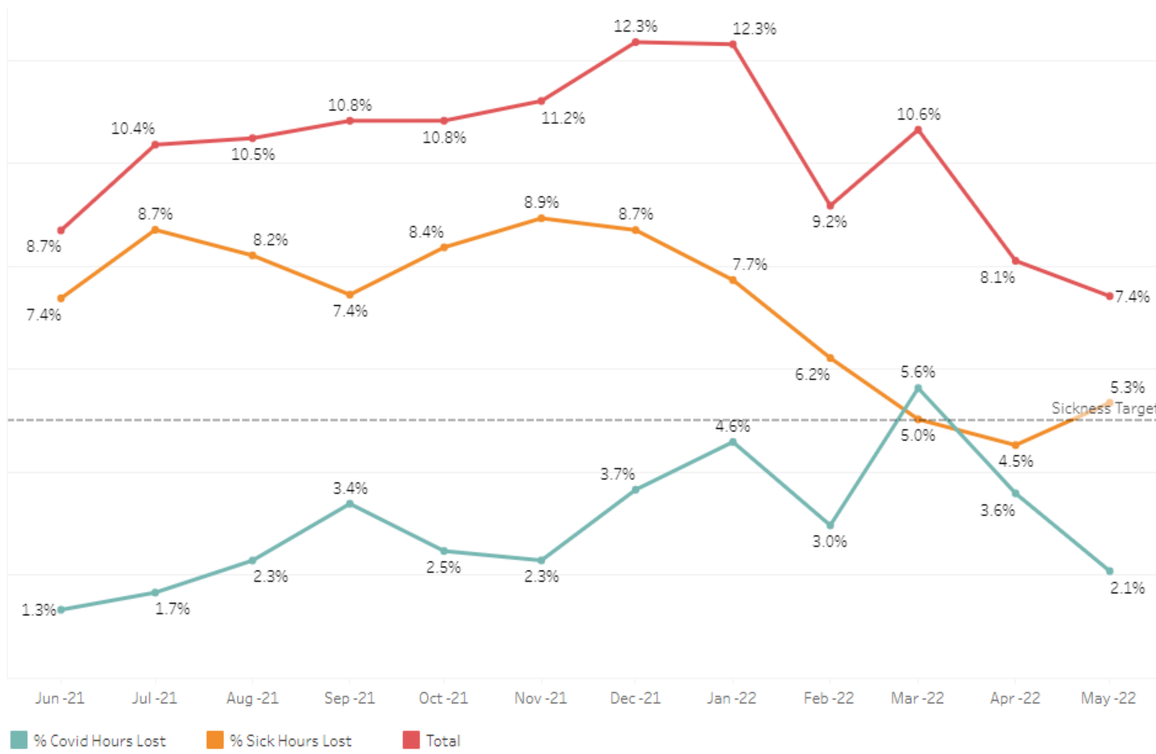
Month: May, 2022

Roster Loc...: (All)

Covid Absence

May 2022

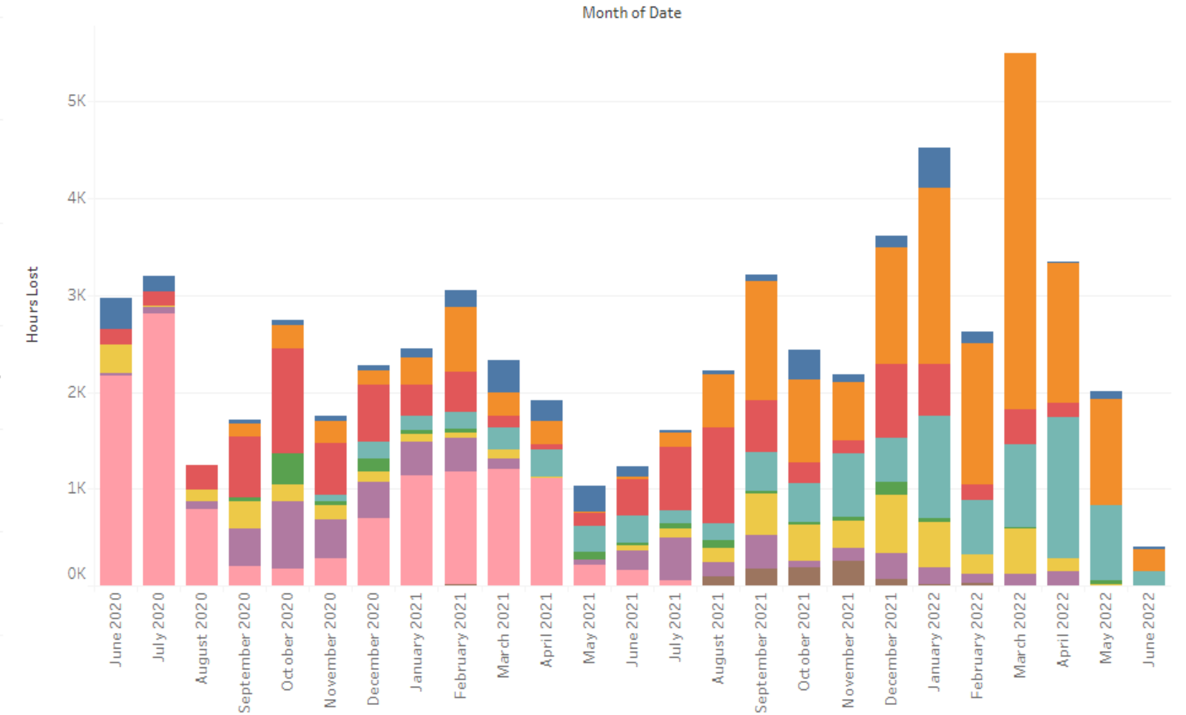
Covid + Absence	Covid + Hours Lost	Covid + WTE	Long Covid + Cases
2.07%	2,004	12.07	4



Absence Reason

- Coronavirus
- Coronavirus ? Covid 19 Positive
- Coronavirus ? Household Related ? Self Isolating
- Coronavirus ? Long Covid
- Coronavirus ? Quarantine
- Coronavirus ? Self displaying symptoms ? Self Isolating
- Coronavirus ? Test and Protect Isola
- Coronavirus ? Underlying Health Cor
- Coronavirus ? Vaccination Reaction

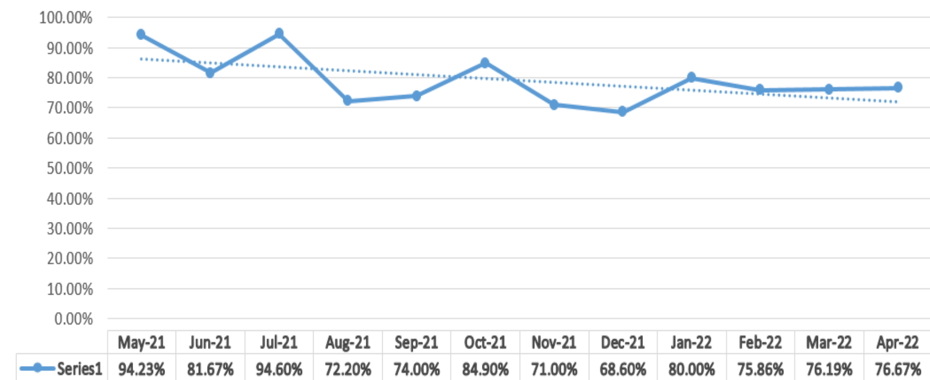
WTE Lost to Special Leave



Occupational Health

EASY Compliance – April 2022

DATE	No of Staff Included	No of staff reporting sick*	No of staff referred to EASY**	Compliance Rate %
May 2021	666	52	49	94.23%
June 2021	662	60	49	81.67%
July 2021	670	37	35	94.60%
August 2021	681	54	39	72.2%
September 2021	686	50	37	74%
October 2021	687	73	62	84.9%
November 2021	695	76	54	71%
December 2021	679	67	46	68.6%
January 2022	682	45	36	80%
February 2022	683	29	22	75.86%
March 2022	684	63	48	76.19%
April 2022	675	60	46	76.67%



Occupational Health KPIs – Quarter 4 2021/22

On receipt of an appropriately completed Management Referral form, an appointment will be offered and an OH report returned to the referring manager and HR within 15 working days.

Month/Quarter	Total Referrals	KPI Actual working days	KPI set	Comments
January 2022 Q4	17	23.7	15	Department closed for 2 weeks from 24th December to 5th January 2022.
February 2022 Q4	17	15.3	15	
March 2022 Q4	22	8.5	15	
Total	56	Average 14.1	KPI 15	

KPI for 4th Quarter of 2021/2022 is skewed due to 2 week closure of department over Christmas and recovery work in January and February.

Month /Quarter	DNAs	Self Referrals
January 2022 Q4	3	1
February 2022 Q4	3	2
March 2022 Q4	0	3
Total	6	6

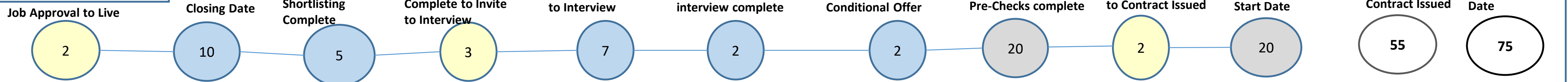
Recruitment – May 2022

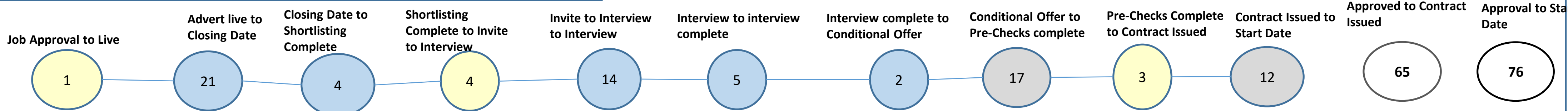
Posts in Recruitment Process

Job Family	Calendar YTD No of Posts	Calendar YTD No of Candidates	Current Month No of Posts	Current Month No of Candidates
Administrative Services	7	7	3	3
Allied Health Professions	1	1	0	0
Executive Level	1	1	0	0
Medical and Dental	1	1	1	1
Nursing and Midwifery	18	43	2	2
Other Therapeutic	5	5	1	1
Support Services	12	17	2	2
Total	45	75	9	9

Posts by Recruitment Stage

Job Status	Calendar YTD	Current Month
Complete	19	0
Conditional	8	1
Interview	5	3
Job Closed – no OR no suitable applicants	3	0
Live Advert	2	2
Shortlisting	6	3
Unconditional	1	0
Vacancy Withdrawn	1	0
Total	45	9





Responsibility Key:

- HR
- Recruiting Manager
- Outwith TSH

Annual Leave, Overtime and Excess

Date Para... May, 2022

Roster Lo... (All)

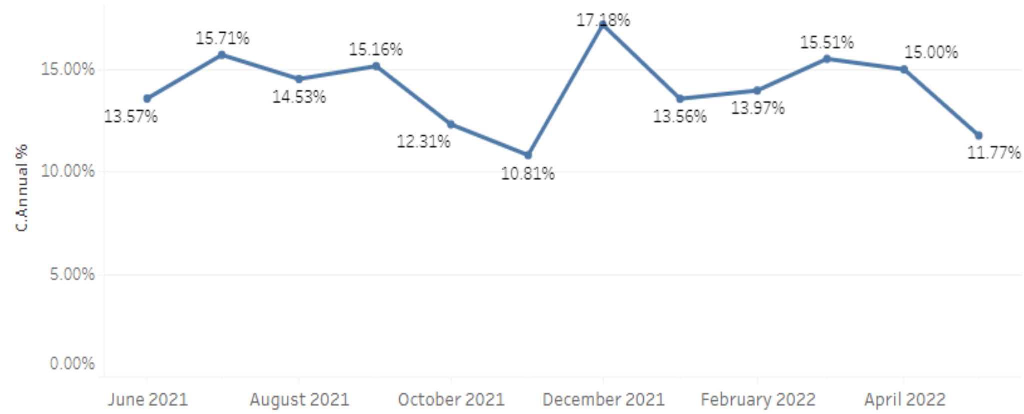
Annual Leave, Overtime and Excess

May 2022

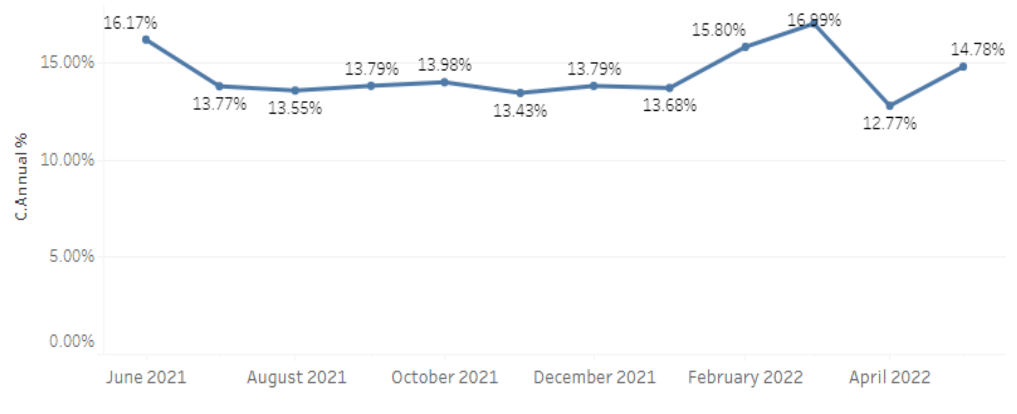
Hours Used

To Meet Clinical Demand	41,169
No Reason Selected	7,914
Linked To Absence	6,348
Coronavirus	2,472
Escort Duties	2,194
Special A patient	826
Other	500
Hospital cover	468
To Meet Workload Demand	388
Linked to Absence - Bank ..	362
Unknown - due to absence..	322
To Meet Managerial Requ..	142
To Adjust Skill Mix	140
Constant Observations	118
Coronavirus Test and Prot..	90
Routine Additional Hours	45
Coronavirus Vaccination	34
Rota Gap	32
Mand training ? Manag of ..	26
Late cancellation	11
Ambulance Service Exten..	11
Mandatory Training	7
Mand Training - Nursing S..	5
Immunisation Programme	1
Grand Total	63,625

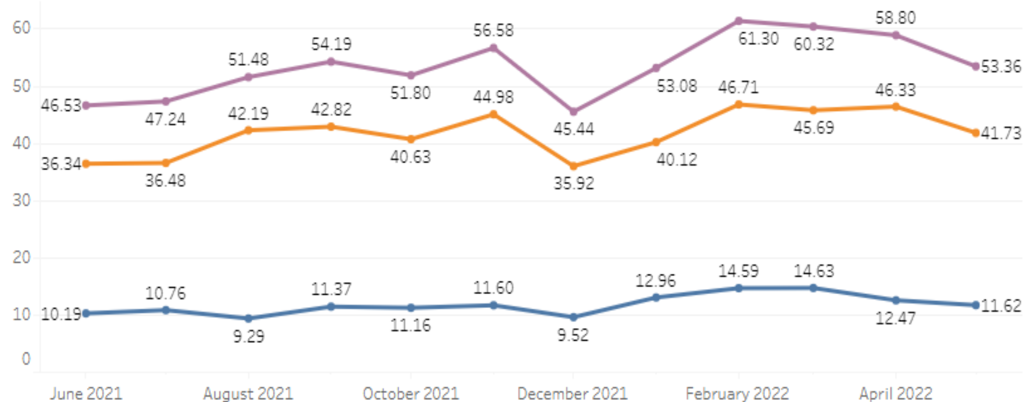
Annual Leave All Areas



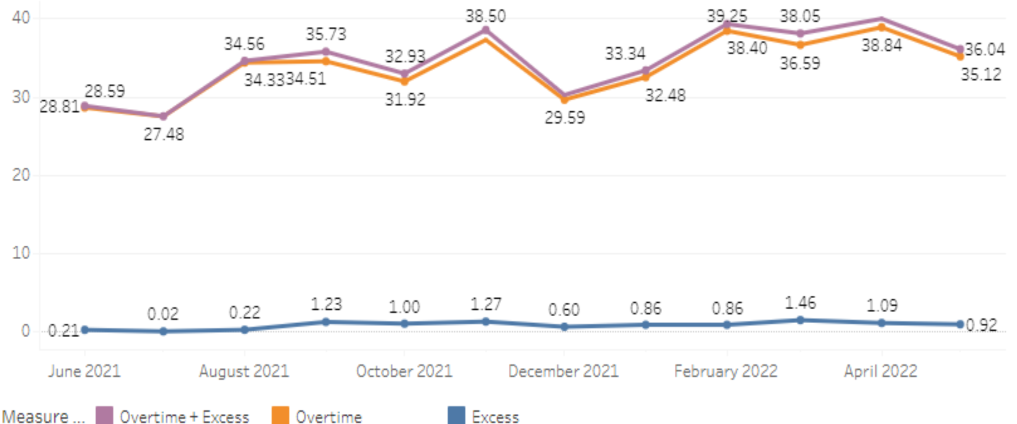
Annual Leave - Wards



Supplementary Hours As WTE All Areas



Supplementary Hours As WTE - Wards



ER Case Management – May 2022

ER Casework

New ER Cases 2022/23	April	May	June	July	August	September	October	November	December	January	February	March
Capability- informal												
Capability - formal												
Conduct - informal	1											
Conduct - formal	1											
Bullying & Harassment - informal		1										
Bullying & Harassment - formal												
Grievance- informal												
Grievance - formal												
Whistleblowing												
Total	2	1	0	0	0	0	0	0	0	0	0	0

ER Casework – timescales

Ongoing ER Case Work	<1 month	1-3 months	3-6 months	6+ months	Total
Capability - formal					0
Conduct - formal		1	1		2
Bullying & Harassment - formal	1	1			2
Grievance - formal				1	1
Whistleblowing					0

Ongoing Grievance currently awaiting guidance from STAC

Attendance Management

Active Monitoring 2022	Feb	Mar	Apr	May	Grand Total
Stage One	3	17	18	4	42
Stage Two	1				1
Grand Total	4	17	18	4	43

Staff actively being monitored from effective date of monitoring

Workforce Establishment Figures – April 2022

NURSING	Band	Establishment	Actual	Variance
	Band 7	12.00	11.00	1.00
	Band 6	31.00	29.83	1.17
	Band 5	128.30	111.06	17.24
	Band 4	8.00	8.00	0.00
	Band 4 HA	6.00	6.00	0.00
	Band 3	107.70	100.03	7.67
	Supplementary staff	0.00	12.40	-12.40
	Total	293.00	278.32	14.68

SKYE	Band	Establishment	Actual	Variance
	Band 7	3.00	2.80	0.20
	Band 6	5.00	4.81	0.19
	Band 5	9.00	9.23	-0.23
	Band 4	13.40	12.00	1.40
	Band 3	5.00	3.37	1.63
	Total	35.40	32.21	3.19

PSYCHOLOGY	Band	Establishment	Actual	Variance
	Band 8D	1.00	1.00	0.00
	Band 8C	3.00	2.70	0.30
	Band 8B	1.00	0.00	1.00
	Band 8A	4.00	2.71	1.29
	Band 7	4.00	4.00	0.00
	Band 6	8.00	6.00	2.00
	Band 5	4.00	4.50	-0.50
	Total	25.00	20.91	4.09

AHP	Band	Establishment	Actual	Variance
	Band 8A	1.00	1.00	0.00
	Band 7	1.78	1.69	0.09
	Band 6	3.00	3.00	0.00
	Band 5	4.00	4.60	-0.60
	Band 4	2.01	2.01	0.00
	Band 3	0.41	0.41	0.00
	Total	12.20	12.71	-0.51

TOTAL COMBINED VACANCIES BY GRADE

Band	Establishment	Actual	Variance
Band 8D	1.00	1.00	0.00
Band 8C	3.00	2.70	0.30
Band 8B	1.00	0.00	1.00
Band 8A	5.00	3.71	1.29
Band 7	20.78	19.49	1.29
Band 6	47.00	43.64	3.36
Band 5	145.30	129.39	15.91
Band 4	23.41	22.01	1.40
Band 4 HA	6.00	6.00	0.00
Band 3	113.11	103.81	9.30
Supplementary staff	0.00	12.40	-12.40
Total	365.60	344.15	21.45

Workforce Turnover– May 2022

Month %	Month WTE	Month - Number of staff	Rolling Year %	Rolling Year WTE	Rolling Year - Number of staff
0.95	5.82	7	1.61	9.81	12

Reason for Leaving

2021/22	Number of Staff
Dismissal	1
End of FTC	2
Ill Health	1
New Employment with NHS Scotland	7
Other	60
Retirement - Age	8
Retirement Other	1
Vol. Resignation - Other	1
Grand Total	81

2022/23			
	April	May	Total
End of FTC	1		1
New Employment with NHS Scotland	1	1	2
Other	3	6	9
Total	5	7	12

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Staff Governance Committee held on Thursday 17 February 2022 at 9.45am via MS Teams, The State Hospital, Carstairs. **SGC(M) 22/01**

Chair:
Non-Executive Director — Pam Radage

Present:

Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Employee Director	Allan Connor

In attendance:

POA Staff side Representative	Alan Blackwood
Organisational Development Manager	Jean Byrne
Professional Nurse Advisor, Practice Development	Josephine Clark
Director of Workforce	Linda Davidson
Chief Executive	Gary Jenkins
UNISON Staff side Representative	Jacqueline McDade
Acting Clinical Operations Manager	Jacqueline McQueen
Board Chair	Brian Moore
Board Secretary	Margaret Smith
PA to Director of Workforce	Rhona Preston ***(Minutes)***

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Pam Radage welcomed everyone to the meeting, noting apologies from Sandra Dunlop, Monica Merson and Michelle McKinlay.

2 CONFLICTS OF INTEREST

There were no conflicts of interest raised.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 18 NOVEMBER 2021

The Committee approved the Minutes of the previous meeting held on 18 November 2021 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

COVID / Staff Development
From the query asked by Cathy Fallon previously Linda Davidson advised the Committee that Study leave had not been impacted, there have been no restrictions placed on this, particularly from The State Hospital, however any impact from the provider moved to online which was very helpful.

STANDING ITEMS

5 ATTENDANCE MANAGEMENT REPORT

Members of the Committee received and noted the report up to 31 December 2021, as summarised by Linda Davidson, Director of Workforce.

The sickness absence figure from 1 December 2021 to 31 December 2021 is 8.60% with the long/short term split being 6.85% and 1.75% respectively. The total hours lost for this period is 8517.75 which equates to 52.33 WTE.

The monthly absence figure has decreased by 0.19% from the November 2021 figure of 8.79%. The November 2021 long/short term split was 6.61% and 2.17% respectively.

The current average rolling 12-month sickness figure is 7.15% for the period 1 January 2021 to 31 December 2021. The long/short term split is 5.73% and 1.42% retrospectively. The total hours lost for this period is 82190.84 which equates to 42.14% WTE.

The average rolling 12-month sickness absence figure represents an increase of 0.16% when compared to the same period last year, with the average rolling absence figure from 1 January 2020 to 31 December 2020 reported at 6.99%.

There has been a decrease in the EASY compliance, therefore HR Advisors issued email reminders to all Managers that all absence should be reported into EASY, ensuring staff are offered support where required.

An increase in covid absence has been recorded over the last couple of months, it is anticipated this will decrease as we move forward.

Stuart Currie suggested comparison work was carried out to check back absences, removing covid and showing Best Case / Worse Case and Actual. Linda Davidson is happy to take this forward and map out information.

ACTION: LINDA DAVIDSON

Members noted the report.

6 HUMAN RESOURCES PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

Members of the Committee received and noted the Employee Relations Activity Report to 31 January 2022 as presented and summarised by the Director of Workforce.

There was some discussion around the timescales being recorded and members are keen to make sure delays are by exception only. The suggestion of including a small narrative explaining where the delays are, for example; sickness absence, covid, resources will be added to future reports. Gary Jenkins and Linda Davidson will also take forward discussions and ensure there is a focus on this area of work to ensure timely resolutions.

ACTION: LINDA DAVIDSON

The committee noted the report.

7 PERSONAL DEVELOPMENT PLAN REPORT

Members received and noted the Personal Development Planning & Review (PDPR) update report at 31 January 2022, presented and summarised by Linda Davidson, Director of Workforce.

The total number of current (i.e. live) reviews was 465 (76.4%) - a decrease of 10.6% from the previous update in November 2021 (which provided compliance data up to 31 October 2021).

A total of 114 staff (18.7%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – an increase of 8.5% from 31 October 2021.

A further 30 staff (4.9%) had not had a PDPR meeting – an increase of 2.1% from 31 October 2021. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

Unfortunately, there has been a reduction in compliance however members of the Team are arranging meetings to provide help and support. Some additional data has since been received and once uploaded onto the TURAS system this will be captured in the next report. Compared to other Boards the compliance levels recorded here remain significantly higher.

Pam Radage noted the reduction but also recognised the achievement of 76.4% compliance rate.

The committee noted the report.

8 WHISTLEBLOWING QUARTERLY REPORT

Members received and noted the Whistleblowing update as presented by the Director of Workforce.

The State Hospital have fully launched the Whistleblowing Standards and the national policy. This included testing of the Datix template and the launch of Learn-Pro modules as the foundation for staff training complimented by a targeted communications exercise. In terms of numbers of those undertaking the training these are:

Staff Training	-	433 plus 2 in progress
Managers Training	-	28 plus 8 in progress

Further communications will be issued to all staff, advising that they should undertake this training and bring themselves up to date with the new Standard.

Between 1 April 2021 to 31 January 2022 there were 2 cases raised.

The first case has now been investigated and concluded.

The second case is subject to an ongoing investigation at Stage 2 and remains “live” until this is concluded. The investigation is likely to be ongoing with an Investigation Report available during March 2022. This is however outwith the timescales set within the National Standard due to the complexity of the investigation.

Brian Moore advised the Committee that recruitment has now commenced for the role of Whistleblowing Champion’s role at Board level, with interviews anticipated to take place over the next few months. This is a difficult timely process however it is hoped this will be concluded early Summer. Following receipt of a letter from the Cabinet Secretary for Health and Social Care, Brian Moore provided a response, this was provided to the Board at their December meeting and can be shared wider if required. At the Whistleblowing session scheduled during April, Brian Moore will be in attendance as Board Chair and if required can provide feedback.

The committee noted the report and update provided.

ITEMS FOR DISCUSSION

9 iMATTER REPORT

The Committee received and noted the iMatter End of Year Report 2021-2022 as presented by Jean Byrne, Organisational Development Manager.

Jean Byrne provided an overview of the National Health and Social Care Staff Experience Report 2021, published 7 February 2022.

From this year's iMatter survey key statistics to note locally are:

- 69% of staff responded i.e. 443 staff out of 642 staff.
- 94% of teams received a report as they had response rates of 50% or over. Four teams did not receive a report.
- 68% of teams completed an action plan i.e. 45/66 team.
- The Board's EEI number was 74.

Every staff member receives the National Report direct to their email inbox. Line Managers are strongly encouraged to access the report and discuss information within their teams / departments.

Response Rate - This year's response rate to the survey was lower than in previous years, but higher than for the Everyone Matters Pulse Survey. This is very possibly due to pressures of staff time and availability due to the pandemic. However, work will continue to ensure this response rate rises in the coming cycle.

Reports – The State Hospital had the second highest rate among all of the boards for reports received, four boards achieved a response rate of 95% and one other board achieved 94%. Our board also had the highest response rate for the patient-facing national boards. This is testimony to the encouragement of managers and the communications strategy around iMatter.

Action Plans - The State Hospital had the 4th highest number of action plans nationally. The top five boards with a high number of action plans were all national boards. It is not unusual for the national board to score higher, possibly due to smaller population size. It can be challenging to get team members together to complete action plans. However, it is important that action plans be completed with full input from the team manager and team members.

EEI - The EEI number for 2021 is lower than in previous years. The difference in 3 points between 2019 and 2021 is statistically significant, indicating that this change is very likely to be true and needs our attention. This is not surprising given the events of the last two years. With an increased focus on wellbeing and some additional resource which is being provided to support the wellbeing agenda, it is expected that the situation will improve in the coming year.

Looking at the score bands for EEI across all of the teams, and comparing with NHS Scotland, in 2021, most of our teams were in the 'Strive to celebrate' group. The number of teams in the 'Monitor to further improve' group has increased since 2019. This is a trend that requires serious attention.

Performance against the Staff Governance Standard - The questions in the iMatter survey are mapped against the Staff Governance standards to illustrate the level of staff engagement. There has been a noticeable decline in each of the areas since 2019. 'Well informed' remains the highest scoring area. Communications during the height of the pandemic were frequent and provided clarity about what was happening in the organisation. It continues to be regular and well shared in a variety of formats whether through digital means, use of posters/notice boards or face-to-face.

With exception to the standard 'Appropriately trained and developed', we have performed marginally less well in comparison with previous years where we performed equally well, if not better, than NHS Scotland. Even taking recent events into account, we must acknowledge the importance of the work and resources required to restore morale and wellbeing.

Areas of Strength – *I am clear about my duties and responsibilities (88: consistently No 1 and generally high across NHS Scotland)*

My direct line manager is sufficiently approachable (87: consistently No 2)

I would recommend my team as a good one to be part of (85: consistently in top 5) (NHS Scotland score of 83)

My team works well together (84: consistently in top 5).

I am treated with dignity and respect as an individual (82)

Local results are consistent with previous years and is a good indicator that we have a particular strength around our teams and our team leaders. The national report makes clear that scores on all questions in My Team/My Line Manager tend to be highest among senior managers which is probably not surprising considering the greater degree of control/autonomy senior managers will experience over their area of work.

Areas of Challenge - *I feel that board members who are responsible for my organisation are sufficiently visible (51: consistently in bottom 4)*

I feel sufficiently involved in decisions relating to my organisation (54: however, it is no longer the lowest score as in previous years)

I am confident performance is managed well within my organisation (55: consistently in bottom 4)

I have confidence and trust in board members who are responsible for my organisation (56: consistently in bottom 4).

While our scores are lower than the national scores, the TSH response mirrors the national response in terms of the key challenges.

Schedule for 2022 - The new iMatter cycle for 2022 will be earlier than expected. This is to realign all the boards' timetables following the disruption of the past couple of years. Key dates are:

- 25th April – Distribution starts i.e. team confirmations and adjustments;
- 20th May 2022 - Team managers will be expected to have updated their team information;
- 23rd May 2022 - Survey issued;
- 27th June 2022 - Reports published;
- 22nd August 2022 - Action plans should be completed.

There was discussion around these dates and Linda Davidson advised that a plea had been made via the HRDs to the Scottish Government due to the timing of the dates clashing with school holidays together with them feeling too soon from the previous survey(s). Feedback is awaited and will be shared once received.

Key Challenges for the Coming Year
The earlier date for completion of the questionnaire in 2022 may be unwelcome to staff. The support of managers will be required to explain, encourage and motivate their teams to respond.

Supporting senior managers and leadership team members at all levels to take ownership of and provide visible and committed leadership for iMatter.

Supporting the wellbeing agenda across the organisation with strong and committed leadership.

Writing up team stories - team managers will be asked to work with their teams to develop stories that can be shared with the rest of the organisation and other boards. This will be challenging where there are competing demands on time.

Alan Blackwood explained that from a nursing perspective there has been significant changes in middle management and is keen to see the impact and outcome and how this will be embedded into the organisation, he hopes the new enthusiasm from new recruits is reflected in the next report.

Linda Davidson advised that the HRDs have discussed the timing of the cycle being over the Summer and that it may not be conducive to good strong action plans. Cathy Fallon raised other concerns around staff possibly feeling 'surveyed out' and suggested communicating to staff early on. Jean Byrne agreed this proactive approach could help get ahead and will look to getting a communication issued to staff early on.

The Committee were content to note this report.

10 DRAFT WELLBEING STRATEGY 2022-2024

The Draft Wellbeing Strategy has been to several meetings and has received numerous comments which have been incorporated. Work continues on the final version which will follow the approval route and come back here for information following final approval at the Board.

11 OCCUPATIONAL HEALTH SERVICES TENDER

Members received the update presented by Linda Davidson, Director of Workforce around the Service Level Agreement for the provision of Occupational Health and Safety Services and the request to extend these services to facilitate local and national discussions.

The State Hospital have a specific requirement for the provision of Occupational Health and Safety Services to support our statutory obligations as a service provider and an employer. The Service Level Agreement in place describes in practical terms the responsibilities of both parties and specifies the arrangements for the provision of services. It primarily relates to the interface of services provided between SALUS and The State Hospital premises or SALUS clinical sites as agreed.

The last service level agreement commenced on 1 August 2018 and was scheduled to end on 31 July 2021. At the Staff Governance Committee in November 2020, it was agreed that the SLA should be extended to allow a short life working group to be established and for The State Hospital to review the current provision. The SLA did allow for an extension subject to agreement by both parties and this extension was within the timescales.

Membership of a SLWG has been agreed and a Terms of Reference has still to be confirmed. Work will continue on looking at engagement with Staff and Managers about the requirements of the provision and the future services required by The State Hospital to support our Staff.

The current SLA is due to end on 31st March 2022 (agreed by Staff Governance). However, there is currently a proposal to review Occupational Health Services within NHS Scotland and a draft Terms of Reference has been developed to facilitate this group.

There is also a national SLWG established to consider the recommendations of the Barron Report. One of the recommendations is the possible establishment of a National Board for Forensic Services.

Whilst the outcome of either of these Groups is unknown at the moment, it is essential that The State Hospital is in a good position moving forward and not commit to a long term SLA without consideration of local and national requirements and review.

Therefore, there is a requirement to consider the extension of the current SLA with SALUS, NHS Lanarkshire for a possible 9 months, to 31st December 2022 with a possible additional 3 month extension to 31st March 2023.

This would assist with the outcomes of the local SLWG to ascertain the requirements for supporting staff within The State Hospital. It will also give time for the national work to conclude and for outcomes and recommendations to be taken on board.

Gary Jenkins advised the Committee of the healthy relationship with SALUS who are very accommodating to tailor the approach required by the Hospital and they provide consistency to the organisation. Alan Blackwood agreed with this and is happy to support from a staff side perspective.

Brian Moore also agreed to support this extension but asked that a timeline is developed. Linda Davidson advised that discussions are also being held through HRDs and could map this out once the timescales are known.

The Committee approved extending the current SLA.

12 PRACTICE DEVELOPMENT UPDATE

Members received and noted the report providing an update on the role of the Nursing Practice Development (NPD) Service, presented by Josie Clark, Professional Nurse Advisor.

A primary function of the NPD Team at the State Hospital is to develop and evaluate nursing practice, support continuous quality improvement and ensure that nurses are equipped to deliver safe and effective patient-centred care through:

- Leading the development of nursing practice
- Delivery of training and education
- Promotion of a culture which is patient focused
- Utilisation of nursing research, recommended best practice and current evidence
- Development of new evidence which will inform nursing practice
- Development of a learning culture
- Influencing and shaping local and national nursing policy

The team comprises of:

- Professional Nurse Advisor
- 2.5 x Senior Nurses
- 1 x Practice Education Facilitator (PEF)

In addition to supporting the hospital's response to the Coronavirus pandemic the Nursing Practice Development Team have continued to focus on a number of key training and development priority areas. These have included:

Implementation of the Improving Observation Practice Framework

Over the past year the team have been working on the development of a new Clinical Observation policy which will replace the hospital's current Forensic Psychiatric Observations policy.

Implementation of Excellence in Care

Excellence in Care is a national care assurance programme which aims to ensure people have confidence they will receive a consistent standard and quality of care no matter where they receive treatment in NHS Scotland.

Implementation of HEPMA (Hospital Electronic Prescribing and Medicines Administration)

Work is now underway to prepare nursing staff for the introduction of HEPMA in April 2022.

See, Think, Act – Relational Security - Relational security is the knowledge and understanding staff have of a patient and of the environment they are working on, and the translation of that information into appropriate responses and care.

Quality Improvement (QI) Leadership training

Three members of the team have now completed quality improvement leadership training through attendance at both the ScLIP and ScIL programmes.

Dementia Specialist Improvement Lead (DSIL)

One member of the team is currently undertaking the DSIL programme, which is a bespoke,18-month development initiative, set at the expertise level of the Promoting Excellence knowledge and skills framework.

Dementia Training

NPD have been working collaboratively with University West of Scotland and TSH nursing colleagues to develop a bespoke training package which supports nursing staff to increase their knowledge and skills in caring for people who are living with dementia.

National Trauma Training

In 2016 NHS Education for Scotland was asked by the Scottish Government to develop a set of resources to promote and implement trauma informed practice within Scotland.

Epilepsy Training

Over the past 18 months NPD have been working collaboratively with nursing colleagues, both within The State Hospital and NHS Lanarkshire to deliver an epilepsy training and support package for nursing staff in the hospital.

Care planning

Work continues ongoing regarding staff support for the development, implementation, and monitoring of nursing care plans.

Clinical Supervision

Work to support and promote clinical supervision activities across the hospital continues ongoing.

Introduction of Future Nurse Standards

Over the last year the NPD team have been working to support the transition of mentors to practice supervisors and practice assessors in line NMC standards.

The Coronavirus pandemic continues to impact delivery of some of the team's key priorities. Changes in personal and sickness absence has also impacted on service capacity. Over the last eight months in particular the team have focused on supporting ward-based nursing staff to ensure safe delivery of day-to-day services, and supported concentrated efforts on recruitment and induction.

Members of the Committee agreed this was a very helpful report and is good to see the continuous improvement. Stuart Currie complimented this comprehensive report which allowed him to get a good understanding in this area.

Members agreed it would be of benefit to receive this meaningful and concise report to a couple of meetings per year. This will be added to the workplan.

ACTION: RHONA PRESTON

ITEMS FOR INFORMATION

13 APPROVED MINUTES FROM HR AND WELLBEING GROUP FROM 14 DECEMBER 2021

Alan Blackwood advised of staff's perception to use the Wellbeing facilities and therefore highlighted that the Wellbeing Centre can be accessed before or after shift and asked that this message is reinforced to encourage staff to utilise this facility available to them.

Members received and noted the approved minute.

ANY OTHER COMPETENT BUSINESS

14 ANY OTHER BUSINESS

There were no other items of competent business for the Committee to consider.

15 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 19 May 2022 at 9.45am via MS Teams**.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No. 20
Sponsoring Director:	Finance & eHealth Director
Author(s):	Finance & eHealth Director
Title of Report:	Patients' Funds Accounts
Purpose of Report:	For Decision

1 SITUATION

The Board is required to approve the Patients' Funds Annual Accounts, for signature by the Chief Executive and the Finance and eHealth Director.

2 BACKGROUND

Patients' funds are the balances of money held by TSH on behalf of patients. The Board's Patients' Funds Annual Accounts are presented in a format directed by the Scottish Government Health & Social Care Directorate (SGHSCD) and require to be audited by external auditors, approved by the Audit Committee and authorised by the Chief Executive and Finance & eHealth Director. Due to site access restrictions, the 2020 and 2021 audit were unable to be conducted at the usual times, and have now were completed for approval in early 2022 – there being no statutory deadline for these reviews. These were approved by the Audit Committee at their meeting on 17 March 2022. The 2022 audit was then completed in May 2022 and approved by the Audit Committee at their meeting on 23 June 2022.

3 ASSESSMENT

The accounts generally show fluctuations in average funds held – simply due to the level of patients' spending and income being fairly inconsistent from one year to the next. The average balance held per patient therefore also fluctuates, with a second consecutive year of a net inflow of funds at a similar level. It should also be noted that an outward transfer was requested pre-March 2022 which would have reduced that inflow by approx. 50% but due to the nature of the transfer it was not able to be transacted until May 2022.

	March 2022	March 2021	March 2020	March 2019	March 2018
Opening Balance	£568,095	£432,617	£459,476	£457,690	£430,265
Receipts	£559,727	£513,243	£441,804	£418,054	£422,575
Payments	£450,724	£377,765	£468,663	£416,268	£395,150
Net in/(out)flow of funds	£109,003	£135,478	£(26,859)	£1,786	£27,425
Closing Balance	£677,098	£568,095	£432,617	£459,476	£457,690
No. of patients at 31 March	113	114	113	110	108
Average funds per patient	£5,992.02	£4,983.29	£3,828.47	£4,177.05	£4,237.87

The Patients' Funds Accounts are audited by Wylie and Bisset who have issued an unqualified audit opinion for all three periods, noting only two minor recommendations re write-back of cheques over 6 months old (2020 £737, 2020 £480).

4 RECOMMENDATION

The Board is asked to **approve** the abstract of receipts and payments of Patients' Private Funds for the years ended 31 March 2020, 2021 and 2022 for signature.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Annual accounts for the Board require approval for authorised signatories.
Workforce Implications	None
Financial Implications	None
Route to the Board (Committee) Which groups were involved in contributing to the paper and recommendations?	Paper prepared by Finance & eHealth Director
Risk Assessment (Outline any significant risks and associated mitigation)	No significant risks identified
Assessment of Impact on Stakeholder Experience	None identified
Equality Impact Assessment	No identified implications
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No identified implications
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT COMMITTEE ANNUAL REPORT

1 April 2021 – 31 March 2022

1 INTRODUCTION

The Report is submitted to meet the requirements within the Audit Committee's (the Committee's) Terms of Reference to submit an annual report of the work of the Committee. The report also seeks to satisfy the Governance Statement requirement for the Committee to provide periodic reports to the Board in respect of Internal Control.

2 MEMBERSHIP AND ROLE OF THE COMMITTEE

Audit Committee Membership	**Role**
B Moore (to 5 July 2021) D McConnell (from 6 July 2021) A Connor P Radage S Currie	To oversee arrangements for external and internal audit of the Board's financial and management systems and to advise the Board on the strategic processes for risk, control & governance. It met four times during 2021/22.

3 AUDIT

External audit coverage of the Board was provided by Azets.

The Internal Audit service was provided by RSM UK.

4 REVIEW OF THE WORK OF THE COMMITTEE

The Internal Audit Operational Plan from RSM for 21/22 was approved by the Committee at its meeting on 25 March 2021. The plan was kept under review for the remainder of the year.

The plan was designed to target priority issues and structures to allow the Chief Internal Auditor to provide an opinion on the adequacy and effectiveness of internal controls to the Committee, the Chief Executive (as Accountable Officer) and the External Auditors.

During financial year 2021/22, the Committee met on four occasions: 17 June 2021, 22 July 2021, 8 October 2021 and 17 March 2022.

During the period from 31 March 2021 and up to the consideration of the Annual Financial Statements on 23 June 2022, the committee has:

- Received progress reports from the Chief Internal Auditors against the Internal Audit Plans approved by the Committee
- Reviewed audit reports and action plans
- Reviewed progress on action taken by management on action plans
- Reviewed the final Annual Report for 2021/22 from the Chief Internal Auditor
- Received the Annual Report and audit certificate for the 2021/22 audit from Azets
- Reviewed the Standing Financial Instructions, Standing Orders and Scheme of Delegation, and recommended these for approval to the Board
- Reviewed its Terms of Reference
- Review the log of waivers of standing financial instructions.
- Considered the Fraud Incident Log
- Reviewed Counter Fraud Service Alerts
- Reviewed Fraud Action Plan
- Reviewed progress made with the National Fraud Initiative
- Received national Audit Scotland reports and performance audit studies, relating to the Health Service and to the wider public sector

- Met in private with Internal and External Auditors
- Reviewed the recommendations received from National Services Scotland from their service audit reports.
- Reviewed the recommendations received from NHS Ayrshire & Arran from the service audit report on the National Single Instance (NSI) system
- Reviewed the annual reports from the Governance Committees
- Reviewed the Code of Conduct
- Reviewed and approved the Annual Audit Committee Assurance Statement to the Board
- Reviewed the summary of Losses and Special Payments
- Reviewed and approved the Losses and Special Payment Policy
- Reviewed and approved the Patients Funds Annual Accounts for submission to the Board
- Reviewed and recommended approval of the statutory Annual Accounts to the Board
- Submitted minutes of meetings to the Board throughout the year
- Reviewed external Audit Plan
- Reviewed and noted update on Business Continuity Resilience arrangements
- Reviewed the annual report on Risk and Resilience
- Reviewed and noted the Procurement Annual Report
- Reviewed and noted the Corporate Risk Register
- Review and agreed Audit Committee Work Plan 2022
- Received an update from the Risk, Finance and eHealth Group
- Received an update from the Security, Resilience, Health and Safety Oversight Group
- Reviewed Category 1 and 2 Annual Update on Outstanding Actions
- Received the Annual Update on State Hospital Resilience Arrangements
- Received the Security Audit 202/21
- Reviewed the Effectiveness of Audit Committee

5 CORPORATE GOVERNANCE

During 2021/22 the Board's Internal Auditors reported on the following significant areas of work:

- Effective Rostering and Overtime Management
- Governance
- Procurement
- Complaints Management
- Property Transactions Monitoring

Implementation of New Clinical Model; Workforce Planning; and Resilience of Security Systems audits were moved to 2022/23 reporting period.

6 CONCLUSION

Based on the work that it has undertaken, the Committee has met in line with the Terms of Reference, has fulfilled its remit and is satisfied that internal controls are adequate to ensure that the Board can achieve the policies, aims and objectives set by Scottish Ministers, to safeguard public funds and assets available to the Board, and to manage resources efficiently, effectively and economically.

I offer my thanks for the continuing support and encouragement of Committee members and also to those members of staff who have worked on the Committee's behalf during 2021/22.

David McConnell
AUDIT COMMITTEE CHAIR
On behalf of the State Hospitals Board for Scotland Audit Committee

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

AUDIT COMMITTEE

TERMS OF REFERENCE

1 PURPOSE

The Audit Committee is a standing committee of the Board and shall be accountable to the Board. Its purpose is to provide the Board with assurance in respect of risk, governance and internal control including financial control.

2 COMPOSITION

2.1 Membership

The Audit Committee is appointed by the Board and shall be composed of at least three Non-executive Board members, one of whom shall act as Chair. Membership will be reviewed annually and disclosed in the Annual Report.

2.2 Appointment of Chairperson

The Chairperson of the Committee shall be appointed at meeting of the Board in accordance with Standing Orders.

2.3 Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The Accountable Officer (Chief Executive), Director of Finance and eHealth, Chief Internal Auditor, a representative from External Audit and any other appropriate officials shall normally attend meetings and receive all relevant papers. Other Directors may also be invited by the Chair of the Committee to attend meetings as required.

All Board Members will have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

Audit Committee members must regularly attend the Committee and if not appropriate action taken.

3 MEETINGS

3.1 Frequency

The Audit Committee will meet at least four times a year to fulfil its remit and shall report to the Board at least twice in each financial year.

The Chair of the Committee may convene additional meetings as necessary.

The accountable officer should attend all meetings but if he/she does not, be provided with a record of the discussions.

The Accountable Officer of the Board may ask the Chair of the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

3.2 Agenda and Papers

The agenda and supporting papers will be sent out at least five working days in advance of the meetings to allow time for members' due consideration of issues. All papers will clearly state the agenda reference, the author and the purpose of the paper, together with the action to be taken.

3.3 Quorum

Two members of the Committee will constitute a quorum.

3.4 Minutes

Formal minutes will be kept of the proceedings and submitted for approval at the next Audit Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Audit Committee may be presented in draft form to the next available Board meeting.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

4 OTHER

In order to fulfil its remit, the Audit Committee may obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of hospital staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee and / or the External Auditor or Internal Auditor. It is expected that this should occur at least once in each financial year.

The Chief Internal Auditor and the representative(s) of External Audit will have free and confidential access to the Chair of the Committee.

The Chair of the Audit Committee should be available at the Board's Annual Accounts Approval Meeting to answer questions about its work.

5 REMIT

5.1 Objectives

The main objectives of the Audit Committee are to provide the Board with the assurance that the State Hospital acts within the law, regulations and code of conduct applicable to it, and that an effective system of internal control is maintained.

The committee periodically assesses its own effectiveness to ensure that the Audit Committee fulfils its remit, this may involve assessing the attendance and performance of each member.

New members receive a suitable induction and declare his/ her business interests.

The duties of the Audit Committee are in accordance with the Audit Committee Handbook, July 2008. http://www.scotland.gov.uk/Publications/2008/08/08140346/

5.2 Internal Control and Corporate Governance

5.2.1 To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment; Risk management strategy, procedures and risk register;
- The effectiveness of the internal control and risk managements systems
- Decision-making processes;
- Receive and consider stewardships reports in key business areas.
- Information;
- Monitoring and corrective action

5.2.2 To review the system of internal financial control which includes:

The safeguarding of assets against unauthorised use and disposition;

- Maintenance of proper accounting records and

- the reliability of financial information used within the organisation or for publication.

5.2.3 To have a mechanism to keep it aware of topical legal and regulatory issues and ensure the Board's activities are within the law and regulations governing the NHS.

5.2.4 To monitor performance and best value by reviewing the economy, efficiency and effectiveness of operations.

5.2.5 To present an annual assurance statement on the above to the Board to support the Directors' Governance Statement on Internal Control.

5.2.6 To take account of the implications of publications detailing best audit practice.

5.2.7 To take account of recommendations contained in the relevant reports of the Auditor General and the Scottish Parliament.

5.2.8 To review audit reports and management action plans in relation to physical security of the Hospital.

5.2.9 To provide assurance to the Board that plans are in place to ensure service continuity and to provide contingencies for emergency situations.

5.2.10 To provide assurance to the Board that plans and mechanisms are in place to ensure that Fraud is properly monitored and reported.

5.3 Internal Audit

5.3.1 To review and approve the Internal Audit Annual Plan.

5.3.2 To review the adequacy of internal audit staffing and other resources.

5.3.3 To monitor audit progress and review audit reports.

5.3.4 To monitor the management action taken in response to the audit recommendations through an agreed follow-up mechanism.

5.3.5 To consider the Chief Internal Auditor's annual report and assurance statement.

5.3.6 To review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.

5.3.7 To review the terms of reference and appointment of the Internal Auditors.

5.4 External Audit

5.4.1 To review the Audit Plan, including the Performance Audit Programme.

5.4.2 To consider all statutory audit material, in particular:

- Audit Reports (including Performance Audit Studies);
- Annual Reports;
- Management Letters.

5.4.3 To monitor management action taken in response to all External Audit recommendations including Performance Audit Studies (following consideration by the Staff Governance Committee or Clinical Governance Committee where appropriate).

5.4.4 To review the extent of co-operation between External and Internal Audit.

5.4.5 Annually appraise the performance of the External Auditors.

5.4.6 To note the appointment and remuneration of External Auditors and to examine any reason for the resignation or dismissal of the Auditors.

5.5 Standing Orders and Standing Financial Instructions

5.5.1 To review changes to the Standing Orders and Standing Financial Instructions.

5.5.2 To examine the circumstances associated with each occasion when Standing Orders are waived or suspended.

5.5.3 To review the Scheme of Delegation.

5.6 Annual Accounts

5.6.1 To review annually (and approve) the suitability of accounting policies and treatments.

5.6.2 To review schedule of losses and compensation payments.

5.6.3 Review the reasonableness of accounting estimates.

5.6.4 Review the external auditors management letter.

5.6.5 To review and recommend approval to the Board of the Annual Accounts.

5.6.6 To report in the Directors Report on the roles and responsibilities of the Audit Committee and actions taken to discharge those.

5.6.7 To review and recommend approval to the Board of the Patients Funds Annual Accounts.

6 AUTHORITY

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

7 PERFORMANCE OF THE COMMITTEE

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis.

The committee shall provide guidelines and/ or pro forma concerning the format and content of the papers to be presented.

The Chairman of the Committee shall submit an Annual Report on the work of the Committee to the Board.

Subject to annual review
This revision: approved March 2022

INDEPENDENT AUDITORS REPORT TO THE STATE HOSPITALS BOARD FOR SCOTLAND

Opinion on abstract

We have audited the attached abstract of receipts and payments of patients' private funds administered by The State Hospitals Board for Scotland ('the abstract') for the year ended 31 March 2020 which has been prepared for the reasons in and on the basis of the accounting policies set out in note 1 to the abstract.

In our opinion the abstract of receipts and payments for the year ended 31 March 2020 has been properly prepared, in all material aspects, in accordance with the requirements of the NHS Board Accounts Manual.

Our report has been prepared for The State Hospitals Board for Scotland, as a body, solely in connection with the audit of the abstract. It has been released to The State Hospitals Board for Scotland on the basis that our report shall not be copied, referred to or disclosed, in whole (save for The State Hospitals Board for Scotland's own internal purposes) or in part, without our prior written consent.

Our report was designed to meet the agreed requirements of The State Hospitals Board for Scotland determined by The State Hospitals Board for Scotland's needs at the time. Our report should not therefore be regarded as suitable to be used or relied on by any party wishing to acquire rights against us other than The State Hospitals Board for Scotland, as a body, for any purpose or in any context. Any party other than The State Hospitals Board for Scotland who obtains access to our report or a copy and chooses to rely on our report (or any part of it) will do so at its own risk. To the fullest extent permitted by law, Wylie & Bisset (Audit) Limited will accept no responsibility of liability in respect of our report to any other party.

Respective responsibilities of board members and auditor

As explained more fully in the Statement of Board Members responsibilities, the board members are responsible for the preparation of the abstract in accordance with the requirements of the NHS Board Accounts Manual.

Our responsibility is to audit, and express an opinion on, the abstract in accordance with the terms of our engagement letter and having regard to International Standards on Auditing (UK).

Scope of the audit of the abstract

An audit involves obtaining evidence about the amounts and disclosures in the abstract sufficient to give reasonable assurance that the abstract is free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances and have been consistently applied and adequately disclosed; and the reasonableness of significant accounting estimates made by the board members. In view of the purpose for which the abstract has been prepared, however, we did not assess the overall presentation of the abstract which would have been required if we were to express an audit opinion under International Standards on Auditing (UK).

In addition we read all the financial and non-financial information in the abstract to identify material inconsistencies with the audited abstract and to identify information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Wylie & Bisset (Audit) Limited, Statutory Auditor
168 Bath Street
Glasgow
G2 4TP
Date: 23 June 2022

STATE HOSPITAL **SFR 19.0**

PATIENTS PRIVATE FUNDS

FOR YEAR ENDED 31 MARCH 2020

ABSTRACT OF RECEIPTS AND PAYMENTS

2019 £		2020 £
	RECEIPTS	
	Opening Balances:	
454,314	Cash in Bank	456,685
1,476	Cash on Hand	891
1,900	Other Funds	1,900
457,690		459,476
417,058	From or on behalf of Patients	440,520
996	Interest on Patients' Fund Account	1,284
875,744	**Total Receipts**	**901,280**
	PAYMENTS	
416,268	To or on behalf of Patients	468,664
	Extra Comforts etc.	
	Closing Balances:	
456,685	Cash in Bank	424,717
891	Cash on Hand	6,000
1,900	Other Funds	1,900
459,476		**432,617**
875,744	**Total Payments**	**901,280**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
459,488	Credit Balances	432,617
- 12	Less: Debit Balances	
459,476		432,617
-	Interest Received but not Credited	-
459,476	**Total Closing Balance**	**432,617**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance ______________________ Date __________

The abstract of Receipts and Payments was submitted at the Board Meeting on 28 April 2022 and duly approved.

Chief Executive ______________________ Date __________

1. Note to SFR19

The Scottish Government Health Directorate requires The State Hospitals Board for Scotland to prepare, on an annual basis, an abstract of receipts and payments of patients' private funds administered by the Board. The abstract of receipts and payments of the patients' private funds has been prepared by the Board, on a cash basis, in accordance with the requirements of the 2019/20 NHS Board Accounts

Manual.

INDEPENDENT AUDITORS REPORT TO THE STATE HOSPITALS BOARD FOR SCOTLAND

Opinion on abstract

We have audited the attached abstract of receipts and payments of patients' private funds administered by The State Hospitals Board for Scotland ('the abstract') for the year ended 31 March 2021 which has been prepared for the reasons in and on the basis of the accounting policies set out in note 1 to the abstract.

In our opinion the abstract of receipts and payments for the year ended 31 March 2021 has been properly prepared, in all material aspects, in accordance with the requirements of the NHS Board Accounts Manual.

Our report has been prepared for The State Hospitals Board for Scotland, as a body, solely in connection with the audit of the abstract. It has been released to The State Hospitals Board for Scotland on the basis that our report shall not be copied, referred to or disclosed, in whole (save for The State Hospitals Board for Scotland's own internal purposes) or in part, without our prior written consent.

Our report was designed to meet the agreed requirements of The State Hospitals Board for Scotland determined by The State Hospitals Board for Scotland's needs at the time. Our report should not therefore be regarded as suitable to be used or relied on by any party wishing to acquire rights against us other than The State Hospitals Board for Scotland, as a body, for any purpose or in any context. Any party other than The State Hospitals Board for Scotland who obtains access to our report or a copy and chooses to rely on our report (or any part of it) will do so at its own risk. To the fullest extent permitted by law, Wylie & Bisset (Audit) Limited will accept no responsibility of liability in respect of our report to any other party.

Respective responsibilities of board members and auditor

As explained more fully in the Statement of Board Members responsibilities, the board members are responsible for the preparation of the abstract in accordance with the requirements of the NHS Board Accounts Manual.

Our responsibility is to audit, and express an opinion on, the abstract in accordance with the terms of our engagement letter and having regard to International Standards on Auditing (UK).

Scope of the audit of the abstract

An audit involves obtaining evidence about the amounts and disclosures in the abstract sufficient to give reasonable assurance that the abstract is free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances and have been consistently applied and adequately disclosed; and the reasonableness of significant accounting estimates made by the board members. In view of the purpose for which the abstract has been prepared, however, we did not assess the overall presentation of the abstract which would have been required if we were to express an audit opinion under International Standards on Auditing (UK).

In addition we read all the financial and non-financial information in the abstract to identify material inconsistencies with the audited abstract and to identify information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Wylie & Bisset (Audit) Limited, Statutory Auditors
168 Bath Street
Glasgow
G2 4TP
Date: 23 June 2022

STATE HOSPITAL **SFR 19.0**

PATIENTS PRIVATE FUNDS

FOR YEAR ENDED 31 MARCH 2021

ABSTRACT OF RECEIPTS AND PAYMENTS

2020 £		2021 £
	RECEIPTS	
	Opening Balances:	
456,685	Cash in Bank	424,717
891	Cash on Hand	6,000
1,900	Other Funds	1,900
459,476		432,617
440,520	From or on behalf of Patients	512,853
1,284	Interest on Patients' Fund Account	390
		0
901,280	**Total Receipts**	**945,860**
	PAYMENTS	
468,664	To or on behalf of Patients	377,765
	Extra Comforts etc.	
	Closing Balances:	
424,717	Cash in Bank	560,195
6,000	Cash on Hand	6,000
1,900	Other Funds	1,900
432,617		**568,095**
901,280	**Total Payments**	**945,860**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
432,617	Credit Balances	568040
	Less: Debit Balances	- 5
432,617		568,035
-	Interest Received but not Credited	60
432,617	**Total Closing Balance**	**568,095**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance ______________________ Date __________

The abstract of Receipts and Payments was submitted at the Board Meeting on 28 April 2022 and duly approved.

Chief Executive ______________________ Date __________

1. Note to SFR19

The Scottish Government Health Directorate requires The State Hospitals Board for Scotland to prepare, on an annual basis, an abstract of receipts and payments of patients' private funds administered by the Board. The abstract of receipts and payments of the patients' private funds has been prepared by the Board, on a cash basis, in accordance with the requirements of the 2020/21 NHS Board Accounts

Manual.

INDEPENDENT AUDITORS REPORT TO THE STATE HOSPITALS BOARD FOR SCOTLAND

Opinion on abstract

We have audited the attached abstract of receipts and payments of patients' private funds administered by The State Hospitals Board for Scotland ('the abstract') for the year ended 31 March 2022 which has been prepared for the reasons in and on the basis of the accounting policies set out in note 1 to the abstract.

In our opinion the abstract of receipts and payments for the year ended 31 March 2022 has been properly prepared, in all material aspects, in accordance with the requirements of the NHS Board Accounts Manual.

Our report has been prepared for The State Hospitals Board for Scotland, as a body, solely in connection with the audit of the abstract. It has been released to The State Hospitals Board for Scotland on the basis that our report shall not be copied, referred to or disclosed, in whole (save for The State Hospitals Board for Scotland's own internal purposes) or in part, without our prior written consent.

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In addition we read all the financial and non-financial information in the abstract to identify material inconsistencies with the audited abstract and to identify information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Wylie & Bisset (Audit) Limited, Statutory Auditors
168 Bath Street
Glasgow
G2 4TP
Date: 23 June 2022

STATE HOSPITAL **SFR 19.0**

PATIENTS PRIVATE FUNDS

FOR YEAR ENDED 31 MARCH 2022

ABSTRACT OF RECEIPTS AND PAYMENTS

2021 £		2022 £
	RECEIPTS	
	Opening Balances:	
424,717	Cash in Bank	560,135
6,000	Cash on Hand	6,000
1,900	Other Funds	1,900
432,617		568,035
512,853	From or on behalf of Patients	559,667
390	Interest on Patients' Fund Account	**120**
0		
945,860	**Total Receipts**	**1,127,822**
	PAYMENTS	
377,765	To or on behalf of Patients	450,724
	Extra Comforts etc.	
	Closing Balances:	
560,195	Cash in Bank	671,106
6,000	Cash on Hand	4,092
1,900	Other Funds	1,900
568,095		**677,098**
945,860	**Total Payments**	**1,127,822**
	Closing Balances accounted for as:	
	Patients' Personal Accounts	
568,040	Credit Balances	677,098
- 5	Less: Debit Balances	-
568,035		677,098
60	Interest Received but not Credited	
568,095	**Total Closing Balance**	**677,098**

I certify that the above abstract of Receipts and Payments is correct, and in accordance with the Books of Account and that the Register of Valuables has been inspected and checked with property held.

Director of Finance ______________________ Date ____________

The abstract of Receipts and Payments was submitted at the Board Meeting on 23rd of June 2022 and duly approved.

Chief Executive ______________________ Date ____________

1. Note to SFR19

The Scottish Government Health Directorate requires The State Hospitals Board for Scotland to pre on an annual basis, an abstract of receipts and payments of patients' private funds administered by Board. The abstract of receipts and payments of the patients' private funds has been prepared by t Board, on a cash basis, in accordance with the requirements of the 2021/22 NHS Board Accounts

Manual.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 21
Author:	Chair of the Audit Committee
Title of Report:	Audit Committee Annual Report
Purpose of Report:	For Decision

1 SITUATION

The Report outlined in Appendix 1 is presented to the committee to meet the requirements within the Committee's Terms of Reference to submit an annual report of the work of the Committee to the Board. The report also supports the Governance Statement in providing periodic reports to the Board from the Committee in respect of Internal Control.

2 BACKGROUND

The establishment of an Annual Report by the Audit Committee is an important assurance process to the Board in considering the effectiveness of internal controls.

The report outlines the work of the Committee, including:

- Frequency of meetings
- The activities of the Committee
- Progress in Corporate Governance
- Update Terms of Reference

An effective system of internal control is fundamental to securing sound financial management of the Board's affairs.

The consideration and review of internal and external audit reports, and management responses, together with reports submitted by other officers, assist the Committee in advising the Board with regard to material risks.

3 ASSESSMENT

This report was presented and agreed at the Audit Committee this morning.

4 RECOMMENDATION

Board Members are asked to approve the Audit Committee Annual Report as demonstrating that the committee has met its remit and terms of reference during 2021/22.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Year end reporting to demonstrate that the committee has met its remit
Workforce Implications	None identified as part of reporting
Financial Implications	None identified as part of reporting
Route To Board Which groups were involved in contributing to the paper and recommendations	Submitted for the approval of the Board
Risk Assessment (Outline any significant risks and associated mitigation)	None identified
Assessment of Impact on Stakeholder Experience	No impact identified
Equality Impact Assessment	Nor required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impacts identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 22
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 31 May 2022
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance, which is also issued quarterly to Scottish Government (SG) along with the statutory financial reporting template.

2 BACKGROUND

SG were ordinarily provided with an annual Operational Plan (OP) and 3-year financial forecast template. The Operational Plans for 2020/21 and 2021/22 were paused due to Covid and replaced with the Board Remobilisation Plan (BRP), however we are now scheduled to submit a draft Operational Plan 2022/23 once again in July 2022.

SG notified the Boards of no Covid funding being available ongoing into 2022/23 at the levels of the last two years and, while this position will remain under review, there are a number of processes now being put in place with individual budget-holders so that the pressures of Covid-related costs which will continue to be incurred will to be met within the specific Directorates as we return to “business as normal” in 2022/23.

There are delays (attributable to Covid) in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be quantified for consideration (in 2022/23).

The draft base budgets have been established (pending notification of the AFC Pay Circular for 2022/23) and these forecast a breakeven year end position, set on achieving £0.811m efficiency savings, as referred to in the table in section 4.
This is subject to change once we receive the pay circulars but to manage this prudently we are also maintaining an element of contingent reserve until the final pay award levels are known from SG.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £40.696m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional allocations.

The Board is reporting a small underspend of £0.021m to May 2022, with revenue spending overall on forecast trajectory.

PAIAW funding is held as a reserve for the current year. This is a significant element for the Board because of our high levels of overtime and high Nursing vacancies.
Some pressure potentially remains re prior years' PAIAW still outstanding – claimants being in the hand of CLO (some of whom have recently been paid.) This has been accrued at March 2022.

Additional at March 2022, some costs of the work started in 2021/22 re the eRostering project, M365 licences, and related pressures have been accrued to fund an element of anticipated costs in 2022/23.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -

Covid-19
Because of the late advice from SG that Covid would no longer be funded there are some hanging cost pressures which will need to be managed within Directorates, which will be regularly monitored.

Clinical Model review update
There is risk noted that the updated Clinical Model review is expected to differ in structure from that which was originally considered and evaluated pre-Covid – current indications being that while this is not expected to give additional costs above current levels, originally anticipated savings will not be realised.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will be closely monitored in 2022/23.

Extra PH for Platinum Jubilee
It is noted that there is the cost of one day's additional holiday in 2022/23.

3.3 Year-to-date position – allocated by Board Function / Directorate

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 2	Budget WTE	Actual WTE
Nursing And Ahp's	22,118	3,771	3,795	(24)	402.10	417.30
Security And Facilities	6,515	1,095	1,120	(24)	121.62	115.29
Medical	2,923	487	439	48	18.55	20.18
Chief Exec	1,979	330	308	22	21.96	20.42
Human Resources Directorate	961	160	161	(0)	14.65	15.56
Finance	2,586	431	465	(34)	29.43	31.66
Cap Charges	2,641	440	445	(4)	0.00	
Misc Income	(600)	(100)	(200)	100	0.00	0.00
Central Reserves	1,572	20	83	(63)	0.00	0.00
	40,696	**6,635**	**6,614**	**21**	**608.31**	**620.41**

Nursing – mainly affected by Ward Nursing overtime pressure, and it is anticipated that leavers replaced by new starts in year will contribute to the underachieved savings.

Security & Facilities – Gas overspend pressure noted, and additional security staff overtime costs.

Medical – Benefits are noted from income received and a small element of research underspend.

CE – Forensic Network underspend noted, with a review due next month.

HR – no issues noted.

Finance – ehealth notes new staff cost pressures for which we are awaiting confirmation of strategic funding expected in line with prior years.

Capital Charges –The budget is currently carried forward from previous year, awaiting SG confirmation of the required change to the allocation (core to non-core adjustment). £2.620m is the most recent estimate, and once confirmed this will be presented in the first quarterly template return to SG.

Miscellaneous Income (MI) – The budget now recognises income billed for exceptional circumstance patients. This anticipated new income has reduced required savings.

Central reserves – Most significant are pressures are inflation for pay awards held centrally awaiting circular; PAIAW costs reserve; and Apprenticeship Levy reserve. Anticipated RRL confirmations are awaited, for example as noted above for expected additional “bundled” funding such as for annual eHealth strategic costs.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(41)	0	(41)
Finance	(42)	0	(42)
Nursing & AHP's	(347)	40	(307)
Human Resources	(29)	0	(29)
Medical	(68)	0	(68)
Security & Facilities	(115)	30	(85)
Unidentified (phased ytd) - so all 'achieved'	(169)	0	(169)
Total	**(811)**	**70**	**(741)**

While an improved level of recurring saving remains a national / audit focus, it should be noted that of the Hospital's budget only 15% of costs are non-pay related while by comparison, many territorial boards have a non-pay cost element of around 65% and other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.; while certain boards also treat vacancy savings, or a proportion thereof, as recurring savings.

Savings phased evenly over the year (twelfths). Draft budgets have unidentified savings currently set at £0.169m.

National Boards Contribution
The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge which the Board agreed and approved for 2021/22 remained at £0.220m, and this is also currently forecast for 2022/23.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m. Additionally, carried forward is the unspent 2021/22 allocated project funding for Key Safes & MSR's – this will be added when we receive our first allocation letter for 2022/23.

With regard to the Perimeter Security Project allocation, while there are elements of unforeseen delays in the project – likely now to Autumn 2022 – requiring unspent monies in 2021/22 to be carried forward.

CAPITAL CRL 2022/2023 AS AT MAY 2022	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
	£'k	**£'k**	**£'k**	**£'k**
PERIMETER SECURITY				
STANLEY SECURITY SOLUTIONS LTD		167	167	0
THOMSON GRAY LTD		29	29	0
TSH STAFFING APR - MAR'22		33	33	0
SENSTAR CORP		0	0	0
PERIMETER SECURITY TOTAL (Yr 2 of 2)	**2,879**	**229**	**229**	**0**
CAPITAL				
CAPITAL	**269**	**0**	**0**	**0**
Total CRL	**3,148**	**229**	**229**	**0**

6 RECOMMENDATION

Revenue
Year to date position is £0.021m underspend, with breakeven anticipated for the year-end.

Capital
Fuller details will be provided since no allocation letter received yet for 2022/23 – it is however anticiaped that our capital allocation will be fully utilised in-year.

The Board, and Scottish Government are asked to note the content of this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position
Workforce Implications	No workforce implications – for information only
Financial Implications	No workforce implications – for information only
Route to SG/Board/CMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Deputy Director of Finance
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.	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed. ☐ There are privacy implications, full DPIA included.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 23
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director / Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project (Public Session)
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial assessment and current issues under consideration by the Project Oversight Board.

2. BACKGROUND

The Governance for the project is provided by a Project Oversight Board (POB) co-chaired by the Chief Executive and the Director of Security, Estates and Facilities.

The Project Oversight Board meets monthly. The POB last met on 22nd June 2022 and is scheduled to meet again on 22nd July 2022.

The Programme Director provided an update on the current status on the project, the Project Risk Register and financial details.

3. ASSESSMENT

a) General Project Update:

Quality targets are being met, project costs are projected to overspend by a small amount and project timescales have been reviewed and adjusted (See “Project Timescale” at point 3b below). A strategic overview of progress during the period from February 2020 to date is below:

- Construction Phase – 45% completed (7 work faces in progress, 18 to be commenced)
- Testing and Commissioning – not yet commenced
- Detailed Design Packages – 100% completed
- Construction Health and Safety documentation – 65% completed (14 to be commenced)

b) Project Timescales & Quality Issues:
Programme Rev 39 has been accepted with caveats; this projects completion on 12 September 2022, exceeding the contract completion date by approximately 20 weeks. The caveats include issues that have the potential to create further slippage.

All quality targets are being met.

c) Finance – Project cost

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	Sept 2022
Contract Completion Date:	April 2022
Main Contractor:	Stanley Security Solutions Limited
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (inc. VAT):	£10,529,255
Total costs to date (Inc. VAT) at end March 2022:	£ 9,432,791

The expenditure to date is in line with the revised plan agreed with the contractor, with the schedule planned for the months to come confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our SG funding drawdown is scheduled accordingly. All project payments are processed only once certification is received confirming completion of works to date.

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

A Rounded breakdown of actual spend to date at end of March 2022 is below.

Stanley	£ 6.784m (5% retention applied)
Thomson Gray	£ 0.699m
Doig & Smith	£ 0.008m
HVM Design	£ 0.017m
VAT	£ 1.501m
Staff Costs	£ 0.424m
	£ 9.433m

50% of the 5% retention is due to be paid at completion, with the remaining 50% to be paid at the end of the defects and liability period of 2 years.

Actual spend to date at 12th June 2022 is broadly in line with the revised Stanley planned schedule of works.

4 RECOMMENDATION

That the Board **note** the current status of the Project.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Update paper on previously approved project
Workforce Implications	N/A
Financial Implications	N/A
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Project Oversight Board
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	N/A
Equality Impact Assessment	N/A
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	N/A
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item no: 25
Sponsoring Director:	Chief Executive
Author:	Head of Corporate Planning and Business Support Clinical Effectiveness Team Leader Corporate Planning and Risk Project Support Officer
Title of Report:	Performance Report 2021/2022 and Comparative Annual Figures
Purpose of Report:	For Noting

1 SITUATION

This report presents a high-level summary of organisational performance for the year from 1st April 2021 until 31st March 2022. Trend data is provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are: Psychological Therapies, Waiting Times and Sickness Absence. Additional local Key Performance Indicators (KPIs) are reported to the Board and included in this report. Board planning and performance are monitored by Scottish Government through the Annual Operational Plan (AOP). As a result of Covid 19 pandemic, Scottish Government requested all NHS Boards submit Remobilisation Plans in place of the AOP for 2021-22. Version 3 of the Remobilisation Plan was submitted to Scottish Government to outline the priority areas of development. This was updated mid-year to Remobilisation Plan Version 4 to cover the period September 21– March 22.

The Board is asked to note that this report covers the unprecedented period of operation due to the Coronavirus pandemic. An Interim Clinical Operational Policy (ICOP) was introduced in March 2020 to ensure prioritization of infection prevention and control measures. The ICOP is supported by daily and weekly data monitoring. This ensures that variations and trends are identified in a timely fashion and improvements made through multi-disciplinary discussion. The data gathered to inform decision making is listed below:

- Number of assaults/attempted assaults and verbal aggression
- Complaints and feedback
- Safe staffing
- Observation levels and seclusion
- Predictive data re violence and aggression
- Numbers of patients who cannot tolerate care in more isolated model
- Access to fresh air, physical activity and timetable sessions
- Participation in sessional activities such as those delivered by AHPs and Psychology.

The figures from the previous three years have been included for comparison. The comparisons between the years have been made on the same periods – annual data against annual data, rolling figures against rolling figures etc.

It should be noted that due to the low number of patients, natural variations in the population can have an effect on the sample and small changes in our Key Performance Indicators (KPI) figures can look more significant when presented as percentages. These limitations should be borne in mind when considering this comparative data. Services have continued to be delivered however not necessarily in the same way prior to Covid 19

2 BACKGROUND

Members receive quarterly updates on Key Performance Indicator (KPI) performance as well as an Annual Overview of performance and a Year-on-Year comparison each June.

3 ASSESSMENT

The following sections contain the KPI data for 2021/22 and highlight any areas for improvement through a deep dive analysis for KPI's that have missed their targets.

There was one KPI which has increased this year and moved into a more positive zone, this is:
- Patients will be engaged in off-hub activity centers during COVID-19.

There are four KPI's which have missed their target this year, these are:
- Patients will have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will be offered an annual physical health review.
- Patients will have a healthier BMI.
- Sickness absence (National HEAT standard is 4%)

	Item	Principles	Performance Indicator	Target	RAG	21/22	20/21	19/20	18/19		LEAD
	1	8	Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	92.67%	94.40%	91.73%	96.9%	*Figure to March each year.*	**LT**
	2	8	Patients will be engaged in psychological treatment	85%	G	85.56%	86.74%	87.93%	92.8%	*Figure to March each year.*	**KMcC**
	3	8	Patients will be engaged in off-hub activity centres	90%	-	-	-	83%	81.7%	*This indicator was closed in June 2020 to accommodate engagement during restrictions.*	**KMcC**
	3.1	8	Patients will be engaged in off-hub activity centres during COVID-19	90%	G	92.47%	83.33%	-	-	*Figure to March each year.*	**KMcC**
	4	8	Patients will be offered an annual physical health review.	90%	R	51.78%	56.67%	98.48%	93%	*Figure for Apr 2021 - Mar 2022.*	**LT**
	5	8	Patients will undertake 90 minutes of exercise each week (Annual Audit)	80%	G	78.75%	75.00%	60.70%	56.3%	*Average figure for April 2021 – March 2022.*	**KMcC**
	6	8	Patients will have a healthier BMI	25%	R	10%	10.50%	8.75%	13.7%	*Average figure from April 2021 – March 2022.*	**LT**
	7	5	Sickness absence (National HEAT standard is 4%)	** 5%	R	6.39%	5.30%	5.92%	8.26	*Figure for April 2021 – March 2022.*	**JW**
	8	5	Staff have an approved PDR	*80%	G	85.25%	80.58%	86.68%	80.9%	*Figure to March 2022.*	**JW**
	9	1, 3	Patients transferred/discharged using CPA	100%	G	100%	100%	100%	97%	*Figures for April 2021 - March 2022.*	**KMcC**
	10	1, 3	Patients requiring primary care services will have access within 48 hours	*100%	G	100%	100%	100%	100%	*Figures for April 2021 - March 2022.*	**LT**
	11	1, 3	Patients will commence psychological therapies <18 weeks from referral date	**100%	G	98.66%	97.66%	99.78%	98.5%	*Figure to March 2022.*	**KMcC**
	14	2, 6, 7, 9	Patients have their clinical risk assessment reviewed annually.	100%	G	96.49%	95.35%	97.68%	99%	*Figure to March 2022.*	**LT**
	15	2, 6, 7, 9	Attendance by all clinical staff at case reviews	Individual	-	69.3% overall	67.40% overall	71.5% overall	65.6% overall	*Figures for April 2021 – March 2022.*	**All Leads**

No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals

Target: 100%

Data for 2021/22: 92.67%

Performance Zone: Amber

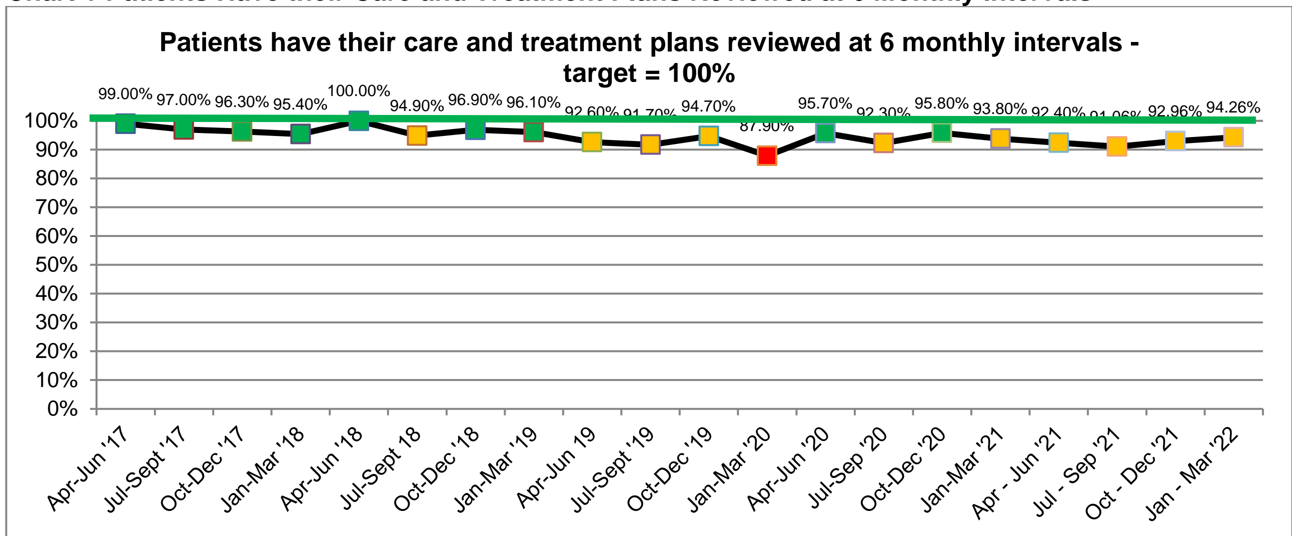
This is a Mental Health Act requirement for any patients within high secure settings. This indicator measures the assurance of patients receiving intermediate and annual case reviews. Care and Treatment Plans are reviewed by the multidisciplinary teams at case reviews and objectives are set for the next 6 months.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	A	A	92.67%	94.40%	91.73%	96.9%

Performance has decreased in 2021/22 as the annual average for this indicator was 1.73% lower than that of 2020/21. All four quarters of 21/22 were within the amber performance zone as too was the performance zone for the annual percentage. There were 16 separate instances during this reporting year where a patient waited beyond the specified 6 months of reviewing their care and treatment plans. In addition, there was 21 separate instances of patients who did not have their documentation uploaded within the specified period for their care and treatment plan at that time.

All dates are set in line with the relevant date of an annual review or renewal followed by a 6 monthly review after that. MHPSG are reviewing the CPA process and this is being governed through Clinical Governance. Health Records staff continue to send reminder emails to RMOs and medical secretarial staff to advise that a patient's review or renewal of detention is due. The renewal of detention ties in with the annual CPA document being completed. These continue to be completed and uploaded to RiO by secretarial staff in shorter timescales than previously noted.

Chart 1 Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals



No 2: Patients will be Engaged in Psychological Treatment

Target: 85%

Data for 2021/22: 85.56%

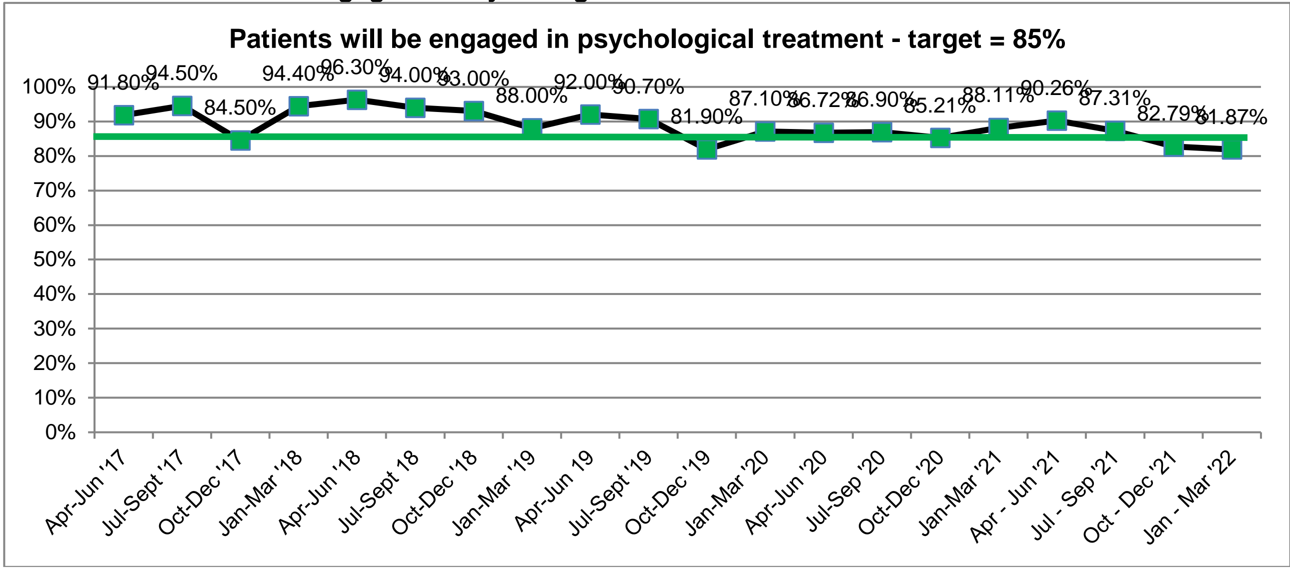
Performance Zone: Green

This indictor is a main priority of National Mental Health Indicators. This indicator measures the percentage of patients who are engaged and involved in psychological treatment.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients will be engaged in psychological treatment	85%	G	G	G	G	85.56%	86.74%	87.93%	92.8%

Performance over the course of the year remained within the green performance zone. The annual average of 85.56% fell minimally from 86.74 the previous year.

Chart 2 Patients will be Engaged in Psychological Treatment



No 3.1: Patients will be Engaged in Off-Hub Activity Centers during COVID-19

Target: 90%

Data for 2021/22: 92.47%

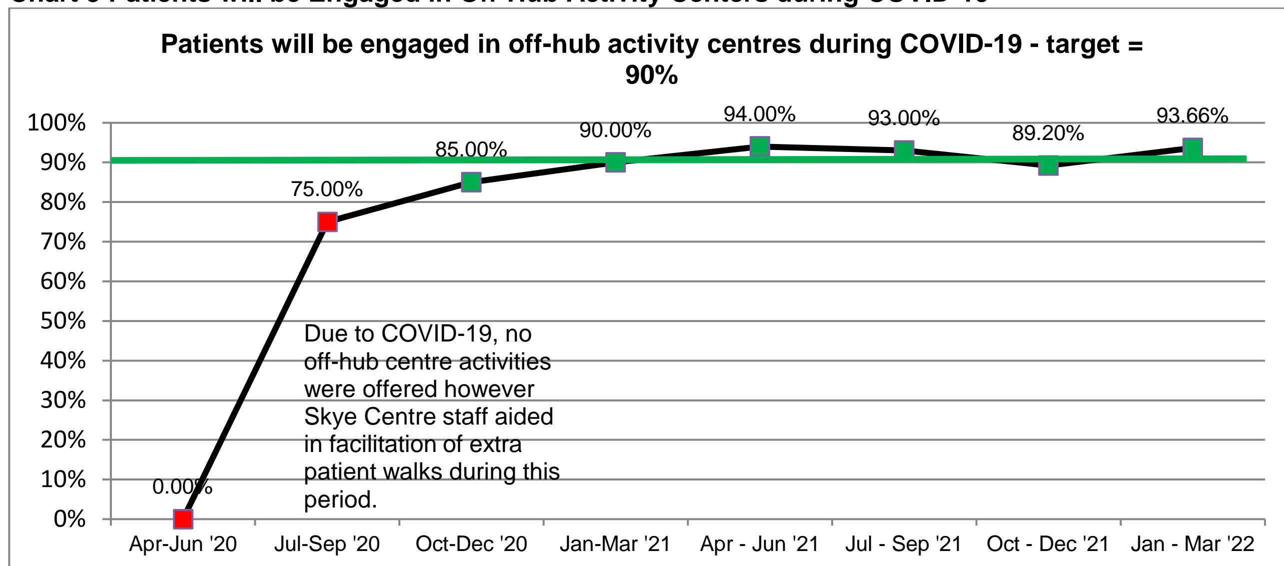
Performance Zone: Green

This measures the number of patients who are engaging in some form of timetable activity which takes place off their hub. The sessions may not necessarily directly relate to the objectives in their care plan however recognised as therapeutic activities. This will continue to be reported through the Operating Model Monitoring Group (OMMG).

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	92.47%	83.33%	-	-

This indicator was adapted to incorporate different modes of engagement during COVID-19. This indicator averaged at 92.47% for this reporting year; a 9.14% increase on last years' figure.

Chart 3 Patients will be Engaged in Off-Hub Activity Centers during COVID-19



No 4: Patients will be Offered an Annual Physical Health Review

Target: 90%

Data for 2021/22: 51.78%

Performance Zone: Red

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator currently measures the offer of an annual health review and not the uptake. This is being reviewed to ensure that the KPI accurately captures physical health reviews carried out.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients will be offered an annual physical health review	90%	R	R	R	A	51.78%	56.67%	98.48%	93%

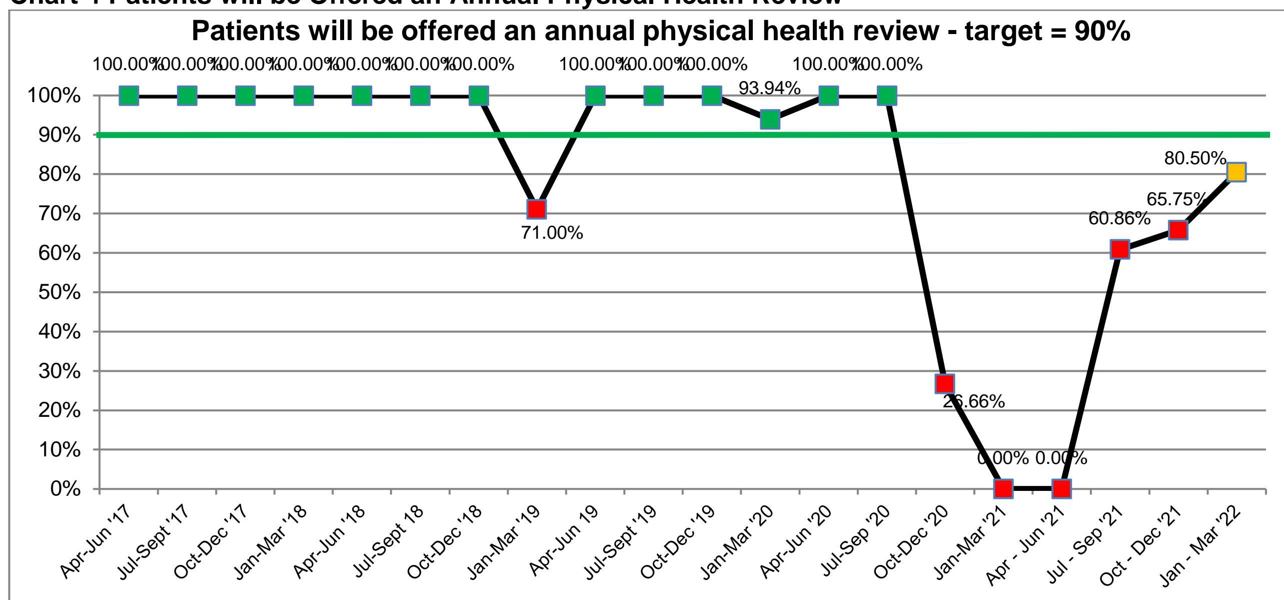
The overall average during 2021/22 was 51.78%; this is a decrease of 4.89% from the year 2020/21. Quarter 1 sat with 0% compliance which rose significantly in Q2 60.86% where formal invites to patients surrounding their annual physical review were recommenced. Q3 increased further to 65.75% compliance and Q4 saw a considerable rise again to 80.5% compliance.

During this period, patients were, and still are, routinely receiving their annual bloods and ECG assessments in addition to the weekly support offered from the visiting Advanced Nurse Practitioner (ANP) for patients who required more regular assessment and intervention. Any physical health issues with our patients was actioned within 48 hours via the Health Centre and liaison with Junior Doctors during this period has been vital to ensuring that any personal physical issues / needs of our patients are met. In addition, onward outpatient referrals are still being sent through the Health Centre should there be any requirement beyond TSH capabilities, in conjunction with ANP visits.

Staff shortages from August 2021 to March 2022 resulted in clinics being cancelled which then led to some annual reviews not being carried out. All patients who were due to be seen for an annual physical health review had an overview carried out by our Practice Nurse. The GP contract previously held by Medwyn Medical Practice will change over to a private provider for the following 12 months.

Work has progressed regarding the amendment of this KPI to reflect the uptake and quality of the physical health care provided. The Practice Nurse has liaised with the high secure estates in NHS England regarding their provision and procedure of offering an annual physical health review to all their patients. The Health Centre has devised a checklist template, benchmarked against the other high secure facilities, which will be completed for every patient when their annual review is due to highlight all their physical health needs and checks.

Chart 4 Patients will be Offered an Annual Physical Health Review



No 5: Patients will be Undertake 90 Minutes of Exercise Each Week

Target: 80%

Data for 2021/22: 78.75%

Performance Zone: Green

This links with national activity standards for Scotland. We acknowledge that the national standard is 150 minutes per week however, 90 minutes of exercise was chosen due to this being a challenging target for the hospital with the addition of an obesity issue within the patient group. This measures the number of patients who undertake 90 minutes of exercise each week.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients will undertake 90 minutes of exercise each week	80%	G	G	A	R	78.75%	75.00%	60.70%	56.3%

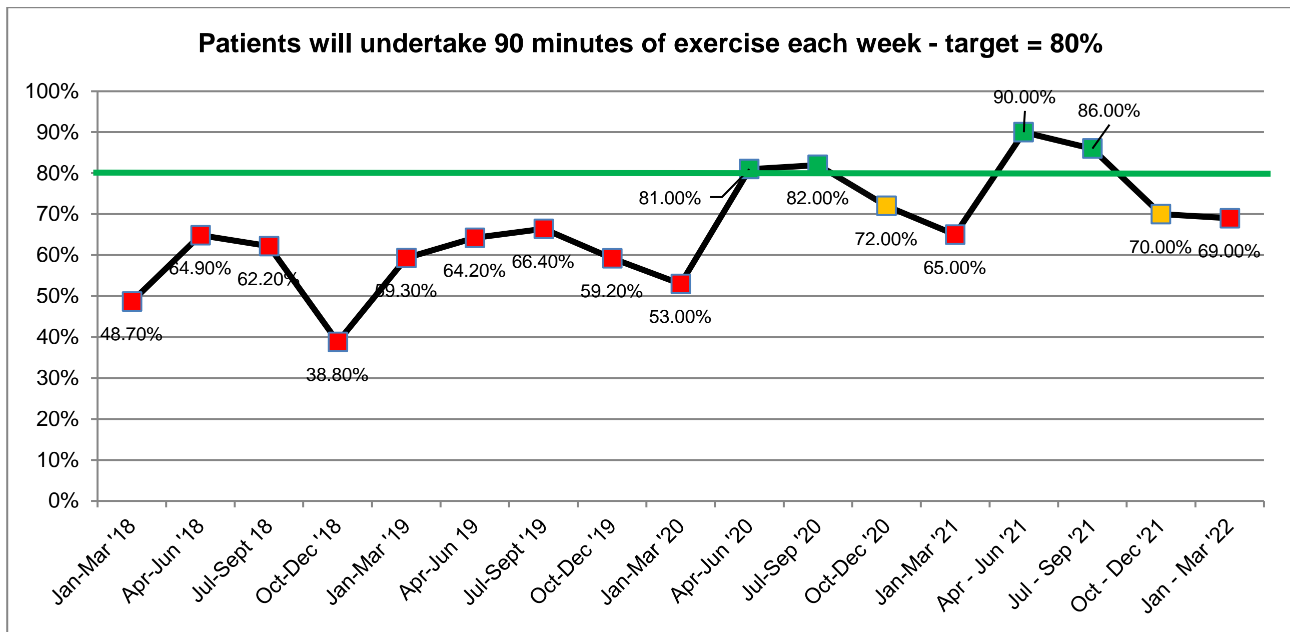
The target for this indicator is 80% and the overall average for year 21/22 was 78.75%. This is a slight increase on last years' performance of 3.75%. This indicator remains in the green zone for the second consecutive year. Q1 of this reporting year saw the highest ever recorded compliance rate since its data collection began.

The dip in early January 2022 may have been attributed to numerous issues such as staff resourcing issues, bubble model of patient care and poor weather. It should be noted that the figures increased and the local KPI target was achieved in February and early March 2022 however an outbreak of Covid-19 saw staffing figures drop with up to 25 patients and 5 wards entering isolation.

Data recorded is patient participation in moderate physical activity intervention. This data includes patients participating in Sports and Fitness, Gardens, ward activities and escorted walks. This data also includes patients using Ground Access as a means of physical activity. Caution should be used to the data however, as this is based on patient self-reporting. This will continue to be reported through the Operating Model Monitoring Group (OMMG). Quarterly reporting is also provided to the Physical Health Steering Group (PHSG) who review the trend data and suggest possible ways of improving the uptake of Physical Activity.

It should be noted that the current KPI of 80% of patients will undertake 90 minutes of exercise each week is planned to change as at 1st April 2022. Clarification will be sought for the Chair of the PHSG regarding what the updated KPI will be however it will increase to 150 minutes of exercise per week.

Chart 5 Patients will be Undertake 90 Minutes of Exercise Each Week



No 6: Patients will have a Healthy BMI

Target: 25%

Data for 2021/22: 10%

Performance Zone: Red

This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.

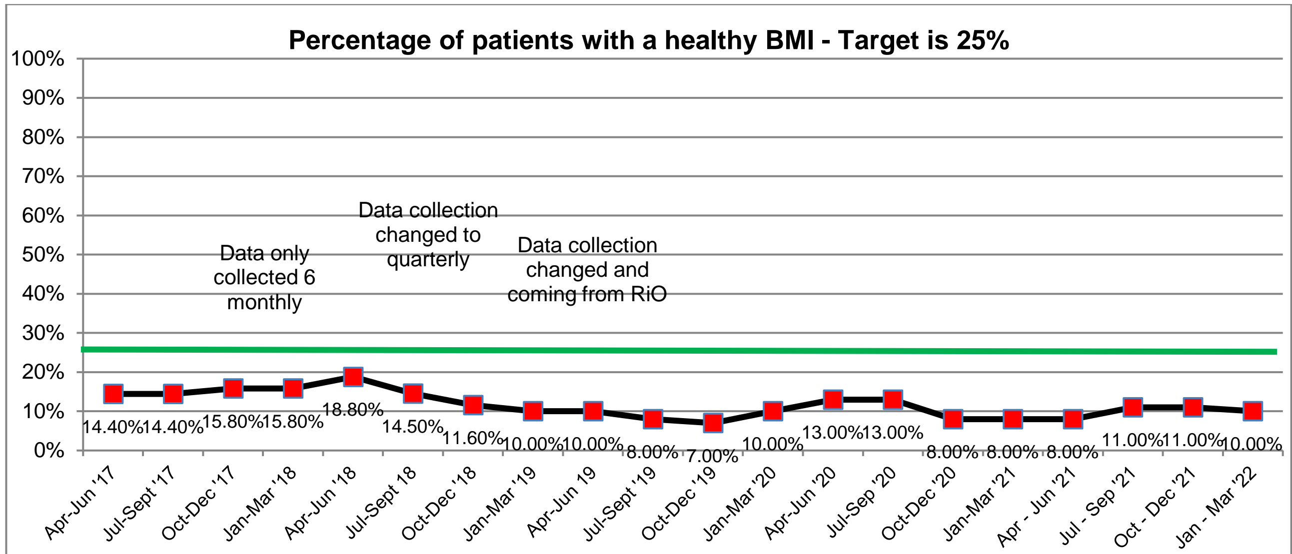
Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients will have a healthier BMI	25%	R	R	R	R	10%	10.50%	8.75%	13.7%

The average percentage of patients who have a healthier BMI decreased from 10.50% in the previous year to 10 % in this reporting year. In Q1 there was a maintenance of 8% from Q4 of the previous year which was followed by a 3% increase to 11% in Q2 which was maintained through to Q3. However, there was a decline of 1% in Q4 to 10%. This indicator remains within the red performance zone for this reporting year.

The PHSG have requested monthly monitoring reports to review the data and going forward, the Supporting Healthy Choices Group (SHCG) remits to change the culture in TSH for maximising physical activity and promoting healthier lifestyles; including dietary changes where appropriate. Options to consider how groups and ward-based weight loss interventions may be delivered have been included within the plan of work.

The Hospital is, at present, recruiting a new post of a Practitioner (Health) Psychologist which will be an asset to this work stream as a new post which underpins the commitment to improve the physical health and well-being of patients on their recovery journey.

Chart 6 Patients will have a Healthy BMI



No 7: Sickness Absence (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%

Data for 2021/22: 6.39%

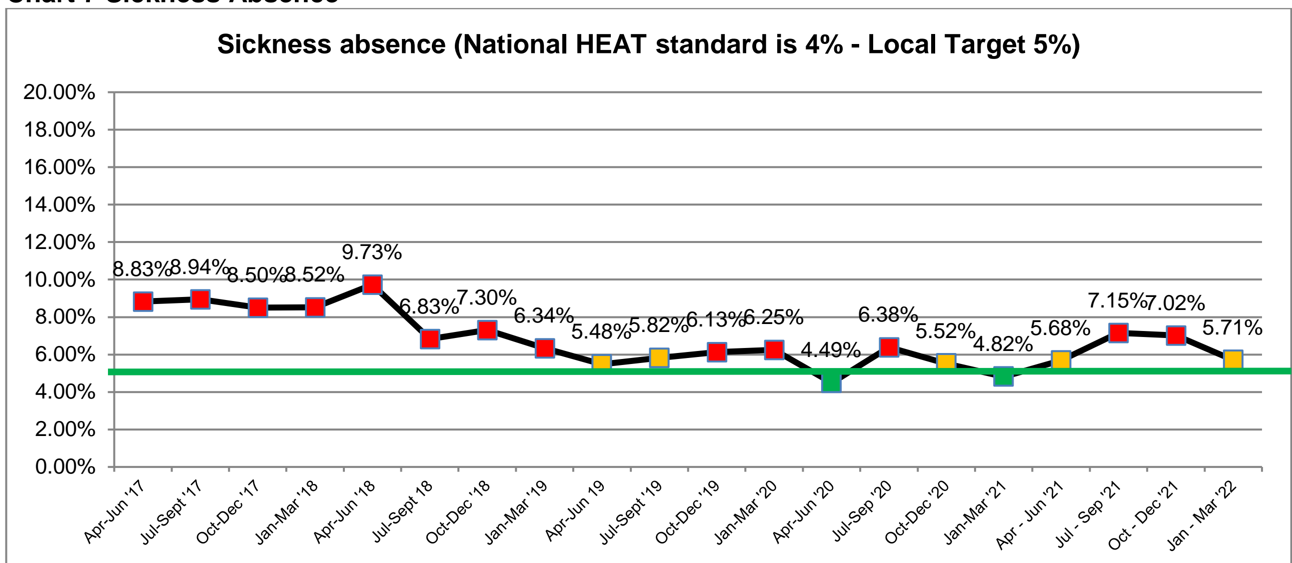
Performance Zone: Red

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Sickness absence rate (National HEAT standard is 4%)	** 5%	A	R	R	A	6.39%	5.30%	5.92%	8.26%

In the reporting period 1 April 2021 to 31 March 2022, the rate of absence was 6.39% compared to 5.3% in the previous year - this is an increase to sickness levels by 10.9%. This is against a 5% target. This moves TSH into the red performance zone from green for this reporting year.

It should be noted that in accordance with guidance set out in DL(2020)5 Coronavirus (Covid-19): National Arrangements for NHS Scotland Staff, staff absence and sickness related to Covid-19 is recorded as special leave and does not count towards sickness absence triggers.

Chart 7 Sickness Absence



Details of working hours lost due to COVID-19 related special leave expressed monthly totals, are provided below. This ensures that the data comparison is valid for year on year.

Table 1 Working Hours Lost due to Covid 19

Month	Total Hours Lost	Total Hours Lost (%)
April 2021	1943.40	2.08%
May 2021	986.18	1.02%
June 2021	1341.06	1.54%
July 2021	1545.95	1.61%
August 2021	2972.70	2.15%
September 2021	3072.11	3.27%
October 2021	2336.34	2.39%
November 2021	2140.71	2.28%
December 2021	3229.11	3.33%
January 2022	3995.38	4.14%
February 2022	2456.32	2.80%
March 2022	5160.83	5.28%

No 8: Staff have an Approved PDR

Target: 80%

Data for 2021/22: 85.25%

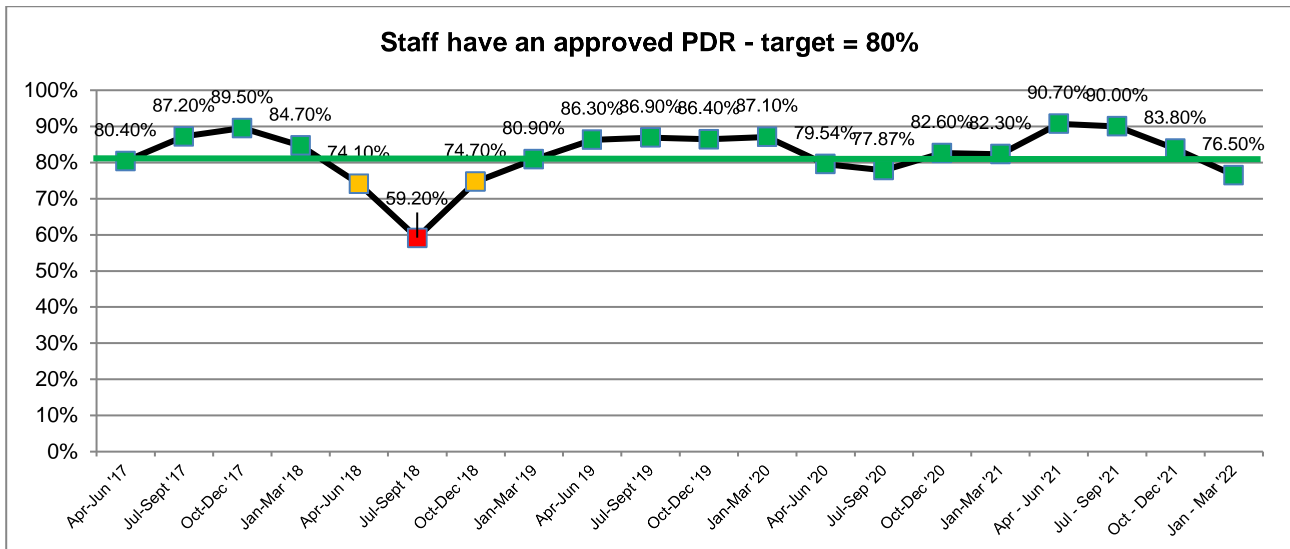
Performance Zone: Green

This indicator relates to the National Workforce Standards; measuring the percentage of staff with a completed PDR within the previous 12 months.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Staff have an approved PDR	80%	G	G	G	G	85.25%	80.58%	86.68%	80.9%

The PDR compliance level at 31 March 2022 was 76.5% - the reporting year averaging at 85.25%. This is a 4.67% increase from the 2020/21 figure of 80.58%. This indicator has consistently been within the green zone since March of 2019. Fluctuations have occurred throughout this time however compliance has been maintained.

Chart 8 Staff have an Approved PDR



No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for 2021/22: 100%

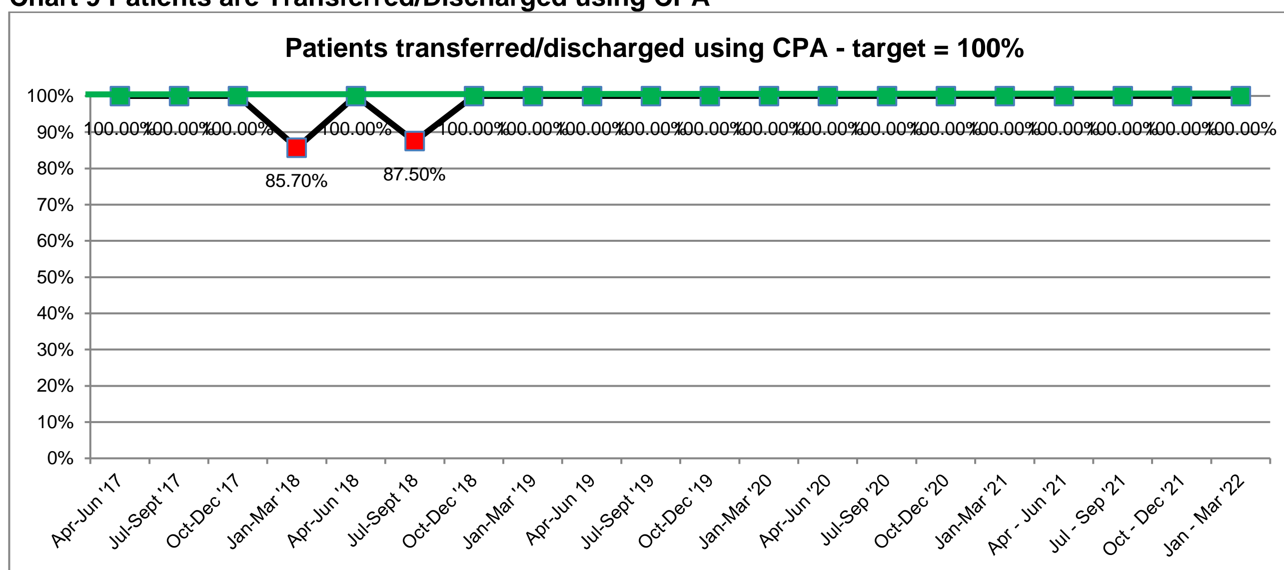
Performance Zone: Green

The indicator is linked to the Mental Health Act, 2003 and the streamlining of discharges and transfers. The number of patients transferred out using CPA process are measured through this indicator.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	100%	100%	97%

100% of patients were discharged / transferred using the Care Programme Approach (CPA).

Chart 9 Patients are Transferred/Discharged using CPA



No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

Target: 100%

Data for 2021/22: 100%

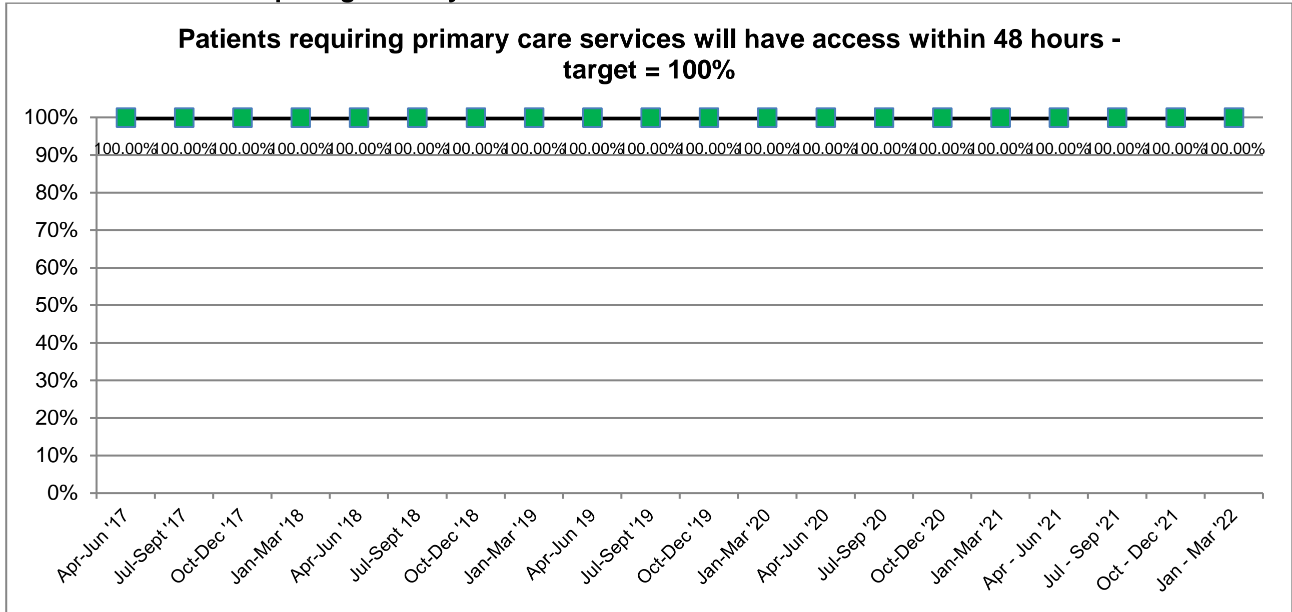
Performance Zone: Green

This indicator is linked to National Health and Social Care Standards as published by Healthcare improvement Scotland (HIS). Primary care services include any service at our Health Centre including triage.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	100%	100%	100%

This indicator has consistently stayed at full compliance since its data collection began.

Chart 10 Patients Requiring Primary Care Services Will Have Access within 48 Hours



No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

Data for 2021/22: 98.66%

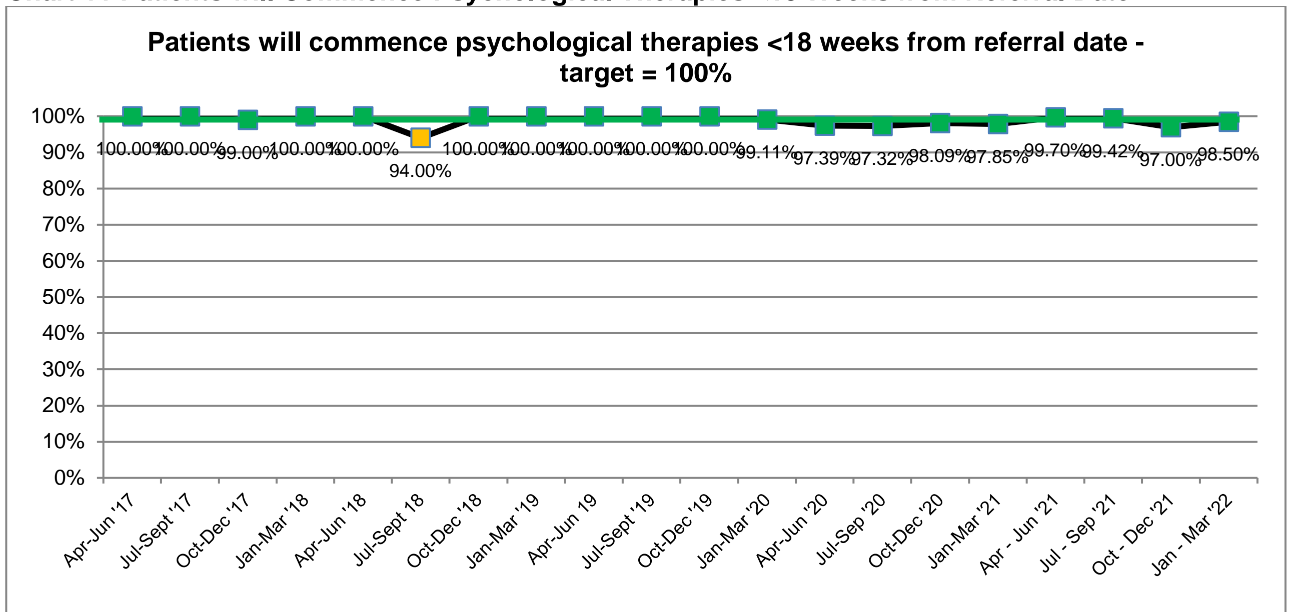
Performance Zone: Green

The indicator correlates to National Mental Health Indicators for Scotland to ensure that no patient waits more than 18 weeks to commence some form of psychological therapy.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	G	G	98.66%	97.66%	99.78%	98.5%

There was a slight increase in this year's figure against 2020/21's figure (1%). Compliance was still maintained throughout 2021/22 for this indicator.

Chart 11 Patients will Commence Psychological Therapies <18 Weeks from Referral Date



No 14: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

Data for 2021/22: 96.49%

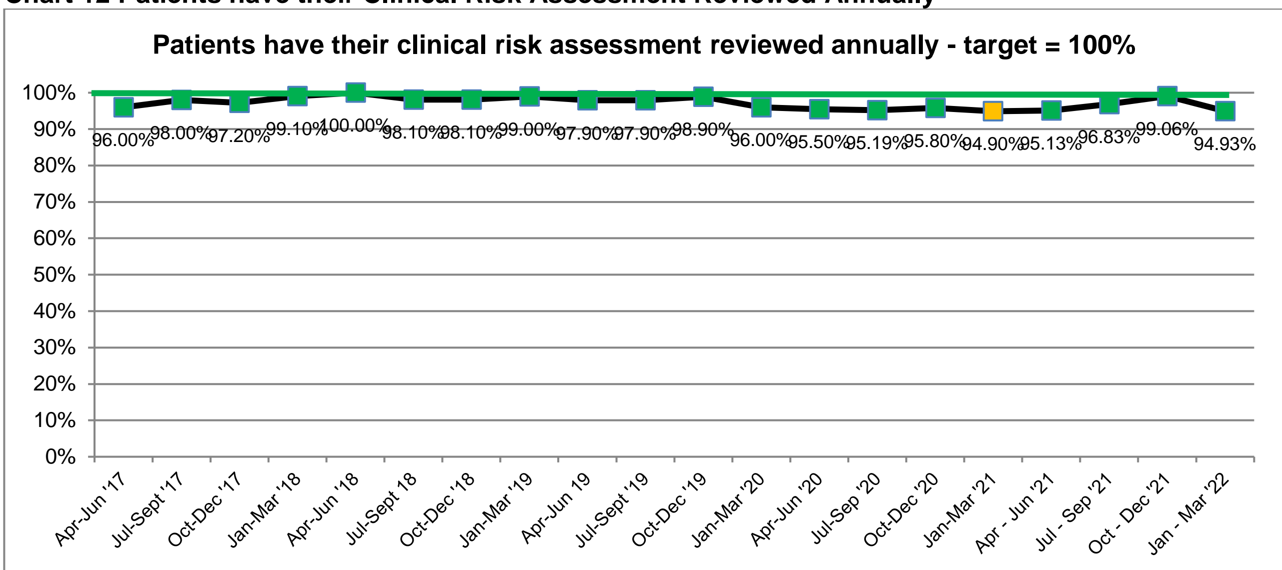
Performance Zone: Green

The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	21/22	20/21	19/20	18/19
Patients have their clinical risk assessment reviewed annually.	100%	G	G	G	A	96.49%	95.35%	97.68%	99%

Performance has remained only slightly below the 100% target throughout the year. The average figure for this indicator in year 2021/22 is 96.49% and only during Q4 did we see a move into the amber zone. Monitoring and auditing of the system integrated in 2017 are ongoing.

Chart 12 Patients have their Clinical Risk Assessment Reviewed Annually



No 15 Attendance by clinical staff at case reviews.

The table below provides comparative data on the extent to which professions met their attendance target. The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over 5 years.

Table 2 Attendance by clinical staff at case reviews

Professional Group	Target	18/19	19/20	20/21	21/22	Increase/Decrease
RMO	90%	90.9%	90%	78.5%	87.25%	+8.75%
Medical	100%	97%	96%	79%	90.5%	+11.5%
KW/AW	80%	63.6%	78.3%	66%	58.75%	-7.25%
Nursing	100%	96.5%	97.8%	92.3%	97%	+4.7%
OT	80%	64.2%	86.3%	77.8%	77.5%	-0.3%
Pharmacy	60%	59.4%	61.3%	63.5%	81.5%	+18%
Clinical Psychologist	80%	84.3%	71.3%	67.8%	68.25%	-0.45%
Psychology	100%	84.5%	87.8%	78.3%	84.75%	+6.45%
Security	60%	41.2%	52.5%	41.8%	40.75%	-1.05%
Social Work	80%	80.8%	73.8%	87%	86%	-1%
Dietetics	tbc	23.6%	60.8%	77.3%	59.75%	-17.55%
Skye Centre Activity	tbc	1.1%	2.3%	0%	0%	No change
Hospital Wide	**n/a**	**65.6%**	**71.5%**	**67.4%**	**69.3%**	**+1.9%**

RMO – during 2021/22, there was an increase in RMO attendance at case reviews: the figure rose by 8.75%. This profession's average moved to the green zone for this reporting year.

Medical – during 2021/22, there was 11.5% rise in medical attendance at case reviews. This increase moves this profession into the amber zone for this reporting year.

Key Worker/Associate Worker – there has been a decrease of 7.25% in attendance for 2020/21. This means that they remain in the red zone for this reporting year.

Nursing – attendance from nursing during 2021/22 has risen by 4.7%. This moved this profession from the amber zone into the green zone for this reporting year.

Occupational Therapy – during 2021/22, attendance from occupational therapy has declined by 0.3% from the previous year. This profession remains in the green zone for this reporting year.

Pharmacy – there has been a significant increase in this reporting year of 18%. This profession has remained in the green zone for this reporting year.

Clinical Psychologist – there has been a slight decrease of 0.45% attendance for 2021/22. This means that this clinical team has remained in the red zone for this reporting year.

Psychology – during 2021/22, there was a rise of 6.45% in attendance for this department. This profession remains in the red zone despite this reduction.

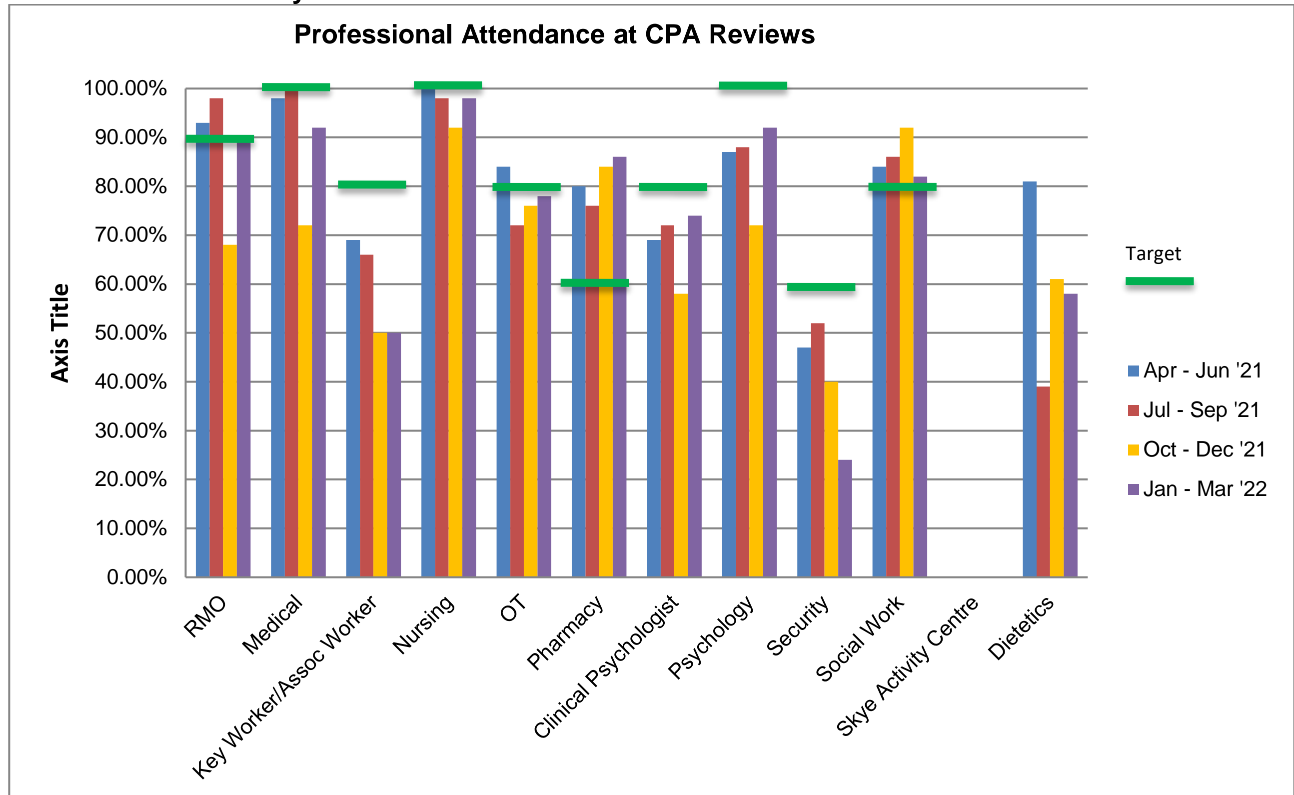
Security – there was a 1.05% decrease in Security attendance during 2021/22. The profession remains in the red zone for this reporting year.

Social Work – there has been a 1% decrease in attendance at case reviews. This profession remains in the green zone for this reporting year.

Dietetics – during 2021/22, attendance from dietetics has decreased during this reporting year by 17.55%. There is no target for this profession as of yet.

Skye Centre Activity – during 2021/22, there was no attendance from Skye Centre staff at case reviews. This figure is the same as the previous reporting year. There is no target for this group as of yet.

Chart 13 Attendance by clinical staff at case reviews.



4 RECOMMENDATION

The Board are asked to **note the contents of this report.**

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020), the Operational Plan and the Remobilisation Plan submitted to Scottish Government in September, to cover the period September 20 – March 21.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations?	Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included.

APPENDIX 1

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q3	RAG Q4	Overall attendance Jan – Mar 2022 (n=50)	Overall attendance Oct – Dec 2021 (n=50)	Overall attendance Jul – Sep 2021 (n=50)	Overall attendance Apr – Jun 2021 (n=45)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	R	G	90%	68%	98%	93%
				Medical **(LT)**	100%	R	A	92%	72%	100%	98%
				Key Worker/Assoc Worker **(MR)**	80%	R	R	50%	50%	66%	69%
				Nursing **(MR)**	100%	A	G	98%	92%	98%	100%
				OT**(MR)**	80%	G	G	78%	76%	72%	84%
				Pharmacy **(LT)**	60%	G	G	86%	84%	76%	80%
				Clinical Psychologist **(JM)**	80%	R	A	74%	58%	72%	69%
				Psychology **(JM)**	100%	R	A	92%	72%	88%	87%
				Security **(DW)**	60%	R	R	24%	40%	52%	47%
				Social Work **(KB)**	80%	G	G	82%	92%	86%	84%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc			58% (n=28)	61%	39% (n=19)	81% (n=16)

APPENDIX 2: QUARTERLY KEY PERFORMANCE INDICATORS FOR 2021-2022

Performance Indicator	Target	RAG Q1 21/22	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	A	A	94.26%	This indicator remains in the amber zone for quarter 4.
Patients will be engaged in psychological treatment	85%	G	G	G	G	81.87%	This indicator remains green for this quarter.
Patients will be engaged in off-hub activity centers	90%	-	-	-	-	-	This indicator was closed in June 2020 to accommodate engagement in off-hub activities during the pandemic.
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	93.66%	This figure includes drop-in sessions which took place in hubs, grounds and the Skye Centre.
Patients will be offered an annual physical health review	90%	R	R	R	A	80.50%	Offering of annual health reviews recommenced in August 2021.
Patients will undertake 90 minutes of exercise each week	80%	G	G	A	R	69%	This indicator moves into the red zone for quarter 4.
Patients will have a healthier BMI	25%	R	R	R	R	10%	The percentage of patients with a healthier BMI has slightly fallen in Q4.
Sickness absence rate (National HEAT standard is 4%)	** 5%	A	R	R	A	5.71%	January's figure was 7.09%, February's figure was 5.27% and March's figure was 4.77%.
Staff have an approved PDR	*80%	G	G	G	G	76.50%	This indicator has been within the green zone since March 2019.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	6 patients were transferred during this quarter all using CPA. 1 patient death.
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains 100% in Q4.
Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	G	G	98.50%	4 patients waited beyond the specified wait time during November and December 2021.
Patients have their clinical risk assessment reviewed annually.	100%	G	G	G	A	94.93%	As at 31 March 2022, there were 113 patients in the hospital. Nine were new admissions and four patients had an out of date risk assessment.
Attendance at CPA Reviews (Refer to Appendix 1)							

Definitions for red, amber and green zone

- For all but item 6 and 7: green is 5% or less away from target, amber is between 5.1% and 10% away from target and Red will mean we are over 10% away from target.
- For item 6 'Patients have a healthier BMI': green will be 3% or less away from target, amber will be between 3.1% and 5% away from target and red will be over 5% away from target.
- For 7 'Sickness absence': green is less than 0.5% from target, amber will be between 0.51% and 1% away from target and red will be over 1% and away from target.

Paper No. 22/58

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 26
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Risk Management Facilitator
Title of Report:	Risk & Resilience Annual Report 2021/22
Purpose of Report:	For Noting

1 SITUATION

This annual report provides the Board with details of the activity undertaken within the Risk and Resilience Department over period 1 April 2021 until 31 March 2022.

2 BACKGROUND.

The Risk and Resilience Team is involved in a range of functions from the maintenance of risk registers, the development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, and Duty of Candour.

3 ASSESSMENT

Changes within Department

Head of Risk and Resilience

In December 2020 the Risk Management Team Leader left post. Recruitment began in March 2021 for a new full time post – Head of Risk and Resilience which was filled in May 2021. The post reports directly to the Director of Security, Estates and Resilience and works alongside the Head of Security and Head of Estates. The Department continues to be supported by the full time Risk Management Facilitator and Part-Time Risk Project Support Officer.

Committee and Groups Structure

Following consultation, it was agreed to split the Security, Risk and Resilience and Health & Safety Group into the following groups/committees:

- Health, Safety and Welfare Committee
- Security and Resilience Group

- Climate Change and Sustainability Group

Each group meets quarterly and reports into the Security, Risk and Resilience, Health and Safety Oversight group chaired by the Director of Security, Resilience and Estates.

Areas of Good Practice

In addition to the positive outcomes highlighted throughout the report, there are a number of additional areas of good practice in relation to risk management across the hospital including:

- Effective monitoring of risk information by groups and committees
- Regular monitoring of patient-specific risks by clinical teams
- Strong evidence on learning from incidents, with local action being taken to minimise recurrences

Areas of good practice within the risk management team include:

- Continued development of the Corporate Risk Register with risk owners, the risk register has seen some positive movement over the last year as a result of further control measures being implemented.
- Updated Local Risk Register work completed and continued development in place
- Completion and sign off of all of outstanding RSM recommendations
- Continued development within the Risk and Resilience Team including Datix Training, Having Difficult Conversations and Investigation Training. The team has also started to work towards their NEBOSH qualification.
- Appointment of Head of Risk and Resilience to the Risk and Resilience Team.

Identified issues and potential solutions

The main focus for the Risk and Resilience Team in 2022/23 will be to ensure that the training plan for the Control Book Holders is actioned to allow for the Control Book Audit Programme will resume. The team will also continue to ensure each Resilience Plan is up to date and fit for purpose to ensure The State Hospital (TSH) is prepared for every eventuality.

Future areas of work and potential service developments

TSH has been in talks with an external agency, RSM to assist with development work in relation to theorganisation's Risk Appetite. This work is planned to be completed throughout 2022/23 with members of the Board and the Security Directorate.

Work is ongoing to continue to develop Datix, Local Risk Register and Corporate Risk Register which will continue to help improve the way that risk is managed within TSH. This is being actioned by the Risk Management Facilitator and monitored by relevant groups.

4 RECOMMENDATION

The Board is invited to note the Risk and Resilience Annual Report for the period 2021/22.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The Risk Management Annual Report provides the board with an update of the activity of the department over the last year in line with governance arrangements.
Workforce Implications	There are no workforce implications related to the publication of this report. The report provides information on various workforce factors including Complaints, RIDDOR and Training.
Financial Implications	There are no financial implications related to the publication of this report. The report provides financial information on Claims.
Route To Board Which groups were involved in contributing to the paper and recommendations	Audit Committee
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report. Significant incidents over the financial year are highlighted.
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)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

Paper No. 22/58

THE STATE HOSPITALS BOARD FOR SCOTLAND

Risk and Resilience Annual Report

2021-2022

Prepared by: Risk Management Facilitator

Approved by: Director of Security, Estates and Resilience

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4. Summary
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1. Risk Management Department

1.1 Introduction

The Risk and Resilience Department, part of the Security Directorate, is involved in a range of functions from the maintenance of risk registers, development and review of Resilience Plans, Incident Reporting and Enhanced Reviews, Health & Safety, Duty of Candour to the administration of Datix.

1.2 Aims and Objectives

- Development, implementation and review of Risk and Resilience policies and procedures;
- Proactive identification of risks potentially impacting on The State Hospital (TSH), with the subsequent management of these risks through recognised risk management tools and techniques;
- Implementation of Incident Review processes to ensure significant adverse events are adequately investigated with the development of Action Plans to enhance organisational learning; and
- Supporting a "Quality" culture by developing staff competencies and improving risk management practices within TSH.

2. Governance

2.1 Committees/Groups

The Audit Committee has overall responsibility for evaluating the system of internal control and corporate governance, including the risk management strategy and related policies and procedures.

Risk management has been embedded within a variety of TSH committees, with regular reports on risk activity presented to the Security and Resilience Group, Climate Change and Sustainability Group and Health, Safety and Welfare Committee with oversight from the Security, Risk, Resilience, Health and Safety Oversight Group. Relevant incidents, the corporate risk register and policy management are also reported to the Audit, Clinical Governance and Staff Governance Committees on a quarterly basis.

The Groups within the Directorate have changed within the last year and are supported now by the following Groups and Committees:

- **Health, Safety and Welfare Committee (HSW)** operates in partnership with staff, and plays a key role in monitoring and reviewing Health and Safety incidents and policy implementation.
- **Security and Resilience Group (SRG)** monitors and reviews progress on emergency and resilience plans, ensuring that core plans are in place, tested and reviewed, with the minutes being reported to the CMT.
- **Climate Change and Sustainability Group (CCSG)** is a new group whose aim is to ensure that the principles of sustainability are embedded in NHS The State Hospital Board for Scotland's strategic programme. The Group will ensure an integrated approach to sustainable development, harmonising environmental, social and economic issues.
- **Security, Risk & Resilience, Health & Safety Group** oversees the progress of HSW Committee, SRG and CCSG. The purpose is to govern and direct work across all three sub-groups to align to the overall strategy for the hospital.
- The committee and groups report issues to the **Audit Committee** after each meeting and the minutes are circulated at that committee.
- **Hospital Management Team** and **Organisational Management Team** are group structures within The State Hospital. Risk and Resilience have a presence at both these meetings to provide updates on current risk and resilience work as well as receive and monitor actions. Both of these groups feed into the **Corporate Management Team.**
- **Patient Safety Group** for which a report is prepared separately on an annual basis for Clinical Governance Committee.

In addition to the above Groups and Committees. Risk and Resilience also have a presence at other Hospital Groups including Infection Control, Information Governance, Corporate Governance and Clinical Governance.

3. Key Work Activities (2021-2022)

3.1 Risk Management

3.1.1 Changes within Department

Head of Risk and Resilience

In December 2020 the Risk Management Team Leader left post. Recruitment began in March 2021 for a new full time post – Head of Risk and Resilience which was filled in May 2021. The post reports directly to the Director of Security, Estates and Resilience and works alongside the Head of Security and Head of Estates. The Department continues to be supported by the full time Risk Management Facilitator and Part-Time Risk Project Support Officer.

Committee and Groups Structure

Following consultation it was agreed to split the Security, Risk and Resilience and Healthy & Safety Group into the following groups/committees:

- Health, Safety and Welfare Committee
- Security and Resilience Group
- Climate Change and Susatinability Group

Each group meets quarterly and reports into the Security, Risk and Resilience, Health and Safety Oversight group chaired by the Director of Security, Estates and Resilience.

3.1.2 Corporate Risk Register (Appendix A)

A corporate risk is a potential or actual event that:

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

The corporate risk register has been in existence since 2005 with incremental changes being made as risk exposure changes. In February and March 2012, board members and hospital managers participated in two, half-day workshops to review and update the Corporate Risk Register to ensure that it continued to reflect the risk profile of the organisation following the move to the new hospital. A report was published in April 2012, and presented to the Audit Committee. The Corporate Risk Register was evaluated by internal audit and a report published in January 2016. This was reviewed by the Audit Committee. The frequency of risk review and detail contained within the Corporate Risk Register has been reviewed and updated.

The hospital's risk register process was subject to internal audit in February 2019 with the final report presented in March 2019. 10 recommendations were made, 5 graded as low, 5 graded as medium. RSM have closed off all of the 10 actions with a final action now signed off.

Action	Priority	Estimated Completion	Current Status
The current version of the Risk Register does not currently record any assurances that have been received. This is important to support the assessment of the current risk	Medium	30 April 2021	Closed, action as been implemented.

score/ comfort over the effectiveness of the controls.			

3.1.3 Department/Local Risk Registers

Department/Local Risk Registers contain risks that are particular to a specific department, are within the capability of the local manager to manage and are monitored and reviewed by the Head of Department. All departments are expected to develop a Local Risk Register, together with relevant risk assessments and action plans (if indicated).

The Head of Department will inform the relevant Executive Director of their departmental/local risks and indicate those risks to be reviewed (by exception) for inclusion to the Corporate Risk Register. This will include all current very high and high graded risks. The Head of Department is also responsible for developing, reviewing, and updating the local Risk Register.

The process for the Local Risk Register continued to be managed by the Risk Management Facilator with each department within the hospital having an active register which is reviewed frequently. The register continues to develop in response to changes within the hospital environment. This is managed by members of the Hospital Management Team and Organisational Management Team.

CMT are updated on progress by the Director of Security, Estates and Resilience.

3.2 Resilience

The Head of Risk and Resilience has overall responsibility for the management of Resilience within TSH on behalf of the Director of Security, Estates and Resilience. The Director also chairs the Security, Risk and Resilinece, Health and Safety oversight group and Security and Resilience Group. The Risk and Resilience Department also produces an annual report for the Boards' Audit Committee and regular Resilience Reports to the relevant groups.

3.2.1 Resilience Plans

TSH currently has the following plans in place to deal with the impact of the following situations:
Over the course of this year ALL plans are being reviewed and placed onto a new format with the addition on a new Buisness Impact Assessment and Critical Activity Recover

Level 2 Plan	Review Date	Status
Loss of Card Activated Access / Egress systems	June 2025	*Plan review was overdue but has been recently reviewed and updated to reflect new systems. Plan up to date and walk through test has been completed to ensure plan is accurate.*
Electrical Supply	May 2025	*Plan review was overdue. Full review of plan complete and plan updated to new format. Our resilience is tested on a regular basis with on-load and off-load generator tests, but there is a full function tests carried out yearly bringing on-site supply generators to reflect and test full load impacts.*
Procurement	January 2025	*Plan review was overdue. Full review of plan is now complete and plan updated to new format. As a result new SLA's and MOU's have been signed with partners and other boards to reflect changes*
eHealth	June 2020	*Plan review is overdue but is under review. This plan is sitting with Head of E-Health for review.*

		Over the last few years the way of working and new systems have been introduced to E-Health to assist with resilience, meaning that the whole new plan will require to be re-developed. This is under way. A full test is planned once review is complete
Fuel Shortage	September 2020	*Initial review completed, further review required. Working with Head of Estates*
Lockdown	September 2020	*Currently with Head of Security for review. Plans being drawn up to test imminently.*
Loss of Control Room	March 2025	*Plan review was overdue but has been recently reviewed and updated to reflect new systems. Plan up to date. A full test of the plan was carried out in Deecmber 2021 and actions were taken as a result of the test. All outstanding actions are now complete and plan has been updated to reflect accuracy.*
Pandemic Flu	January 2022	*Plan review is overdue but we are aware. Plan is with Infection Control for review. A fuller and conscise review will take place in due course to ensure that all lessons learned over the last two years have being captured.*
Pharmacy	May 2022	*Plan review is overdue. Review has commenced. Plan with Head of Department for review. New Head of Department has just been appointed. Extension has been requested. Over the last 2 years resilience planning has played an important part in providing the service and have no concerns that this is not fit for purpose to continue in the interim.*
Water Supply	September 2022	*Under review will change to new format*
Heating Failure	September 2022	*Under review will change to new format*
Telecommunication Failure	September 2022	*Plan reviewed and ready to publish. Testing took place earlier in the year of the plan and actions arose from the testing. These remedial actions are now complete.*
Food Supplies	September 2022	*Under review will change to new format*
Loss of Accommodation	September 2022	*Under review will change to new format*
Adverse Weather	October 2022	*Under review will change to new format*
Loss of Staff	March 2023	*Under review will change to new format*
Extreme Loss of Staff	May 2023	*Under review will change to new format*
Laundry	July 2023	*Under review will change to new format*

During 2021/22, the Head of Risk and Resilience carried out a full review of the TSH Level 2 Resilience Plans, with the findings being as follows:

- Eight Level 2 Resilience Plans required to be reviewed. These reviews are now complete and four plans are fully developed and published with four being currently updated with relevant information for accuracy. This will be complete as soon as practicable, but current plans are still fit for purpose.

3.2.2 Resilience Related Incidents

In line with the approved Resilience Framework all resilience related incidents are reported via Datix, with Level 2 and 3 incidents being reported directly to the Secuity, Risk and Resilience Group.

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

Level 1: Incidents which cause minor service disruption with one area/department affected which can be contained and managed within the local resources

Level 2: Incidents which cause significant service disruption, interruption to hospital routine, special deployment of resources and affect multiple areas/departments.

Level 3: A major/emergency situation which seriously disrupts the service and causes immediate threat to life or safety. These incidents will require the involvement of the Emergency Services

Over the year April 21 – March 22, there have been 0 level 3 and 19 level 2 incidents.

	2017/18	2018/19	2019/20	2020/21	2021/22
Level 2	7	4	2	0	19
Level 3	0	0	0	4	0

Staffing Issues
17 of the Level 2 incidents were caused by staffing issues. Staff Resource incidents have been increasing over the last year due to impact from Covid-19. Of these incidents 17 were deemed to have significant impact on patient care resulting in ward closures and cancellation of activities/outings

Site Wide IT Failure
IT web based systems stopped working i.e. outlook, MS Teams, PMTS, all personal drives and departmental drives. Due to an issue with an internal switch the system locked itself to prevent corruption of data. The system was put back into a usable state although one system remained offline for longer than anticipated. When the issue with that system was found it was also restored. No data was lost during this time but there was a lack of availability.

Power Failure
Following an external power failure, several systems within the control room failed to restart once generator kicked in. Incident command team stood up to oversee all issues as they arose and the ongoing operational issues within the organisation. Two UPS's supplying the rear desk and a section of the front desk failed. Estates staff attended and replaced the units within a 30-minute period.

3.2.3 Training and Exercising

The Resilience Committee previously planned and reviewed exercises in relation to resilience. This will be a focus of the new Head of Risk and Resilience and will be monitored by the Security, Risk and Resilience Group.

Police Scotland

The Head of Risk and Resilience he has been responsible for taking forward the relationship with Police Scotland. There is now an active and positive relationship with Police Scotland. Development has taken place in several areas of operation and this will continue.

From a local level we now have a direct team from Police Scotland responsible for all activity within the State Hospital in regards to general policing matters. This team is lead by the local response Seargent for the area. This in turn will bring a consistent approach to any crimes we may have to report, but will also allow us to learn and develop our procedures and practices and we receive input from the single team. As part of this development we have delivered awareness sessions to all local shift response teams. These teams will be first on scene for any ongoing incident and it is importanat that both them and us understand what to expect on arrival during any incident. The next stage in this project is to deliver information to all local response Inspectors who will be Police Incident Officer during a level 3 incident within the hospital.

Tactical plans have been developed with other strategic and tactical departments within Police Scotland. Additionaly TSH and PSOS are currently finalising a new Memorandum of Understanding to help develop our relationship and understanding of our interoperability with each other. This work will continue.

In October of last year working alongside Police Scotland TSSH staff helped to deliver training to new negotiators. This relationship has now developed further and we are working alongside Police Scotland to develop and deliver training for our own Critical Incident Communicators with delivery of the first course due in November of this year. This will be a great development for the State Hospital.

Incident Command training

Over the last year development work has been ongoing to improve our Incident Command structure and operation. A full review of our incident command structure has taken place with recommendations put forward to improve the way in which we prepare and respond to incidents.Work is now ongoing to deliver the recommendations. Training has also been reviewed and new training has been developed to improve our delivery and input.

Two Silver Command courses were ran last year seeing three new Silver Commanders being appointed to the on call cohort. All three were tested under realistic conditions following training and development. Work is ongoing to develop on-line training to ensure commanders have a reference point for learning. A further Silver Command course is scheduled for July 2022. This will culminate in a live exercise with involvement from our partner agencies but using remote access arrangments.

Three 'Golden Hour' sessions were delivered during 2021/22 to refresh existing staff and provide training to new staff fulfilling the role of senior clinical cover/security manager. Other planned sessions were unable to begin due to Covid-19 Restrictions. Future sessions are planned alongside some additional training provided by the Security Department.

Incident command was stood up multiple times throughout the year allowing staff to put into practice previous learning. Debriefs and Category 1 and 2 Reviews provided the hospital with a chance to hear feedback and use incidents as a learning opportunity.

Level 2 Exercises

Testing took place on two 'level 2' plans over the year.

Loss of Control Room. A full test was carried out during working hours successfully. Small points of action arose, these actions have now been completed and the plan has been updated accordingly.

Loss or Telecommunications. The opportunity to test arose from a need to upgrade our incoming telephone lines. BT requested the opportunity to complete the work. To allow BT to carry out their work, telephone system controller AX2 was taken off line. This resulted in all internal phone lines connected to AX2 being inoperable, with all phone lines on controller AX1 still working. Following the incident small points of action arose. These actions have now been completed and the plan has been updated accordingly.

The Extreme Loss of Staff plan was fully reviewed due to the ongoing Covid-19 pandemic situation. This is used in conjunction with the Loss of Staff plan and Standard Operating Procedures should staffing levels drop to even more severe levels. Planned exercises and testing for Level 2 plans were restricted due to the Covid-19 restrictions at the time.

Level 3 Plans

Work was unable to progress on the continued development of Level 3 plans due to pressures on the emergency services during the Covid-19 pandemic. Work on this has now restarted.

3.2.4 NHS Standards for Organisational Resilience

In May 2018, the Scottish Government updated its "NHS Scotland: Standards for Organisational Resilience document (2016), to reflect changes within the health and social care context, new policy imperatives and newly identified "Best Practice". This document specified minimum standards and related measure/performance indicator criteria for resilience within NHS Boards across Scotland.

TSH's Lead for Resilience (Security Director) has responsibility for ensuring these Standards are achieved and are monitored by TSH Security, Risk and Resilience and Health and Safety Group.

Risk and Resilience are working in line with these standards and an annual report is returned to Scottish Government for assurance. At this time the standards are being reviewed, but we continue to work toward the current standards.

3.3 Health & Safety

3.3.1 Control Book Audits

Health & Safety electronic Control Books (eCB's) provide the infrastructure to manage Health & Safety arrangements across TSH.

TSH currently operate circa 41 eCB's hosted on TSH's intranet which are usually audited within a 2-year cycle to ensure compliance with organisational and local policies/procedures including but not exclusive to recording, progressing and escalation of 'Health & Safety' issues and identification of new or emerging hazards and associated risks.

Covid restrictions and lack of trained Control Book Holders impacted on the ability ability to schedule Control Book audit programme during 2021/22.

3.3.2 Recommendation from 2021/22 Audit

There are a number of new Control Book Holders with outstanding training needs. With ongoing restrictions in classroom training delivery and staff availability to attend training, review the audit programme to determine if focus of audit activity should move from outstanding books to established control books to allow progression of subsequent audit programmes.

Action: Training details in section 3.3.3.

Audit format should also be reviewed to ensure it continues to meet the organisations 'needs'.

Action: Audit paused until training schedule is underway

3.3.3 2022/23 Training Plan

As a result of the imposed restrictions Control Book training was unable to be facilitated in 2021/22. A decision was made at Health and Safety Group to pause the Audit Programme until training resumes. Over the last year there has been a number of changes in existing posts which has resulted in the need for further training.

A training plan has been created for 2022/23 to target new and deferred control books as well as any staff who require further training to improve audit score. Staff in new posts who have been allocated as Control Book Holder have also been targeted for training.

Training delivery has been reviewed and has been combined into 1 full day training rather than 2 separate half days. Decision for this was due to difficulties in scheduling Day 2 training which suffered from a lower uptake due to staffing resource issues.

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

RIDDOR requires employers to report incidents that 'arise out of or in connection with work resulting in: the death of any person; specified injury to any person or hospital treatment to non-employees; employee injuries resulting in over 7-day absence from work; dangerous occurrences and specified occupational diseases'. There has been a slight increase of 1 in reported RIDDOR incidents in comparison to 2020/21.

	Q1	Q2	Q3	Q4	2019/20	2020/21	2021/22
'Specified' Injuries*	0	0	0	1	**1**	**2**	**1**
Over 7 day lost time Injury	3	0	1	0	**9**	**2**	**4**
Total	3	0	1	1	**10**	**4**	**5**

3.4 Fire

Two fire alarms occurred during the year to which both received a response from Scottish Fire & Rescue Service. On one occasion, this was due smoke from the use of a toaster setting off the alarm. The other was an instance where the fire alarm was activated with no obvious signs of smoke or flames.

3.5 Incident Reporting

Datix is the hospital's electronic incident reporting system, and is accessible to all staff via the intranet and a link from each computer desktop in the hospital.

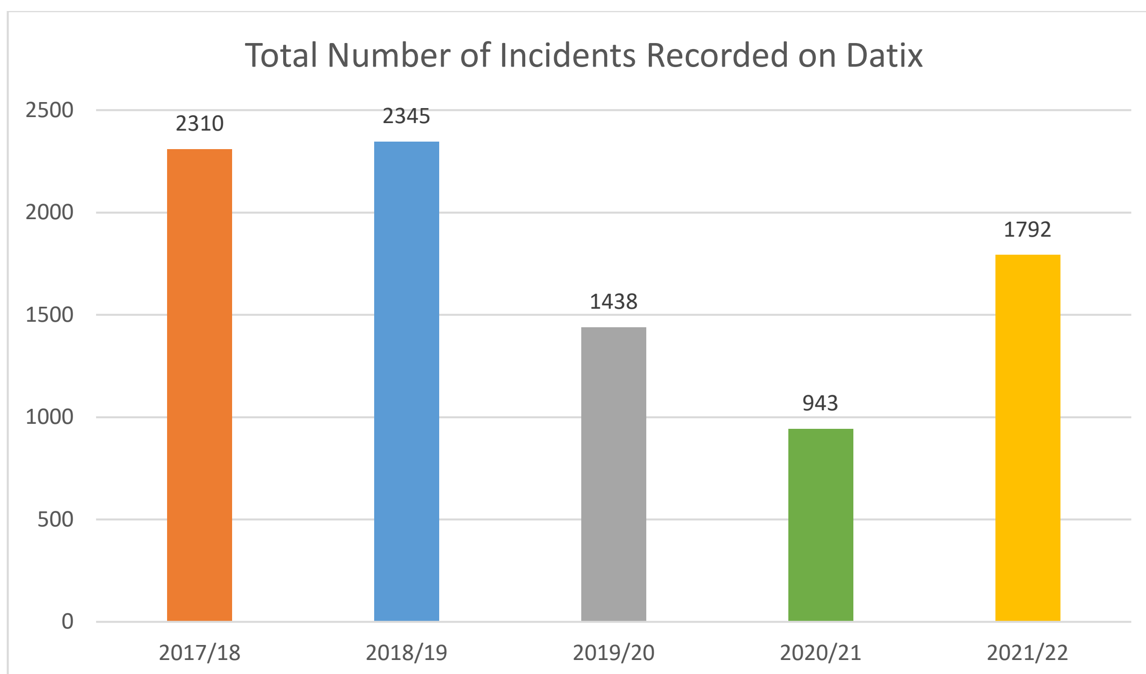
Each reported incident is investigated locally to ensure appropriate remedial and preventative steps have been taken. There are clear processes in place to identify incident trends or significant single incidents.

Datix classifies 7 overarching 'Type' of incident:

- Health and Safety
- Security
- Direct Patient Care
- Other
- Equipment, Facilities & Property
- Communication/Information Governance
- Infection Control

3.5.1 Datix Incidents

1792 incident reports were finally approved during 2021/22; a significant increase in the number of incidents finally approved in 2020/21 (943). The chart below shows the changes in the number of incidents reported within Datix over the last 5 years.



3.5.2 Incident 'Type' Trends over last 5 years

Incident Type	2017/18	2018/19	2019/20	2020/21	2021/22
Health & Safety	1219	1095	712	413	**461**
Security	326	396	138	93	**139**
Direct Patient Care	270	214	146	142	**146**
Other	231	426	219	115	**846**
Equipment/Facilities/Property	175	117	106	78	**75**
Communication/Information Governance	66	51	32	48	**65**
Infection Control	23	46	82	55	**60**
Totals	**2310**	**2345**	**1435**	943	**1792**
*Average Patient Population	109	107	106	114	115

* based on bed compliment at end of each quarter/4

In comparison with the figures for 2021/22, there has been an increase in the number of incidents reported from 2020/21 in all categories with the exception of Equipment, Facilities and Property.

The number of incidents recorded in 2021/22 has almost doubled on the previous year. This has been fuelled by the rise in incidents with the 'Other' category which contains the Staffing Resource Incident Category. 838 Incidents were recorded under this category as TSH continues to monitor current staffing resource issues.

Another substantial increase is within the Security Directorate. This is as a result of prohibited items at Security being recorded on Datix in an effort to reduce the number of items being found during the staff search.

Incidents continue to be monitored by the Risk and Resilience Team and fed into the relevant groups

3.5.3 Risk Assessment

The process of Risk Assessment within TSH involves the consideration of two key factors, i.e. likelihood (e.g. rare, unlikely, possible, etc.) of a given event occurring and the impact (or consequence) that the event may have on the organisation (e.g. financial, reputational, operationally, regulatory, etc.).

Likelihood	Potential Consequence				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very high	Very high
Likely	Medium	Medium	High	High	Very high
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The following table provides details of the number of "high" graded risk incidents reported since 2017/18, which have increased substantially. Incidents were as a result of an increase in Communication/Information Governance Incidents specifically relating to confidential information being sent to the wrong recipent and Staffing Resource Issues where a ward was closed for period of time. Due to the incidents happening more frequently likelihood was increased and incidents were graded as High or Very High. Both issues are being monitored.

Year	No. of "High" or "Very High"Graded Risk Incidents
2017/18	3
2018/19	4
2019/20	1
2020/21	0
2021/22	628

3.6 Enhanced Adverse Event Reviews

All incidents/near misses assessed as being a Very High (red) risk, will result in a Level 1 Review. Other incidents may be subject to a Level 1 review at the request of CMT/Clinical Team.

Level 1 is the most rigorous type of incident review, using root cause analysis to ensure appropriate organisational learning. At least one appropriately trained reviewer, supported by a member of the risk management department, will undertake Level 1 investigations.

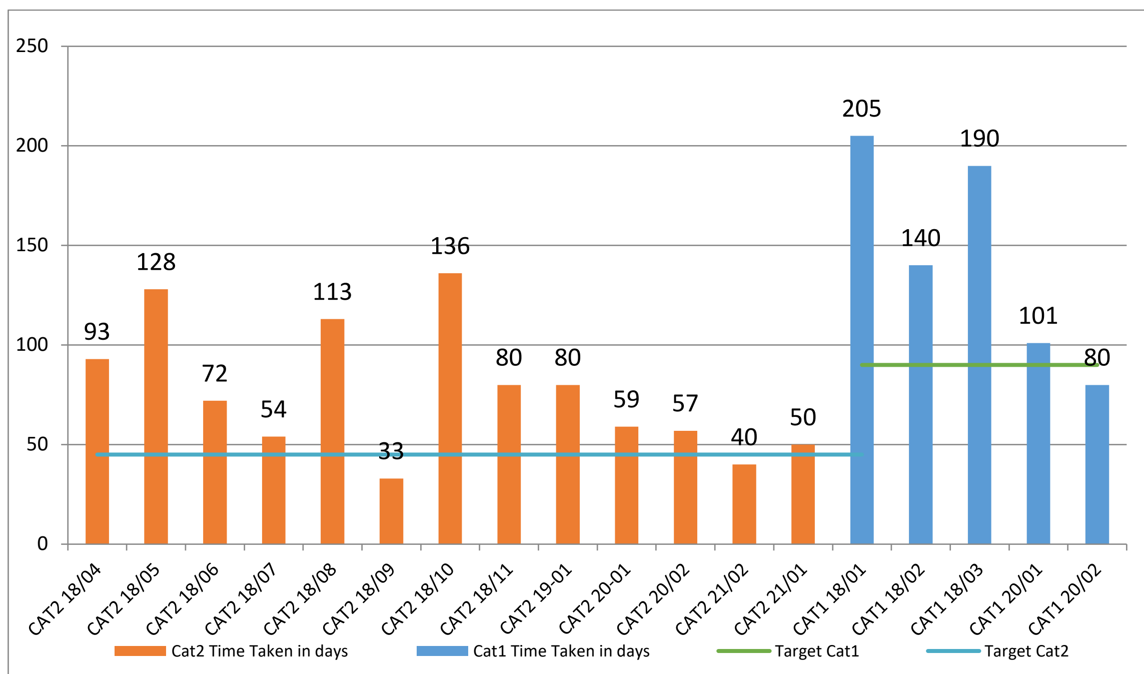
Level 2 Reviews are utilised for less serious incidents, whereby, an in-depth investigation is required to identify any learning points and to minimise the risk of the incident recurring. The Review is carried out by an appropriately trained member of the Risk Management Team, with the aim to establish the facts of an incident quickly with a target to report back to the CMT within 45 days of the terms of reference being agreed.

No Category 1 Reviews were commissioned during 2021/22

Three Category 2 Reviews were commissioned during 2021/22:

- Cat 2 21/01 – Patient Acquitted Unexpectedly
- Cat 2 21/02 – SRK Use
- Cat 2 21/03 - Fracture

The graph below shows the length of time taken to complete the various Enhanced Adverse Event Reviews from approval of the terms of reference to the report being agreed by CMT.



***At time of writing Cat 2 21/03 is awaiting approval**

3.7 Training

3.7.1 Health & Safety Awareness Training

During 2021/22, a total of 556 staff completed the new Health & Safety Essentials online training module.

At 31 March 2022, overall compliance for Health & Safety Awareness training was 96.1% (an increase of 3.9% from 2020/21).

3.7.2 Manual Handling Training

During 2021/22, a total of 183 staff completed the Manual Handling Essentials online training module and 13 new staff completed the Level 2 Practical Training in Safer Manual/Patient Handling.

At 31 March 2022, manual handling training had been completed by 97.3% of staff (a decrease of 1.8% from 2020/21).

Of this total, 96.1% *of* staff had completed the Manual Handling Essentials online training programme, with 91.7% of this group fully compliant with the bi-annual refresher requirements. In addition, 86.3% of staff had completed Level 2 Practical Training in Safer Manual/Patient Handling (an increase of 2% from the previous year).

3.7.3 Fire Safety Training

During 2021/22, a total of 506 staff completed the Fire Safety Awareness online training module.

At 31 March 2022, a total of 98.4% of staff had completed fire safety awareness training (a decrease of 1.1% from 2020/21).

A total of 80.5% of the above group were fully compliant with annual refresher training requirements (a decrease of 5.8% from 2020/21). The reduction in compliance with annual refresher requirements was due primarily to high levels of COVID-related staff absence during Quarter 4, plus the associated impact on staff availability and capacity to complete refresher training within the required timeframe.

3.7.4 Level 1 PMVA Training

During 2021/22, a total of 170 staff attended PMVA Level 1 'Personal Safety & Breakaway' training.

Level 1 'Personal Safety & Breakaway' training is mandatory for non-clinical staff, with refresher training provided every 2 years. At 31 March 2021, 98.9% of staff in the target group had completed Level 1 'Personal Safety & Breakaway' induction training. A total of 76.8% of staff within the target group were fully compliant with Level 1 PMVA refresher training requirements (an increase of 2.4% from 2020/21).

Delivery of PMVA Level 1 refresher training continued to be impacted by the COVID pandemic during 2021/22 – with a deferment in place for a significant part of the year for Level 1 refresher training for staff in non-patient contact roles. A compliance improvement plan was introduced in January 2022, with a target to achieve a minimum of 90% compliance for PMVA Level 1 refresher training by the end of June 2022.

3.7.5 Level 2 PMVA Training

During 2021/22, a total of 246 staff attended PMVA Level 2 Refresher training.

Level 2 'Prevention & Management of Violence & Aggression' training is mandatory for all clinical staff employed under TSH terms & conditions, with refresher training provided annually. At 31 March 2021, 100% of staff within the target group had completed Level 2 'Prevention & Management of Violence & Aggression' induction training. Of the staff within the target group, a total of 72.5% were fully compliant with PMVA Level 2 training requirements (a decrease of 16.3% from 2020/21).

Compliance levels for PMVA Level 2 Refresher training significantly reduced from September 2021 to January 2022. This was due primarily to high levels of COVID-related staff absence, plus the associated impact on staff availability and capacity to release staff to attend refresher training within the required timeframe. A compliance improvement plan was put in place in January 2022, with a target to achieve a minimum of 90% compliance by the end of June 2022.

3.7.6 Workshop on Raising Awareness of Prevent (WRAP) Training

A limited number of WRAP training courses were delivered during 2021/22 due to ongoing restrictions on non-essential face-to-face training in response to COVID-19. During 2021/22, there were 4 courses delivered and a total of 38 staff attended the WRAP training.

At 31 March 2022, WRAP training had been completed by 68.3% (an increase of 1.7% from 2020/21).

3.8 Freedom of Information (FOI) Responses

The State Hospital changed the mechanism of recording FOI requests as from 1 April 2019. Instead of reporting the number of applications received we are now reporting the number of questions asked.

During 2021/22 the Risk Management Team received two FOI requests and provided data for both.

4. Summary

4.1 Areas of Good Practice

In addition to the positive outcomes highlighted throughout the report, there are a number of additional areas of good practice in relation to risk management across the hospital including:

- Effective monitoring of risk information by groups and committees
- Regular monitoring of patient-specific risks by clinical teams
- Strong evidence on learning from incidents, with local action being taken to minimise recurrences

Areas of good practice within the risk management department include:

- Continued development of the Corporate Risk Register with risk owners, the risk register has seen some positive movement over the last year as a result of further control measures being implemented.
- Updated Local Risk Register work completed and continued development in place
- Completion and sign off of all of outstanding RSM recommendations
- Continued development within the Risk and Resilience Team including Datix Training, Having Difficult Conversations and Investigation Training. The team has also started to work towards their NEBOSH qualification.
- Appointment of Head of Risk and Resilience to the Risk and Resilience Team.

4.2 Identified issues and potential solutions

The main focus for the Risk and Resilence Team in 2022/23 will be to ensure that the training plan for the Control Book Holders is actioned to allow for the Control Book Audit Programme will resume. The team will also continue to ensure each Resilience Plan is up to date and fit for purpose to ensure TSH is prepared for every eventuality.

4.3 Future areas of work and potential service developments

TSH has been in talks with an external agency, RSM to assist with developing the organisations Risk Appetite. This work is planned to completed throughout 2022/23 with members of the board and the Security Directorate.

Work is ongoing to continue to develop Datix, Local Risk Register and Corporate Risk Register which will continue to help improve the way that risk is managed within TSH. This is being actioned by the Risk Management Facililtaor and monitored by relevant groups.

5. Next Review Date

The next annual report will be submitted to the Audit Committee in June 2023.

Appendix A: Corporate Risk Register

Appendix A

Ref No.	Category	Risk	Initial Risk Grading	Current Risk Grading	Target Risk Grading	Owner	Action officer	Next Scheduled Review	Governance Committee	RA	AP	Monitoring Frequency	Movement Since Last Report
Corporate CE 10	Reputation	Severe breakdown in appropriate corporate governance	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Board Secretary	01/06/22	Board	Y/Y	N/A	Quarterly	-
Corporate CE 11	Health & Safety	Risk of patient injury occurring which is categorised as either extreme injury or death	Extreme x Possible	Extreme x Rare	Extreme x Rare	Chief Executive	Chief Executive	01/09/22	Clinical Governance	Y/Y	N/A	Quarterly	-
Corporate CE 12	Strategic	Failure to utilise appropriate systems to learn from prior events internally and externally	Major x Possible	Moderate x Possible	Moderate x Unlikely	Chief Executive	Risk Management Team Leader	01/09/22	Risk and Resilience Group	Y/Y	N/A	Quarterly	-
Corporate CE 13	Strategic	Inadequate compliance with Chief Executive Letters and other statutory requirements	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Chief Executive	Board Secretary	01/09/22	CMT	Y/Y	N/A	6 monthly	-
Corporate CE 14	ALL	The risk that Coronavirus (Covid-19) could affect The State Hospitals primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff.	Major x Almost Certain	Major x Possible	Minor x Possible	Chief Executive	Chief Executive	01/07/22	CMT	Y/Y		Fortnightly	Likelihood ↓
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	01/07/22	Clinical Governance Committee	Y/Y	Y/Y	Monthly	-
Corporate MD 32	Medical	Absconsion of Patients	Major x Unlikely	Major x Rare	Moderate x Rare	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 33	Medical	Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)	Moderate x Unlikely	Moderate x Unlikely	Moderate x Unlikely	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate MD 34	Medical	Lack of out of hours on site medical cover	Major x Unlikely	Major x Unlikely	Major x Unlikely	Medical Director	Associate Medical Director	01/09/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	01/08/22	CMT	Y/Y	N/A	Quarterly	-

Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	01/08/22	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	01/08/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	01/08/22	CMT/Risk and Resilience Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/08/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	01/08/22	Infection Control Committee	Y/Y	N/A	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	01/08/22	CMT	Y/Y	N/A	Quarterly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/07/22	CMT	Y/Y	Y/Y	Quarterly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	01/07/22	CMT	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/07/22	PMVA Group and CMT	Y/Y	N/A	Monthly	Likelihood ↑
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	30/05/22	Audit Committee, RF&P Group & CMT	Y/Y	N/A	Quarterly	-
Corporate FD 91	Service/Business Disruption	IT system failure/breach	Moderate x Possible	Moderate x Possible	Minor x Possible	Finance & Performance Director	Head of eHealth	30/05/22	Information Governance Group & CMT	Y/Y	N/A	Quarterly	-

Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/05/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	30/07/22	Information Governance Group & CMT	Y/Y	Y/Y	6 Monthly	-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/05/22	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Unlikely	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/05/22	H&S Committee	Y/Y	N/A	Monthly	Likelihood ↑

Paper No: 22/59

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 27
Sponsoring Director:	Chief Executive Officer
Author(s):	Chief Executive Officer
Title of Report:	Communications Development Model
Purpose of Report:	For Decision

1 SITUATION

In the private session of the Board (28 April 22), members reviewed an optional appraisal presented by the Chief Executive and developed by the Head of Communications. Four options were presented, with Board members agreeing Option 4: Service Transformation.

2 BACKGROUND

The Board recognises the importance of communicating it's aims and objectives, within the developing arenas of media and digital communications. The Board has already identified the need for a change in its approach, especially in how the organisation is perceived. The Board acknowledges the excellent work of the Head of Communication, but recognises the challenge of having only one employee designated to this essential function.

Following the Annual Review, the Minister noted his desire to see improvement to the hospital website. This is mentioned at point 14 of the feedback letter of 21 April.

3 ASSESSMENT

The preferred option chosen by the Board is an in-house Delivery Model with Service Transformation. It increases the remit and scale of the communication function with the responsibility and accountability for electronic communications returning to the Communications function from eHealth.

The Communications function would then take responsibility for all electronic communications, i.e. Website, Intranet, ONELAN screens, and audio visual production including video and voice recordings.

The Head of Communications has welcomed this option, and has developed two job descriptions to enable the model to progress. The job descriptions have been written in a way that ensures these posts complement and provide dual resilience (where possible) and for the wider Communications function. This service development resolves the longstanding challenges of having a single handed communications specialist.

The cost for both posts at mid-point, including employer costs, is circa £80k per annum:

- **Communications Officer (Digital) Band 6 (under evaluation)**

  In addition to mainstream communications, this post will be the lead specialist for digital communications, making the best use of digital technologies in the design and delivery of services. This involves developing, managing and evaluating the Hospital's existing range of digital channels and platforms including the staff intranet, external website, ONELAN screens, social media channels, and other marketing platforms. In particular, this post will lead on the redesign of the State Hospital's website, and support the transformation / redevelopment of the existing staff intranet in line with the new Office 365 / SharePoint platform.

  In summary – main focus on content management systems, and the creation of visually appealing content (graphic design).

- **Communications Officer (PR and Media) Band 5 (under evaluation)**

  This post also covers mainstream communications, and the development of audio / visual materials such as videos and blogs. However, there is a particular emphasis placed on public relations, media relations, and social media engagement.

  In summary – main focus is on raising the profile of the State Hospital by engaging and educating stakeholders through the day to day management of social media channels and creation of content.

Additional work is currently being scoped to assess if an early rapid redesign of the website can be undertaken as a one off project. This is a similar process to that used by the Forensic Network for Scotland.

4 RECOMMENDATION

The Board will now receive regular updates on the programme of digital transformation for the hospital, and dedicated reporting in this respect is received at every second meeting.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	In support of the Board's Communications Strategy.
Workforce Implications	There are implications as outlined within the paper presented.
Financial Implications	There are budgetary implications as outlined within the paper presented.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested.
Risk Assessment (Outline any significant risks and associated mitigation)	This supports the organisational delivery of key objectives, and the risks to this function are presented.
Assessment of Impact on Stakeholder Experience	Outlined within the paper.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No issues identified.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications , full DPIA included.

Paper No. 22/60

THE STATE HOSPITALS BOARD FOR SCOTLAND

NHS SCOTLAND

Date of Meeting:	23 June 2022
Agenda Reference:	Item No: 28
Author:	Board Secretary
Title of Report:	Model Code of Conduct for NHS Boards
Purpose of Report:	For Noting

1 SITUATION

A Model Code of Conduct for NHS Boards was published on 7 December 2021, following Parliamentary approval on 27 October 2021. Since then national guidance regarding the implementation of this has been progressed with the NHS Board Secretaries Group as well as the Standards Commission for Scotland.

2 BACKGROUND

In line with this, public bodies were required to seek the agreement of their Board to the code, and thereafter to publish their Code of Conduct on their websites by Friday 10 June 2022.

3 ASSESSMENT

Due to the timings required, this was circulated electronically to Board Members during May for their approval, and this was then confirmed to the office of the Cabinet Secretary for Health and Social Care.

Further to this, discussions with the Standards Commission for Scotland highlighted a need for clarification on paragraph 4.20 of the Model Code. This relates to “Interest in Shares and Securities”. It should be noted that paragraph 4.19 in the 2014 version of the Model Code included the qualification that an interest in shares and securities should only be registered if it could be “*significant to, of relevance to, or bear upon, the work and operation of the public body*”. However, the corresponding paragraph 4.20 of the 2021 revised Model Code did not contain this provision. The Standards Commission for Scotland and the Ethical Standards Commissioner agreed that this was an omission and that paragraph 4.20 of the Code should therefore be applied in line with the 2014 provision.

It is confirmed that the Code of Conduct has now been published on our website, including the above revision to it.

4 RECOMMENDATION

The Board are asked to note this update.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To formally report the revised Code of Conduct, as published
Workforce Implications	No specific proposal to consider
Financial Implications	None Identified
Route To Board Which groups were involved in contributing to the paper and recommendations.	Submitted for noting, following previous Board agreement
Risk Assessment (Outline any significant risks and associated mitigation)	Not required for reporting
Assessment of Impact on Stakeholder Experience	Not required for reporting
Equality Impact Assessment	Not required for reporting
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

Code of Conduct for Members of
THE STATE HOSPITALS BOARD FOR SCOTLAND

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ANNEXES

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SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at Annex A.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

Duty
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

Selflessness
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

Integrity
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

Objectivity
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

Openness
I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

Honesty
I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

Respect
I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

SECTION 3: GENERAL CONDUCT

Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy/maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

Remuneration, Allowances and Expenses

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

Gifts and Hospitality

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never ask for or seek any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or

hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

Use of Public Body Resources

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

Dealing with my Public Body and Preferential Treatment

3.28 I will not use, or attempt to use, my position or influence as a board member

to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

Appointments to Outside Organisations

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registrable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registrable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to (g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.8 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

Category Two: Other Roles

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

Category Three: Contracts

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.20 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

Category Four: Election Expenses

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

Category Five: Houses, Land and Buildings

4.18 I have a registrable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the public, or could influence my actions, speeches or decision-making.

Category Six: Interest in Shares and Securities

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

Category Seven: Gifts and Hospitality

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

Category Eight: Non–Financial Interests

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

Category Nine: Close Family Members

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

SECTION 5: DECLARATION OF INTERESTS

Stage 1: Connection

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body or of which I am a member by reason of, or in implementation of, a statutory provision, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or
b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

Stage 2: Interest

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

Stage 3: Participation

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

SECTION 6: LOBBYING AND ACCESS

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their

behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.

b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

ANNEX A: BREACHES OF THE CODE

Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 (“the Act”) provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland (“Standards Commission”) and the post of Commissioner for Ethical Standards in Public Life in Scotland (“ESC”).

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body’s Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

Hearings
8. On receipt of a report from the ESC, the Standards Commission can choose to:

- Do nothing;
- Direct the ESC to carry out further investigations; or
- Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel decides that a member has breached their public body's Code, it is obliged to impose a sanction.

Sanctions
10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- Censure: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
- Suspension: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
- Disqualification: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

Interim Suspensions
11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

ANNEX B: DEFINITIONS
"Bullying" is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

"Chair" includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

“Code” is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

"Cohabitee" includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

“Confidential Information” includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

"Election expenses" means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

“Employee” includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

“Gifts” a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

“Harassment” is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

“Hospitality” includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

“Relevant Date” Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the 5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

“Public body” means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

“Remuneration" includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

“Securities” a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

“Undertaking” means:

a) a body corporate or partnership; or

b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

NHS SCOTLAND

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the meeting of the Audit Committee held on Thursday 17 March 2022 at 9.45am via Microsoft Teams **AC(M) 22/01**

PRESENT:

Non-Executive Director	David McConnell **(Chair)**
Employee Director	Allan Connor (11am)
Non-Executive Director	Stuart Currie
Non-Executive Director	Pam Radage

IN ATTENDANCE:

Internal	
Chief Executive	Gary Jenkins
Director of Finance and eHealth	Robin McNaught
Head of Corporate Planning and Business Support	Monica Merson
Board Chair	Brian Moore
Head of Procurement	Stuart Paterson (11am)
Board Secretary	Margaret Smith
Director of Security, Estates and Resilience	David Walker
PA to Director of Nursing, AHPs and Operations	Sharon Bruce **(Minutes)**
External	
Internal Audit, RSMUK	Victoria Gould
Azets	Karen Jones
Azets	Nicola MacKenzie
Head of Internal Audit, RSMUK	Asam Hussain

DRAFT

1 APOLOGIES

David McConnell chaired the meeting and welcomed those present.

Apologies were noted from Fiona Higgins, PA to Directors of Finance and eHealth and Security, Estates and Resilience; Brian Moore, Chairperson and Mark Richards, Director of Nursing, AHP and Clinical Operations.

2 CONFLICTS OF INTEREST

There were no conflicts of interest to note.

3 MINUTES OF THE PREVIOUS MEETING OF 07 OCTOBER 2021

The Minutes of the previous meetings held on 07 October 2021 were **approved** as an accurate record of discussion following the amendment to Item 6 which should read the ‘Internal Audit Tracking Report’.

ACTION: FIONA HIGGINS

4 MATTERS ARISING - ACTION NOTES UPDATE

Members **noted** the action log update with the following being recorded:

Cyber Crime Report

It was reported that Thomas Best and Robin McNaught have attended training hosted by the UK Government. National updates are still awaited, Robin McNaught has agreed to follow this up. Once received he will pull together a summary report for June 2022.

ACTION: ROBIN MCNAUGHT

Service Level Agreements
Members **noted** that Robin McNaught met with the West of Scotland Finance Directors in relation payments for exceptional circumstance patient payments. A further meeting will take place mid-April with an update being provided to the Audit Committee in June 2022.

5 INTERNAL AUDIT PROVISION

Members formally noted that the proposal to make a direct award of a continuing Internal Audit contract to RSMUK, on a one-year basis had been considered and **approved** by the members of the Audit Committee, through a circulated report. This proposal was then put to the Board on 24 February 2022 where is was also approved. RSM will therefore be offered a one-year contract for the period 01 April 2022 to 31 March 2023.

Members **noted** this decision.

INTERNAL CONTROL AND CORPORATE GOVERNANCE

6 ANNUAL UPDATE ON STATE HOSPITAL RESILIENCE ARRANGEMENTS

Members **received** and **noted** the Resilience Update presented by David Walker, Director of Security, Estates and Facilities. The paper provided an overview of current resilience arrangements. It was highlighted that the hospital has robust arrangements in place for managing resilience and emergency planning incidents; these arrangements are supported by testing and training. Serious incidents do occur, and when these take place, appropriate reviews are undertaken with associated learning being noted.

An audit of the Hospital's Critical Planning and Business Continuity was issued in September 2020. The report noted that TSH had put plans into full operation during the Covid-19 pandemic and noted that management were in the process of revising their documentation to reflect lessons learned at the time of audit. The audit found 5 minor areas in which improvements can be made. Management actions 1, 3, 4 and 5 have been completed with work ongoing around one outstanding action.

Priorities for 2022 include:

- Continue to review Loss of Staff and Extreme Loss of Staff Plans
- Review, test and update all Level 2 plans as per workplan
- Incident Command recruitment for role
- Training for new Incident Command personnel
- Maintaining building relationships with multi-agency sectors
- Finish Level 3 multi-agency plan review
- Test at Level 3 plan if and when restrictions permit.

Members **noted** the content of the report.

7 SECURITY AUDIT 2020/21

Members **received** and **noted** a report on a Security Audit presented by David Walker, Director of Security, Estates and Facilities. It highlighted that the last audit of the security department took place in 2016 which had resulted in a full report being published identifying areas of good practice and areas for further development. An action plan had also been agreed with the agreement that a further up to date audit would take place however the emergence of the Covid-19 pandemic delayed the process. This current report provides an update to the action plan and on the current position of CQIF Reviews and TSH Security Audits, as facilitated by the Forensic Network.

Throughout the pandemic security staff continued to monitor practice and processes through local audits which was fed in to the security Governance Group. In January 2022 a review began of the current position using the existing audit processes and themes to gather together a body of information and evidence. It is hoped that this evidence will be of value when the department carries out the proposed future CQIF audit.

Also of note was the introduction of new randomised drug screening process. Members were informed that the security department has adopted the 'Verum' system which covers 50+ panels of substances and includes regular updates for the most common NPS's. The process for making these random has also changed with the security department identifying who and when to test ensuring that this is tailored to the individual with a minimum number agreed over a 12 month period. The option for ward staff to make a target search if there is any intelligence or suspicious behaviours still remains.

Members **noted** the full content of the report.

8 CORPORATE RISK REGISTER

Members **received** and **noted** a report on the Corporate Risk Register which was presented by David Walker, Director of Security, Estates and Facilities. It was reported that 5 risks are due for review as of 01 March 2022. Risk owners have been contacted to provide their updates. It was proposed that FD91 – IT System Failure or Breach be split in to Maintenance of System backups; IT System Failure and Failure to Comply with Data Protection Arrangements. Members were supportive of this proposal.

It was also noted that there has been 2 grading increases over the reporting period which is predominantly due to staffing issues. These are HRD112 – Compliance with mandatory PMVA Level 2 refresher training, and ND73 – Lack of SRK Trained Staff. Both risks are reviewed regularly by the Corporate Management Team.

In relation to Risk CE14 – the risk that Covid-19 could affect The State Hospital's primary aim to provide high quality, effective care and treatment and maintain a safe and secure environment for patients and staff, it was queried as to whether it would be beneficial to hold a workshop in the future based board experiences during the pandemic. It was noted that a Board development session has been arranged for this purpose to note experiences locally. It was suggested that it may be helpful to link in with Healthcare Improvement Scotland also, Asam Hussain, Head of Internal Audit, also highlighted that RSMUK has seen a lot of appetite for this type of workshop and therefore agreed to link with David Walker the Risk Champion to help facilitate a similar event for The State Hospital.

ACTION: ASAM HUSSAIN

Members **noted** the content of the report.

9 CAT 1 AND 2 ANNUAL UPDATE ON OUTSTANDING ACTIONS

Members **received** and **noted** outstanding actions following Category 1 and 2 Reviews. It was noted that there has been significant improvement with a number of actions being closed off and two Category 2 Reviews underway.

Members **noted** the content of the report.

10 POLICY UPDATE

Members **received** and **noted** Policy Update Report presented by Robin McNaught, Director of Finance and E-Health. It was reported that substantial progress continues to be made to ensure the policies are updated. As at 8 March 2022 The State Hospital has132 policies, with 8 being past their review date. Thanks and recognition was given to the Policy Approval Group for monitoring progress.

11 FRAUD UPDATE

Members **received** and **noted** an update on fraud allegations and notifications received from Counter Fraud Services, which was presented by Robin McNaught, Director of Finance and eHealth. Members noted that since the previous Audit Committee a number of alerts had been received with two new allegations in relation to fraud were received since the last report. All other earlier allegations were confirmed to have been closed off.
Members **noted** the content of the alerts circulated by Counter Fraud Services in the last quarter and the update on fraud allegations.

12 FRAUD ACTION PLAN

Members **received** and **noted** an update on the Board's approach to countering fraud and the level of engagement with Counter Fraud Services based on the discussions from the annual customer engagement visit. The update was presented by Robin McNaught, Director of Finance and eHealth.

It was reported that since the last update, the hospital shared CFS alerts with relevant personnel via Staff Bulletins and the intranet.

Details of the engagement activities include participation on the annual customer engagement visit with CFS which took place on 08 June 2021. The State Hospital participates in the national matching exercise (on a 2 yearly timetable) and the current exercise is nearly completed – the Hospital isawaiting information from other Boards, for any staff appearing on the payroll for TSH and other organisations.

In terms of the Fraud Action Plan it was reported that this demonstrates a proactive approach to tackling any financial crime within TSH. The two main fraud risks at TSH are procurement and sickness/absence, both of which are addressed by the introduction of two virtual sessions which will be run by CFS. There will also be a virtual presentation aimed at HR staff and nominated investigation managers involved in internal investigations under the new Once for Scotland Workforce Investigations Policy.

Members were informed that the CFS Partnership Agreement with the Board is being updated and will be issued to the health boards for review before being issued Scottish Government for the Chief Executives signature. The new agreement will come in to force on 01 April 2022.

Members noted progress on engagement activities and noted the update on communication and review of the Fraud Action Plan statement from CPS.

13 PATIENT FUNDS ACCOUNTS

Members **received** and **noted** report on Patients' Funds Accounts which was presented by Robin McNaught, Director of Finance and E-Health. It was reported that the accounts generally show fluctuations in average funds held – simply due to the level of patients' spending and income being fairly inconsistent from one year to the next. The average balance held per patient therefore also fluctuates.

The Patients' Funds Accounts are audited by Wylie and Bisset who have issued an unqualified audit option for both periods, noting only two minor recommendations which include a re write-back of cheques over 6 months old.

Members also noted the Statement of Board Member Responsibilities. Robin McNaught and Brian Moore agreed to present paper to the next State Hospital's Board on behalf of this Committee and recommend that they approve this statement.

ACTION: BRIAN MOORE/ROBIN MCNAUGHT

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INTERNAL AUDIT

14 AUDIT FOLLOW UP/PROGRESS REPORT 2021/22

Members **received** and **noted** the internal audit plan for 2021/22 which was approved by the Audit Committee on 23 March 2021. This report provides an update on progress against that plan and summarises the results of work to date.

It was noted that one final and one draft report has been issued since the last Audit Committee, those were Complaints audit and Procurement audit and the audits were graded as providing substantial and reasonable assurance, respectively.

The internal work for next year will cover a number of areas, including:

- Resilience of security Systems (June 2022)
- IT Health Check (August 2022)
- Implementation of the New Clinical Model (September 2022)
- Key Financial Controls (November 2022)
- Incident Management (December 2022)
- Workforce Planning (January 2023)

Discussion took place regarding the timing of audits and it was agreed to reassess Workforce Planning and it was agreed that Asam Hussain should look to schedule this around June/July, being mindful of the need for winter planning.

ACTION: ASAM HUSSAIN

15 AUDIT TRACKING REPORT

Members **received** and **noted** the Tracking Report which provides TSH comments on their progress made in respect of previous internal audit findings and agreed management actions.

Of the 20 actions reviewed since the last Audit Committee, it was reported that 6 actions had been implemented and 12 actions are currently being implemented.

- 6 of these actions relate to the eHealth function audit with many of the actions awaiting sign off by executives or Policy Approval Group before being complete.
- 1 relates to Accounts Payable audit – this action is dependent on NSS signing the SLA for services provided (update this has now been signed and can therefore be closed).
- Updates on the 3 outstanding actions from Clinical Observations report noted that progress against the action continued to be impacted by Covid-19 and winter staffing pressures, however the roll out of newly devised patient care plans has remobilised in the past few weeks with completion due Autumn 2022.
- Two actions relate to Critical Planning and Business Continuity audit in respect of training and business impact assessments, which is ongoing but was impacted by Covid-19, is underway and being led by the new Head of Risk.
- One action related to the job evaluation review and acceptable timescales for the valuation process being agreed and documented within the Significant Change – New Post Policy. The Significant Change – New Post Policy was due for sign off by the Policy Approval Group however the policy requires further updating to reflect Scottish Government requirements. Review of the policy did not identify that it had been updated to reflect the audit findings so further work is required.

Members **noted** the update.

16 DRAFT INTERNAL AUDIT PLAN 2022/23

Asam Hussain reported verbally on the first draft list of the internal audit coverage for the upcoming year, based on the long term internal audit strategy previously agreed.
The planned exercises are noted and considered at item 14 above.
The Audit Committee discussed and noted the planned coverage as recorded above.

17 PROCUREMENT AUDIT REPORT

Members **received** and **noted** the Procurement Internal Audit Report. It was reported that RSMUK reviewed the relevant Procurement Policy, which was in draft at the time of audit. RSMUK confirmed that it included key principles of procurement legislation and detailed the procurement processes and expenditure milestones. The policy was submitted to the Policy Approval Group for sign off.

Following review of a sample of 5 procurement activities, 7 areas were identified to require action, 5 of those were graded as low priority and 2 of medium priority. The report concluded that the Board can take reasonable assurance that the controls are suitably designed, consistently applied and effective.

The committee **noted** the report and that Stuart Paterson, Head of Procurement is taking all actions forward.

18 COMPLAINTS MANAGEMENT

Members **received** and **noted** the Complaints internal audit. Following review of the processes in place for managing complaints received by The State Hospital's Board for Scotland, it was found that the control framework was appropriate with only a few areas where improvements could be made to strengthen assurances obtained.

The review found minor weaknesses in how the Hospital promotes the feedback process, how the Hospital identifies lessons learnt, trends and themes and how they report on these lessons learnt, themes and trends to drive improvements. 3 areas were identified to require action, all 3 being graded as low priority which are being taken forward by Margaret Smith, Board Secretary and Complaints Manager.

Overall, the report concluded that the Board can take substantial assurance that the controls are suitably designed, consistently applied and effective.

The committee **noted** the report and the arrangements for taking forward the action points.

EXTERNAL AUDIT

Members were informed that Karen Jones, Azets, has taken over as Engagement Lead, and Nicola MacKenzie has been appointed as Audit Manager. Members commented that they welcomed the appointments that had been made.

19 INTERIM AUDIT UPDATE 2021/22

Karen Jones of Azets indicated that there were no Interim Audit reports or recommendations to be made from External Audit work, but that if any matters did arise they would be raised with management and, where necessary, reported to the Committee.

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20 EXTERNAL AUDIT PLAN

Members **received** and **noted** External Audit Plan, which covers the audit strategy, the audit of the financial statements, the wider scope audit and the audit outputs and fees. Two main key audit risks in the financial statements were noted to be asset valuations and provisions.

In terms of the wider scope audit it was highlighted that an additional audit dimension has been added, this being value for money. As outlined in the Scottish Public Finance Manual, accountable officers have a specific responsibility to ensure that arrangements are in place to secure best value in public services. Audit Scotland have requested that, at least once during the term of their audit appointment, they will carry out audit work on the Board's arrangements relating to the best value theme of fairness and equality. They will consider this in the context of the wider scope audit work in 2021/22 and include commentary on their annual report as appropriate.

Members welcomed the clarity and coverage of the External Audit Plan and **noted** the content of the full report.

STANDING DOCUMENTATION

21 REVIEW OF STANDING DOCUMENTS

Members **received** and **noted** the Annual Review of Standing Documentation which covers the updated changes to Procurement Legislation relating to tending and contracting and bringing TSH in line with other public bodies. Changes to the documentation were noted as:

- Sections 10.27, 10.3.2 – removing EU reference, update re new Procurement Regulations
- Sections 10.3.4, 10.3.5 – updated tender thresholds to comply with Procurement Act 2014, updated tender waiver from £5k to £10k
- Section 10.3.10 – updated re new TSH Procurement Policy
- Section 10.4.1 – updated re new legislation

Standing orders have been fully updated in line with NHS national guidance and prescribed formatting. No further amendments being proposed.

Members **approved** the review of Standing documentation and recommended their adoption by the Board at next meeting in April.

22 REVIEW OF TERMS OF REFERENCE AND CODE OF CONDUCT

Members **received** and **noted** update on Review of Terms of Reference and Code of Conduct as presented by Robin McNaught, Director of Finance and E-Health. It was highlighted that there are no changes to either the Terms of Reference or the Code of Conduct as presented to last year's Audit Committee in March and the Board in June. The Committee approved the Code of Conduct and Terms of Reference.

23 REVIEW OF ACCOUNTING POLICIES

Members **received** and **noted** an update on the Review of Accounting Policies as presented by Robin McNaught, Director of Finance and E-Health. This paper provides an update on the current position with regards to any changes in the accounting policies which require approval.

Members were informed of a minor amendment noted to the draft Accounting Policies. This is with regard to the property valuations noted on 1.27 – for which no full valuation will be reviewed in 2022 having last been implemented in 2021. Instead, and in line with accounting practice, indices will be

applied as provided by industry and sector estimates. The committee noted and approved the Accounting Policies.

OTHER ISSUES

24 DRAFT GOVERNANCE STATEMENT

Members **received** and **noted** an update on the draft Governance Statement as presented by Robin McNaught, Director of Finance and E-Health. This paper provides the Committee with a draft of the Governance Statement which will form part of the Annual Report and Accounts. It should be noted that The State Hospital are awaiting possible notification of any specific covid-related paragraph which NHS Scotland may require to be included. Currently, while the statement refers to covid, it is to note the important fact that the Board's governance structure has continued unaltered throughout the crisis.

On page 6 of the Statement, in the paragraph on Internal Audit reports, members asked that the final version of the Statement should reflect that agreed action plans were in place to address the matters raised in Audit reports.

ACTION: ROBIN McNAUGHT

Members **noted** the draft Statement, with the above proviso..

25 FINANCE, EHEATLH AND AUDIT GROUP UPDATE

Members **received** and **noted** an update on the Finance, E-Health and Audit Group update as presented by Robin McNaught, Director of Finance and E-Health. This paper provides an update on activities relating to finance, e-health and audit provision. The matters being addressed were **noted** by the Committee with no concerns raised.

26 SECURITY, RISK AND RESILIENCE, HEALTH AND SAFETY GROUP UPDATE

Members **received** and **noted** an update from David Walker, Director of Security, Estates and Resilience on the Security, Risk and Resilience, Health and Safety Group. The report highlights matters that were addressed in February 2022. These included:

- Corporate Risk Register
- Security and Resilience Governance
- Health and Safety Governance
- Climate Change and Sustainability Governance
- Security, Resilience, Health and Safety Policies
- New Legislation/Guidance/National Updates
- Approval of updated terms of reference for both the oversight group and the three new sub groups
- Approval of workplan for 2022.

Members **noted** the report.

27 ANY OTHER BUSINESS

There was no other business.

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28 DATE AND TIME OF NEXT MEETING

The next meeting will take place on 23 June 2022 at 0945am, by way of MS Teams.

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