THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 26 AUGUST 2021
at 10am, 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 22 July 2021	For Approval	TSH(M)21/07
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 21/54
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
10.20am	**COVID-19 RESPONSE**		
7.	**Covid 19 Response and Remobilisation:**		
a.	**Resilience Update** Report by the Chief Executive	For Decision	Paper No. 21/55
b.	**Finance and eHealth Update** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/56
10.40am	**CLINICAL GOVERNANCE**		
8.	**Patient, Carer and Volunteer Stories:** **Creative Reflection: Distraction through Activity** Report by the Director of Nursing, AHPs and Operations	For Discussion	Presentation
9.	**Clinical Model Mapping** Report by the Medical Director	For Decision	Paper No. 21/57
10.	**Supporting Health Choices** Report by the Medical Director	For Decision	Paper No. 21/58
11.	**Approved Medical Practitioner Status** Report by the Medical Director	For Decision	Paper No. 21/59
12.	**Quality Assurance and Quality Improvement** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 21/60

13.	**Clinical Governance Committee** Chair's Update – meeting held 12 August 2021 Approved Minutes – meeting held 6 May	For Noting	 Verbal CGC(M)21/02
14.	**Clinical Forum** Chair's Update – approved minutes of meeting held 25 May 2021	For Noting	 CF(M) 21/02
	*** BREAK 11.45am to 12 noon***		
12pm	**STAFF GOVERNANCE**		
15.	**Attendance Performance Report** Report by the Interim Director of Human Resources and Staff Wellbeing	For Noting	Paper No. 21/61
16.	**Whistleblowing Report – Quarter 1, 2021/22** Report by the Interim Director of Human Resources and Staff Wellbeing	For Noting	Paper No. 21/62
17.	**Staff Governance Committee** Chair's Update – meeting held 19 August 2021 Approved Minutes – meeting held 20 May 2021	For Noting	 Verbal SGC(M) 21/02
12.25pm	**CORPORATE GOVERNANCE**		
18.	**Corporate Governance Improvement Action Plan** Report by the Board Secretary	For Decision	Paper No. 21/63
19.	**Finance Report to 30 June 2021** Report by the Director of Finance & eHealth	For Noting	Paper No. 21/64
20.	**Performance Report – Quarter 1 - 2020/21** Report by the Head of Corporate Planning and Business Support	For Noting	Paper No. 21/65
21.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Estates and Resilience	For Noting	Paper No. 21/66
22.	**Corporate Risk Register** Report by the Director of Security, Estates and Resilience	For Decision	Paper No. 21/67
23.	**Board and Committee Membership** Report by the Board Secretary	For Noting	Paper No. 21/68
24.	**Any Other Business**		Verbal
25.	**Date of next meeting** 28 October 2021		Verbal
26.	**Proposal to move into Private session, to be agreed in accordance with Standing Orders.** Chair	For Approval	Verbal

Estimated end at 1.30pm

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH(M) 21/07

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 22 July 2021.

This meeting was conducted virtually by way of MS Teams, and commenced at 10.30am.

Chair: Brian Moore

Present:

Non-Executive Director	Stuart Currie
Employee Director	Tom Hair
Chief Executive	Gary Jenkins
Non-Executive Director	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage

In attendance:

PA to Chair / CEO, Corporate Services	David McCafferty [Minutes]
Director of Security, Resilience and Estates	David Walker

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Mr Moore welcomed everyone to the meeting, and apologies were noted from Mr Mark Richards (Director of Nursing, AHPs and Operations), Cathy Fallon (Non-Executive Director), Margaret Smith (Board Secretary), Lindsay Thomson (Medical Director) as well as John White (Director of HR & Wellbeing).

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 17 June 2021 were noted to be an accurate record of the meeting aside from an amendment to Item 5: Chair's Report, paragraph three should read "Ms Carol Wilkinson, *Vice* Chair of Health Improvement Scotland".

<u>The Board:</u>

1. Approved the minute of the meeting held on 17 June 2021: TSH(M)21/05

4 REPORT ON THE ANNUAL ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2021

The Board received a report (Paper no. 21/45) from the Chair of the Audit Committee comprising the Annual Accounts for The State Hospitals Board for Scotland for the year ended 31 March 2021. The Annual Accounts had been prepared in the format prescribed by the Scottish Government Health and Social Care Directorate (SGHSCD), and then subjected to external review by auditors appointed by Audit Scotland (Azets) to ensure that they presented a true and fair view of the year.

Mr Moore confirmed that Azets had concluded their audit, and that this had been reported to the Audit Committee held today prior to this Board meeting, The Audit Committee considered the report in full with an unqualified opinion from Azets for the Annual Accounts for the year ended 31 March 2021.

On behalf of the Audit Committee, Mr McConnell recommended that the Board adopt the Annual Accounts for the year ended 31 March 2021 and to approve submission to the SGHSCD. Further that the Board should authorise the Chief Executive to sign the Performance Report and the Accountability Report; and that the Chief Executive and Finance and eHealth Director should sign the Statement of Financial Position.

Board Members present noted this position and there was agreement on each of these recommendations.

The Board:

1. Adopted the Annual Accounts for the year ended 31 March 2021.
2. Approved submission of the Annual Accounts to the SGHSCD.
3. Authorised the Chief Executive to sign the Performance Report.
4. Authorised the Chief Executive to sign the Accountability Report.
5. Authorised the Chief Executive and Finance and eHealth Director to sign the Statement of Financial Position.

5 AUDIT COMMITTEE ANNUAL REPORT 2020/21

The Board received a report (Paper no. 21/47) from the Chair of the Audit Committee comprising the Audit Committee Annual Report 2020/21. Mr McConnell made the recommendation to the Board for approval of the report having now confirmed resolution of the national accounting issue in Item 4 above. Audit Committee approved this report with the caveat of amendment to a single item relating to patient funds which would be completed later in the year.

The Board:

1. Approved the Audit Committee Annual Report 2020/21.

6 ANY OTHER BUSINESS

There were no further competent areas of business for discussion at this meeting.

7 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on 26th August 2021, by way of MS Teams, and Ms Margaret Smith would arrange this in conjunction with the Chair and wider Board.

The meeting ended at 10.55am

ADOPTED BY THE BOARD

CHAIR

DATE

THE STATE HOSPITALS BOARD FOR SCOTLAND
ROLLING ACTION LIST

ACTION NO	MEETING DATE	ITEM	ACTION POINT	LEAD	TIMESCALE	STATUS
1	February 2020	Clinical Service Delivery Model (Item 7)	Update on key milestones for delivery – overall financial monitoring and recording on Corporate Risk Register.	R McNaught/ M Merson	Paused in April 2020 – now restarted with update on progress to Board – August 2021	**Considered as part of Board Seminar (May 31st) and agreement to preparatory work for re-start of implementation during 2021.** **On Agenda – August 21 – consider closing action**
2	October 2020	Corporate Risk Register (Item 23)	To track risks no on target for timescales and actions taken direction of travel and include in regular reporting	D Walker	April 2021	**Completed at meeting on 15 April – to be closed**
4	February 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught/ D Walker	June 2021	**Update is included in Covid response report at Item 7a. Full report to be brought to October meeting**
5	February 2021	Resilience Report – Covid-19 (Item 7a)	Provide further detail on actions taken for on PDPRs	J White	April 2021	**Reported and considered at 15 April meeting – to be**

						closed.
6	February 2021	Attendance Management Report (Item 15)	Add board's sickness absence target (5%) to table 3. Provide document map of this report to board and standing committees.	J White	April 2021	**Reported at 15 April meeting – to be closed**
8	February 2021	Board Public Meetings (Item 23)	Review route to enable this and if possible to route to patient cohort	M Smith	August 2021	**Update: On Agenda as part of Corporate Governance Improvement Plan August 21. Consider closing action.**

Updated – 16.08.21 – M Smith

Author:
Margaret Smith
Board Secretary
01555 842012

Paper No. 21/55

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
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

This report provides an update to the Board on the continuing response to the global Covid-19 pandemic by The State Hospital (TSH) by prioritisation of strategies to protect the health and wellbeing of both patients and staff; and to minimise as far as possible the risk of transmission of the virus through staff and patient populations. The Board has received reports at each of its meetings throughout the pandemic, to set out the actions taken as well as remobilisation planning.

NHS Scotland will remain on an emergency footing until at least 30 September 2021, and TSH is following Scottish Government guidance in relation to any requirement for restrictions within the health and care setting. This is focussed through the Remobilisation Plan for the period 1 April 2021 to 31 March 2022, which is being reviewed for any additional actions which should be progressed during the second two quarters of the year. This review is required to be submitted to Scottish Government by 30 September 2021, and the Board will receive further reporting in this respect.

2 BACKGROUND

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.

2.1 Senior Leadership and Management Structure

The new management structure (completed in April 2021) continues to be kept under close review to support further development of the wider leadership structure across the organisation. As part of this, the Hospital Management Team participated in a dedicated workshop supported through the Organisational Development Lead which took place on 16 June 2021. A draft report has been prepared, and the group is now reviewing the recommendations and actions required to progress this workstream.

The Board Secretary continues to take oversight of the whole structure with particular focus on how the system supports effective decision-making and the flow of actions. A linked series of self-assessments for the framework of governance groups within TSH were rolled out on 8 July, closing on 6 August. The results are being analysed and reporting will flow through the relevant groups and committees with overarching reporting to the Corporate Management Team (CMT).

Dedicated support for the response to Covid-19 has been provided through a range of disciplines and departments from infection control, clinical operations, human resources and administrative services. As the hospital continues to remobilise, the requirement for a dedicated support team is now concluding with support being managed through existing directorates. At the same time, the covid support team and command structure can be stood up urgently, should this be required.

The process of reviewing and implementing national guidance from UK Government, Scottish Government and Professional Bodies has continued to be tracked and reviewed through the Scientific and Technical Advisory Group (STAG) reporting to the Corporate Management Team (CMT). The CMT undertook a detailed review of this arrangement on 17 August, focussed on how reporting, which has flowed through STAG, could be re-routed through pre-existing governance structures. It has been agreed to discontinue STAG, with Covid-19 monitoring and risk management reporting to be routed through the Infection Control Committee. This committee's terms of reference are under review to reflect this and strengthen its role. Additionally, TSH will develop a link to the existing Horizon Scanning Team in NHS Lanarkshire. The CMT will continue to receive local monitoring reporting and surveillance as well as national modelling advice at each meeting.

The Strategic Planning and Performance Group (SPP) has been formed and met for the first time on 11 August 2021, to support the development and review of strategy in these areas, reporting to the CMT. A further new governance group is being set up - the Sustainability Management Group (SMG) - the purpose of which is to ensure an integrated approach to sustainable development, harmonising environmental, social and economic issues, and to embed sustainability best practice within TSH. In addition, the Scottish Government has mandatory requirements for climate change reporting, biodiversity reporting, to which all public bodies (including NHS Boards) must adhere.

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 is aware that delivery of care throughout the pandemic has been managed through the TSH Route Map and the Clinical and Support Services Operational Policy. The aim has been to effect a phased remobilisation to support rehabilitative and therapeutic activity for TSH patients, whilst planning service delivery in alignment with the Scottish Government Route Map. From 15 June, the Interim Clinical and Support Services Operational Policy (version 22) supported the re-introduction of patient mixing across the site as well as the reinstatement of rehabilitative and compassionate outings.

The policy remains subject to regular scrutiny and review, underpinned by data gathering and a formal fortnightly review meeting through the Operating Model Monitoring Group. Monitoring

has focused on a range of key areas of data including clinical incidents, observation levels, patient feedback and participation in meaningful activities, including access to fresh air and

participation in exercise. As noted in the previous section, these governance arrangements will continue to be reviewed through CMT to ensure that reporting on key indicators continues at the appropriate level within the governance framework.

3.2 Infection Control

Throughout the pandemic, focussed leadership for infection prevention and control has been at the centre of the approach taken at TSH, with external support from the Public Health team in NHS Lanarkshire. Although national guidance in relation to infection control requirements has now lessened, any such guidance is reviewed for any impact on TSH. A programme of Covid-19 audit work is being conducted as part of the wider programme of infection control audit. In support of this, the service has recruited to a new post of Clinical QI Facilitator to add resilience for the organisation in this area

Since the date of the last Board meeting, there have been no confirmed cases of Covid-19 within the patient population in TSH.

Should a patient be symptomatic and require testing, practice is to isolate the relevant ward and to carry out contact tracing for that patient. This is whilst testing of the patient is conducted and reported upon. Practice has followed national guidance in respect of contacts who have been double vaccinated meaning that a negative PCR test circumvents the need to isolate. Should a positive PCR test be reported, the whole ward will isolate (as a household model).

Table 2: Number of Patient tests, positive and negative results

February – July 2021

Month	Feb	March	April	May	June	July
Total Tests	60	22	11	16	19	17
Asymptomatic tests	59	20	11	15	17	13
Positive results	2	0	0	0	0	0
Negative results	58	22	11	16	19	17

Table 3: State Hospital Staff tests by result, for national test centre results

Date: to 9 August 2021

	Number	% of Total Staff population (n=650)
Staff tests	314	48%
Positive test results	49	8%
Negative test results	265	41%

3.3 Virtual and In Person Visiting

In Person Visiting

In line with national guidance, visiting in person recommenced at TSH on 26 April 2021. Since that date, the Family Centre has supported this. This has been received well by patients and carers. CMT considered future planning on this model on 17 August, with respect of

embedding a person centred approach as well as the security considerations of extending visitor flow in this area. CMT has commissioned a clinically led review to consider all aspects. The existing model will remain in place whilst the review is completed.

Visitors are encouraged to undertake Lateral Flow Device (LFD) Testing, on a voluntary basis to help support infection control within the hospital.

Some patients may not have designated visitors, and additional support for these patients is in place through volunteer visitors, who continue to provide a much valued contribution in this way.

Virtual Visiting

Although there has been a return to in-patient visiting, access to digital visiting has undoubtedly been transformational, in enabling patients and their families and carers to continue to connect when in person visiting has not been possible. This service remains in place and use has remained consistent. Additionally, the Board is aware that an alternative solution to video-conferencing has been identified, which is in use elsewhere in other secure organisations across the U.K. and which may bring additional capability to control and manage video calls locally. Work is progressing to facilitate a ''Proof of Concept'' trial within the hospital. A progress update will be reported to the Board at its next meeting in October 2021.

3.4 Covid-19 Vaccination Programme

TSH has undertaken a programme of vaccination for both patients and staff as part of the national roll out of the Covid–19 vaccination programme. As at 31 July, all eligible staff had been offered the vaccine and 88% of staff in this cohort having been fully vaccinated, with a small cohort declining the vaccine. This figure does not include staff who have been vaccinated by their local NHS Board through the national vaccination programme.

A local planning group is now in place for the roll out of booster vaccinations, with the aim being for identified staff to be offered a third vaccination within TSH, whilst at the same time having the option to access this through their local NHS clinic. A period of six months is required between the second dose and a booster vaccination. The planning assumption is that booster vaccinations will be available from September 2021. It may be possible to combine the booster programme with the annual flu vaccination programme, and JCVI advice is awaited in this regard.

The roll out of the vaccine to patients has continued, with a high uptake of over 90% of patients being fully vaccinated. Measurement of the data in this regard changes continually to reflect the patient flow through admissions in and transfers out of the hospital. All newly admitted patients are offered two doses of the vaccination, if they have not already received this.

3.5 Test and Protect

In line with all other NHS Boards, TSH began a programme to coordinate implementation of LFD testing at a local level, commencing on 28 December 2020. This was originally focussed on patient-facing healthcare workers, but has now been extended to all staff, aligning with the availability of this type of testing to the general public. This self-testing is on a voluntary basis, and all staff are encouraged to undertake and register their test results on a twice weekly basis. However, reporting rates remain low with TSH reporting a rate of 11% to the end of July 2021 (reported as a percentage of the expected overall number of tests). Work is continuing

in partnership with staff side colleagues to continue to encourage staff to report LFD testing twice-weekly.

In addition, TSH requires all contractors coming on site to undertake LFD testing. Auditing of this has continued and monitoring reporting will be submitted to the CMT and the Project Oversight Board. No issues have been noted with uptake and management of this control measure.

3.6 Clinical Care Guidance for COVID -19 patients

The Covid-19 TSH Clinical Care Support Documentation was developed to assist in the care of patients who have Covid-19 within The State Hospital**.** A six bed General Medical ward was established and equipped to accept any patient who required enhanced care for symptoms of Covid-19, and could not be transferred to an acute hospital. Although it was not necessary to use this facility, it remained in place until the end of March 2021.

There has been no change to this position, and TSH is equipped with oxygen supplies and ready to respond should any patient require enhanced care for symptoms of Covid-19 to be delivered on site.

3.7 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. PPE usage and the availability of supplies are closely monitored. Escalation routes remain available through the TSH Single Point of Contact (SPOC), the Director of Security, Estates and Resilience, and through NSS Covid-19 Supplies Portal.

Clinical Staff have been re-fitted with validated FFP3 masks, with a programme ongoing to ensure that all relevant staff, including new staff members, have been fitted appropriately.

There continues to be no significant supply or cost impact for TSH since the withdrawal of the U.K from the European Union on 31 January 2021, and this area is monitored continually through the Director of Security, Resilience and Estates, in conjunction with the Head of Procurement.

3.8 Patient Flow

As part of the wider forensic network, TSH continues to be linked in collaborative work with medium and low security care providers focussed on the challenge of Covid-19. This includes admission to, and transfer between, secure mental health services, suspension of detention and preparation for moving into the community.

The following table outlines the high level position from 1 June to 31 July 2021.

Table 4: Patient flow 1 June to 31 July 2021

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	4	0	4
Discharges / Transfers	4	0	4
Average Bed Occupancy: Available beds/All beds			95% **/** 81.4%

3.9 Workforce

3.9.1 Attendance Management

The Board now receives dedicated reporting in this area, including Covid-19 related absence.

3.9.2 Planning for Extreme Loss of Staff

Although the national positon appears to be more resilient, with restrictions lifting and the organisational risk reducing, the possibility of a change to this positon is being kept under review. The Extreme Loss of Staff Plan for TSH, which was developed at the start of the pandemic, in response to a significant threat to business continuity, is refreshed regularly with local data and knowledge.

3.9.3 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 49 posts actively moving through the recruitment process from the following departments: Housekeeping, Estates, Learning Centre, Skye Centre, Nursing, AHP, Psychology, Medical, Workforce/HR, Catering, and eHealth. Since the date of the last Board meeting, recruitment activity has concluded for posts within Security, Housekeeping, Procurement, Research & Development, eHealth, Infection Control, Workforce/HR & Skye Centre Nursing.

3.9.4 Staff Wellbeing

Staff Wellbeing continues to be prioritised throughout the Covid-19 pandemic, with a focus on how to support and maintain staff health and wellbeing. This workstream is now very firmly embedded in the hospital and is aligned to the Healthy Working Lives Group. The HR and Wellbeing Group supports awareness of the range of workstreams under development.

Work is focussed on establishing a wellbeing strategy and framework for The State Hospital. In support of this, recruitment is progressing for two Organisational Development and Wellbeing part time posts. These are Band 5 fixed term posts for 15 hours a week for a period of 12months. A part time Band 6 pastoral support post is also being progressed with NHS Lanarkshire through a service level agreement.

The Staff Wellbeing Centre continues to be used every day with staff utilising it for tea breaks and lunch breaks as well as making use of massage equipment. Regular internal enquiries

are received from line managers for sign posting and support in relation to wellbeing resources for their staff. The centre has been used as a quiet, relaxed and informal setting for line managers and staff to hold catch-up meetings away from their usual hospital environment.

Our TSH Wellbeing Champion continues to attend the Scottish Government Wellbeing Champions Network. The Minister for Mental Health, Mr Kevin Stewart, attended the July National Wellbeing Champions Network and expressed continued support going forward for the work being carried out by the network and boards.

Pride badges, redesigned to suit a secure environment have been commissioned successfully and re-launch of this initiative will be led through the Wellbeing Centre. There is interest nationally at using this new design more widely in NHS Scotland.

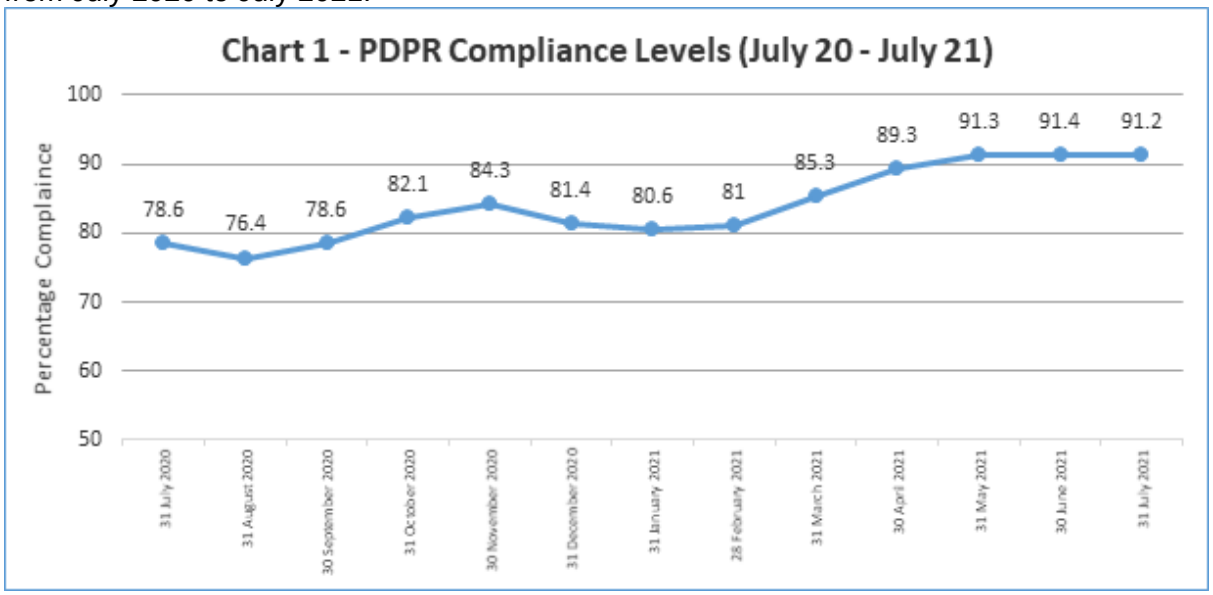
The second 'How Are You' staff wellbeing survey took place between March to May, and results of this survey will be reported back through the HR and Wellbeing Group. The national iMatter survey will be launched on 6 September, with preparation for this at TSH well advanced.

3.9.5 Personal Development Planning and Review (PDPR) compliance

As at 31 July 2021:

- The total number of current (i.e. live) reviews was 548 (91.2%).
- A total of 43 staff (7.1%) had an out-of-date PDPR (i.e. the annual review meeting is overdue).
- A further 10 staff (1.7%) had not had a PDPR meeting. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

Chart 1 shows the trend in organisational PDPR compliance levels for the 12-month period from July 2020 to July 2021.



As indicated in Chart 1, the organisational compliance level has been reported at over 90% for the last 3 months.

3.10 Communication

Staff Bulletins provide communication throughout the organisation, providing high level feedback to staff about national developments, as well as more focussed local updates for TSH.

The Organisational Management Team (OMT) have considered the effectiveness of communications methods during this period. There continues to be a wide range of bulletins issued electronically with arrangements in place to ensure that hard copies are available to staff for whom access to email is not an intrinsic part of their role. In addition, the OMT has supported head of departments and service leads in leadership of effective communication at departmental and team levels.

3.11 Digital Technology

The Board receives regular updates on the programme of digital transformation underway, and an update will be provided separately at this meeting through the Covid Finance and eHealth report.

A more detailed update will be presented at the Board meeting on 28 October 2021.

4 RECOMMENDATION

The Board is invited to:

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

2. To consider future reporting requirements to the Board in this area, and that the need for a specific Covid-19 resilience Report is no longer required, provided that all aspects of relevant reporting are brought to the Board and it committees in line with existing workplans.

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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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Item:	Item No. 7b
Sponsoring Director:	Director of Finance and eHealth
Author(s):	Director of Finance and eHealth
Title of Report:	Financial Governance – Covid-19 / Digital update
Purpose of Report:	Update on Covid financial impact / Digital developments

1 SITUATION

Due to the Covid-19 crisis, additional specific costs are being incurred by the Hospital on an ongoing basis. These costs have been identified since the onset of the crisis in March 2020, as the Hospital operates under new ways of working.

2 BACKGROUND

These specific Covid-related costs were formally reported on a regular basis, through 2020/21, to the Scottish Government's Covid-19 Health Finance team within the Health Finance and Infrastructure Directorate. Feedback / discussion followed directly on each of these reports, including a focus on consistency of reporting between boards, and a discussion for finalisation of the 2020/21 year-end position. This included the late changes made via NSS and their auditors with regard to national 2020/21 PPE funding, as raised and noted at recent Audit Committee and Board meetings when the year-end accounts were finalised.

The 2020/21 position has now been finalised and agreed with SG, and was fully accounted for and audited within our year-end accounts for 31 March 2021.

For 2021/22, on a similar timing basis to 2020/21, an initial report – for the three-month period April-June (Q1) – was submitted to SG in July, incorporating a forecast of expected costs for the remainder of the first half of the new financial year. This is on the basis that Covid-related costs are currently expected to impact on Q1 and Q2 – and discussions are to take place in late August / September with SG to consider any potential impact ongoing into Q3 and/or Q4, or beyond.

For TSH – per 3.2 – these costs continue to relate principally to staff costs and contingent project costs.

3 ASSESSMENT - FINANCE

3.1 Financial Governance and SG allocation

As previously notified, any specific individual costs in excess of £100k with relation to Covid19 are required to be notified for approval to Scottish Government - agreement being in line with governance arrangements approved in 2020 by Chief Executives and Directors of Finance.

While it was initially anticipated that Covid costs for 2021/22 would be reported monthly to SG for allocation agreement in the same way as Q3 and Q4 of 2020/21, it has now been indicated that this will not be the process. Instead, we will continue to report Covid costs through Q1 and into Q2, with the timing of the review for alllocations then to be determined likely to be summer 2021, in a similar way to that which was applied in August 2021 for the early months of the Covis crisis.

We have had initial meetings with our SG finance team in July to review this position and to ensure that sufficient clarity has been provided of the related cost pressures. Our reporting and forecasting is in line with SG expectations and our next follow-up meeting is expected in September.

While our budget for 2021/22 is drafted with an assumption that Covid-related costs will continue though Q1 and Q2 only, we will monitor this position on a month-by-month basis for reporting and forecasting to ensure all relevant costs are included for consideration in the new year's Covid allocation process.

3.2 Covid19 specific costs

Continuing in the main from 2020/21, the principal revenue costs incurred in relation to Covid19 in 2021/22, as submitted in the Board's Q1 return and Q2 forecast are as undernoted.

i. Overtime costs Q1 £130k – additional overtime incurred each month due principally to the increased levels of staff absence arising from Covid absences (classified as special leave), together with an element of high level clinical demands. (This is principally re Nursing, but includes £10k re Infection control and Security).

ii. Nursing recruitment £150k – these costs are to be confirmed with SG with regard to the correct allocation of costs of additional student nurses to confirm if these are to be funded directly through the Covid funding as in 2020/21.

iii. Additional deep cleaning £5k – being extra cleaning requirements specific to rooms for patients with positive Covid test results.

iv. Telephony, related IT and digital costs £3k – being the costs of teleconferencing and other remote communication costs now being incurred – this is now much reduced due to the wider use of Teams.

v. Estates/facilities costs £15k – including the requirement for additional food container for the appropriate provision of safe catering.

vi. "Dual running" staff costs – £12k – relating to Covid support posts ongoing.

vii. Perimeter project contingent costs - while an element of delay was incurred due to the site restrictions in late January / early February, the final value is under evaluation for final agreement as the actual cost, while relating to this period, will be charged in 2021/22.

3.3 Covid19 costs – vaccinations programme

In addition to the above, there are costs to the Hospital which arose from taking forward the programme of Covid-19 vaccinations for frontline staff in 2020/21. These costs (relating to staffing – vaccinators and backfilling of roles, refrigeration / storage of vaccines etc.) were included in 2020/21 reporting and, subject to review, any future costs will require to be notified to SG for appropriate consideration.

4 ASSESSMENT - eHEALTH

A number of key areas currently progressing through eHealth are noted below. An interim 2021/22 Digital Update will be issued to the October Board meeting, in line with timings connected to the recent audit recommendations.

4.1 Digital Inclusion

4.1.1. Hardware / Remote Access

Delivery of new laptops and older laptops being updated with new components has addressed any key gaps noted in hardware availability. An order has also been placed for additional video conferencing equipment.

A significant number of staff now have remote access – reviews are ongoing to ensure we have the optimal remote access solution with any options to improve the system and streamline the user experience where possible being explored.

4.1.2 Tableau

The use of tableau to provide data dashboards has also increased, with a number of requests received and e-health working to deliver on those. The benefits to business that the dashboards can bring has been acknowledged by TSH Board and as it expands it was agreed will be an integral tool to provide insight needed to ensure the Board is delivering service efficiently.

4.1.3 Office 365

This is a significant project for eHealth, with a dedicated subgroup ensuring appropriate focus. Delays in the national roll out of Office 365 have held up the deployment of some elements such as SharePoint, Yammer and One Drive. However, through NSS, a new national licensing agreement has now been agreed with Microsoft which allows further elements of Office 365 to become available to staff. Review is currently underway in line with the national programme to ensure user licences are appropriately allocated and obtained for the differing levels of access required as this is taken forward.

4.2 Other Digital

4.2.1 SCN Dashboards

A proposal for development of SCN Professional Standards Dashboards is now being taken forward. The purpose of this dashboard would be to provide an overview of all areas of nursing professional responsibility and accountability, to enable SCNs to drive forward

improvements in nursing care and this is expected to be an invaluable resource to the nursing directorate.

4.2.2 MS Teams

The increasing use of teams is highlighting the requirement to assess the level of training available to assist staff. While information documents have been shared via the Staff Bulletin and also through the TSH All Users MS Teams Channel it was noted that not all staff are accessing these. Additional learning documents including hints and tips together with appropriate links are being developed, while the network of Teams Champions throughout the Hospital is being engaged.

4.2.3 PuMP eHealth Performance Management

Following the pilot use of this methodology for HR at the Hospital, the eHealth department are now the second group to make use of this, introduced by the Head of Corporate Planning and Business Support. This is being taken forward to ensure appropriate focus on performance management within the department, in particular on such areas as helpdesk responses, and will align top recommendations in recent audit reports and the development of the short/mid/long-term eHealth strategy.

5 RECOMMENDATION

The Board is asked to note this report

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Financial Position and Digital developments
Workforce Implications	No workforce implications – for information only
Financial Implications	No financial implications – for information only
Route to SG/Board/SMT/Partnership Forum Which groups were involved in contributing to the paper and recommendations.	Finance and eHealth Director
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.

Paper No. 21/57

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	Item No. 21/57
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support Consultant Psychiatrist
Title of Report:	Clinical Model Mapping
Purpose of Report:	For Decision

1 SITUATION

Planning for Implementation of the Clinical Model was in an advanced stage prior to the Coronavirus pandemic. Work was paused in March 2020. In preparation for planning for restart, and move towards implementation, of the Clinical Model the CMT agreed at its June 2021 meeting to consider the current context, previous work carried out and what the future conditions would require prior to any restart. This paper sets out the findings from a patient mapping exercise carried out between 15th and 30th June 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 project was progressing well through:

- Planning of workstreams being progressed
- Development of clinical guidance for admission and assessment wards, treatment and recovery, transitions and ID wards
- Development of proposals for seclusion rooms
- Development of a communications plan
- An EQIA being put forward for approval

In May 2021, a presentation was given to the Board outlining the factors that would have to be considered as part of restarting 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 TSH experience of working through Covid 19 pandemic, the interim Clinical Operational Policy and the recommendations from the Barron Review
- Reviewing current patient population to align with new clinical model.

- Considering the financial aspects of the model and reviewing if this continues to be achievable in financial plan 2021/22

3 ASSESSMENT

3.Patient Mapping

Each RMO was asked to assign each of their patients to which ward type from the new Clinical Model would best suit their needs and state if there was agreement across the clinical team for their decisions. The Clinical Forum's definitions of ward type for the mental illness service are:

Admission and Assessment wards: Agreed the purpose of these wards should be about initial assessment (including multidisciplinary assessments, physical health investigations, completion of structured risk assessments and where appropriate, personality assessments) resulting in the clinical team being confident they have a comprehensive and robust understanding of the risk presented by the patient, the needs they have and being able to formulate a comprehensive care and treatment plan to inform the next stage of treatment. The environment will be tailored to the needs of patients within an assessment area – therefore may be more restricted. Care and treatment should be based upon individual patient needs as far as possible, whilst assessment is being undertaken.

Treatment and Recovery wards: these wards will meet the needs of a large portion of our patient group to provide ongoing treatment and rehabilitation once their care and treatment needs are understood. These wards are likely to include patients with complex needs, high dependency and patients with additional physical health needs. Patients who are high risk, but where the risk is well understood and the management of their risk is clearly articulated with a defined care package, should be placed here.

Transition wards: These wards will meet the needs of patients whose risks and needs are well understood and articulated, and the level of care and management required is lower and less intense. The environment will offer the least restrictive area across the site as an opportunity to support appropriate rehabilitation for patients as they progress towards leaving the State Hospital. Patients may have been identified as being ready to move onto less secure settings and should have full grounds access, be fully compliant with their care and treatment, met many of their treatment goals, have a full timetable, and not require to be cared for with increased levels of observations. Should the status of these change significantly, the patient should be transferred back to a Treatment & Recovery ward. These wards are not limited to patient's already on the transfer list, as long as the other criteria are met.

Proposed Clinical Model Site Layout as per March 2020

	Ward 1	Ward 2	Ward 3
Arran	Admission	Treatment/Recovery	Treatment/Recovery
Iona	ID	ID	
Lewis	Admission	Treatment/Recovery	Treatment/Recovery
Mull	Transition	Transition	

3.1 Patient Mapping 15th – 30th June 2021

Hospital population	Admission and Assessment	Treatment and Recovery	Transition	I.D 1 (ASD)	I.D. 2 (Social)
115	24	50	27	7	7
Clinical Model beds available	24	48	24	Ward capacity of 12	Ward capacity of 12

Patient Flow 1st January 2021 – 18th June 2021

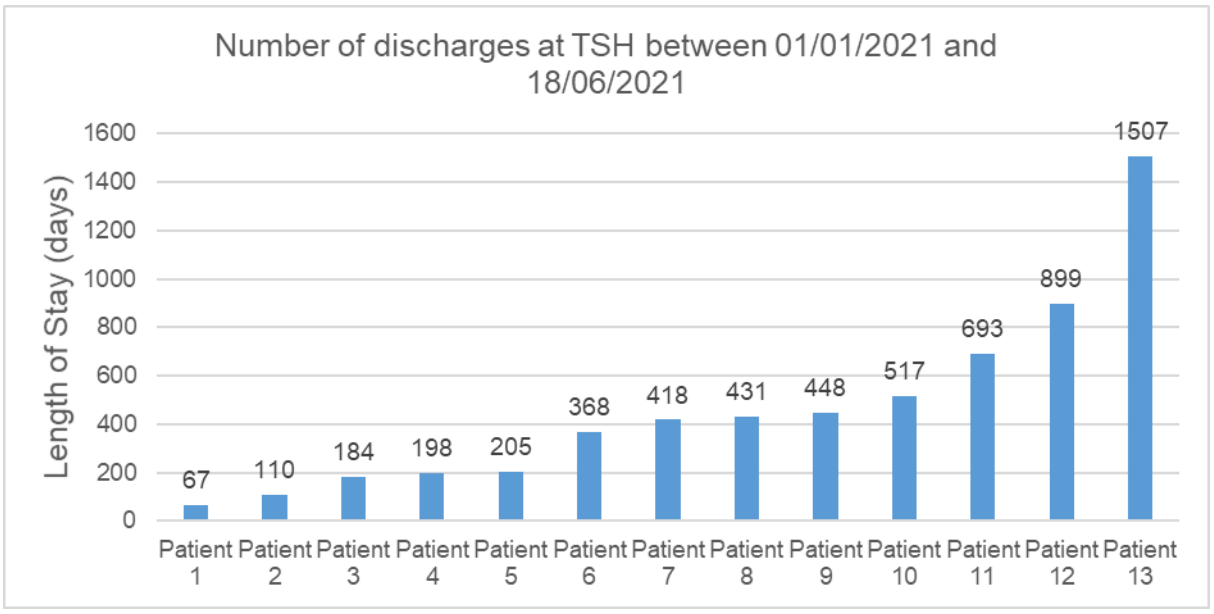
TABLE 1 DISCHARGES DATE AND DICHARGE DESTINAITON

	Admission Date	Discharge Date	Length of stay in days	Discharged to:
Patient 1	29/01/2021	06/04/2021	67	HMP Lowmoss
Patient 2	26/02/2021	16/06/2021	110	HMP Barlinnie
Patient 3	21/07/2020	21/01/2021	184	HMP Grampian
Patient 4	02/09/2020	19/03/2021	198	HMP Edinburgh
Patient 5	23/09/2020	16/04/2021	205	Paisley Sheriff Court
Patient 6	27/01/2020	29/01/2021	368	Rohallion Clinic
Patient 7	20/11/2019	11/01/2021	418	HMP Moss
Patient 8	31/01/2020	06/04/2021	431	Orchard Clinic
Patient 9	13/02/2020	06/05/2021	448	Rowanbank Clinic
Patient 10	03/09/2019	01/02/2021	517	Edinburgh High Court
Patient 11	06/03/2019	27/01/2021	693	Rowanbank Clinic
Patient 12	11/09/2018	26/02/2021	899	HMP Addiewell
Patient 13	11/04/2017	27/05/2021	1507	Rowanbank Clinic
Patient 14	17/02/1998	20/01/2021	8373	Rohallion Clinic
Patient 15	18/03/1988	18/06/2021	12145	Stratheden Hospital

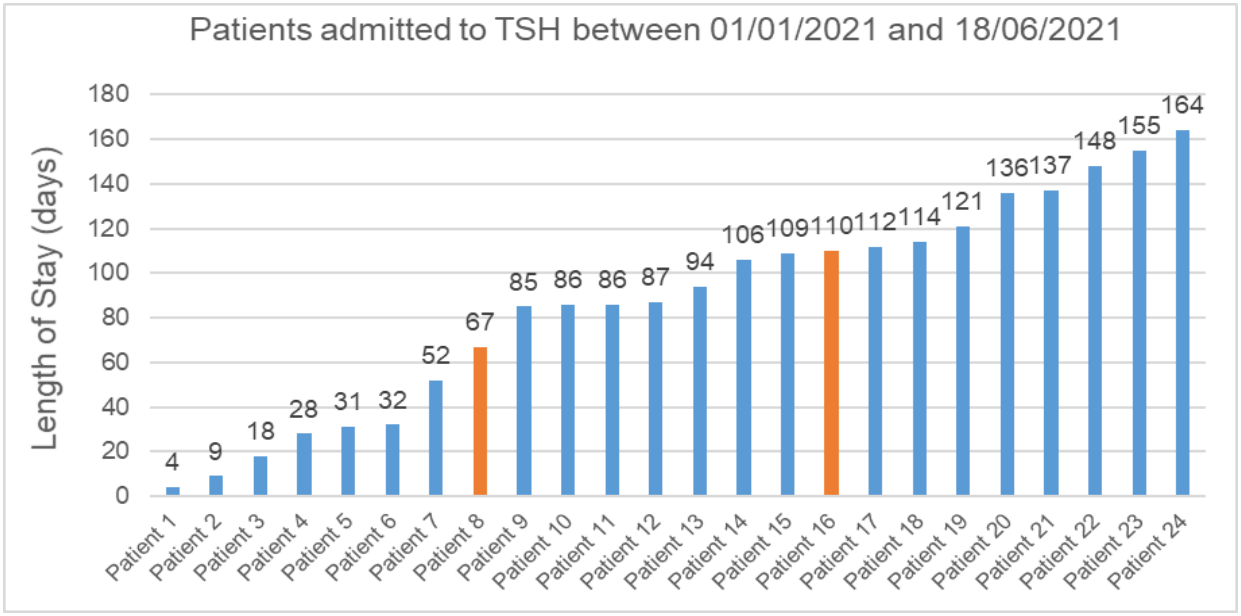
TABLE 2 PATIENTS ADMITTED TO TSH AND LENGTH OF STAY UPTIL 18TH JUNE 21

	Admission Date	Discharge Date	Length of stay in days
Patient 1	14/06/2021	N/A	4
Patient 2	09/06/2021	N/A	9
Patient 3	31/05/2021	N/A	18
Patient 4	21/05/2021	N/A	28
Patient 5	18/05/2021	N/A	31
Patient 6	17/05/2021	N/A	32
Patient 7	27/04/2021	N/A	52
Patient 8	29/01/2021	06/04/2021	67
Patient 9	25/03/2021	N/A	85
Patient 10	24/03/2021	N/A	86
Patient 11	24/03/2021	N/A	86
Patient 12	23/03/2021	N/A	87
Patient 13	16/03/2021	N/A	94
Patient 14	04/03/2021	N/A	106
Patient 15	01/03/2021	N/A	109
Patient 16	26/02/2021	16/06/2021	110
Patient 17	26/02/2021	N/A	112
Patient 18	24/02/2021	N/A	114

Patient 19	17/02/2021	N/A	121
Patient 20	02/02/2021	N/A	136
Patient 21	01/02/2021	N/A	137
Patient 22	21/01/2021	N/A	148
Patient 23	14/01/2021	N/A	155
Patient 24	05/01/2021	N/A	164



*One patient was discharged after a stay of 8,873 days and another after a stay of 12,145 days.



*Patient's 8 and 16 were admitted and discharged within the time period specified.

3.2 Analysis

Mapping

The Clinical Model of 2 Admission and Assessment, 4 Treatment and Recovery, 2 Transition and 2 ID wards is a good fit for current patient population when mapped across, however we have 100 MMI patients and only 96 MMI beds in the new model. There are currently 2 exceptional circumstance patients awaiting beds in Rowanbank and Orchard Clinic and in total 13 patients on the transfer list.

Patient Flow
Admission
There were 24 patients admitted to TSH between 1/1/21 and 18/06/21.
Of these, 2 have been discharged (stay of 67 and 110 days) and 22 remain in TSH.

Analysis of admission and discharge flow indicates that the Admission and Assessment wards would need to aim to move patients on to accommodate new admissions. Within the first 6 months of the year, the number of patient admissions would have filled both wards, therefore the expectation would be that the admission wards would need to move patients within 6 months to accommodate new admissions. The clinical guidance for the admissions ward should reflect that any ongoing behavioural disturbance would not be a barrier to moving on as long as risks were assessed and known. Admission CPA's should be complete within 12 weeks, any court process may be longer and therefore not necessarily be complete when the patients are in the admission wards.

MSR Usage
Seclusion episodes over the last 18 months have been reviewed to analyse the MSR usage and consider how this may impact on the new Clinical Model, particularly with a focus on the Admission and Assessment period. Between 01/01/2020 and 15/07/2021 there have been 33 seclusions involving 17 patients, ranging from 1 to 7 episodes. On 6 occasions more than one seclusion room was in use at the same time. On 2 out of the 6 occasions both patients were in the admission phase of their patient pathway, if these patients had been in the same admission ward then one may have required to be moved. Out of the 33 seclusions, 14 of these were in the patient's admission phase and 19 were in the patient's continuing care phase. We do not currently have data for patients that require intense care in the MSR suite, but are not classified as a seclusion. The work underway with the Level 2 seclusion (as per MWC guidance) should help with this

Discharge
TSH discharged 15 patients between 1/1/21 and 18/06/21. Of these 2 had been admitted this year (stay of 67 and 110 days) and length of stay in TSH for the other 13 ranged from 184 – 12,145 days. Discharge destinations were to NHS Medium Secure (n= 7) or justice services (n= 8). There was 1 patient death not included in these numbers.

Transfer List
As of 30th June there were 13 patients awaiting beds in medium secure, 2 are exceptional circumstance patients awaiting beds in Rowanbank and Orchard Clinic. The remaining 11 are awaiting beds in: Rowanbank (n=9) Orchard Clinic (n= 1) and Rohallian (n=1). With 10 patients in total awaiting a bed in Rowanbank the issue of bed capacity in NHS GG&C impacts on TSH flow significantly.

Analysis of discharged and patients on the transfer list indicate that the Transitions wards would also have a significant flow through, however we also note the number of patients awaiting beds in the west of Scotland Rowanbank clinic as noted above.

The ID population currently sits at 14, the current provision is 1 ward of 12 beds therefore there may be an indication that this service has a need to expand to meet patient numbers.

3.3 Next steps – consideration of range of options from the mapping

The options below have been presented to CMT for consideration. CMT agreed at it's meeting on 17th August that the options should be shared with a wider staff group to discuss and explore potential next steps and gauge support for these.

Option 1

TSH fully explores the contingencies and processes that would be required to be in place to enable progression to the new clinical model.

The most significant issue with this option is that the number of MMI patients currently exceeds the beds available in the model. At the interregional group meeting on the 13th August, 7 patients were fully appraised and ready for transfer to medium secure.

Actions to explore possible temporary solutions –

- Given the only excess bed provision would be in the ID service, initial engagement has taken place with the Clinical Lead in the ID service to explore if this may be resolved with support from the ID Task Force and service. Consideration could be given to 'boarding' identified MMI patients who's individual needs may align with ID service. These patients would remain under the care of their RMO.
- Wider forensic estate - TSH should remain cognisant of wider forensic estate and potential of GGC opening additional beds in medium and low secure, TSH may wish to follow up to understand how this is progressing.

Option 2
TSH agrees to suspend further review of Clinical Model until there is a more favourably picture for patient flow to enable change. CMT is not in favour of this option, however the consideration of the status quo in appraising options is important.

Option 3
TSH plan to progress with a hybrid Clinical Model with 2 Admission and Assessment, 1 ID, 5 Treatment and Recovery and 2 Transition wards until the MMI patient number reduce and 2nd ID ward is reconfigured from the 5th Treatment and Recovery ward.

4 RECOMMENDATION

Board members are asked to note the mapping and update on the restart of the Clinical Model.

Board members are asked to note and support the intention for wider staff discussion and engagement as options are further considered.

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	10
Sponsoring Director:	Medical Director.
Author(s):	Consultant Forensic Psychiatrist/ Lead Dietitian.
Title of Report	Supporting Healthy Choices
Purpose:	For Decision

1 SITUATION

Overweight and obesity rates remain well above the Scottish male average (66%), with the annual variation highlighting this affects 86-93% of the patient population. The associated risk of comorbidities and mortality therefore remains high and alongside the current COVID – 19 pandemic the risk being greater in those who are overweight or obese therefore makes managing this risk within our patient population is a priority.

2 BACKGROUND

High rates of being overweight and obesity persist despite numerous changes to operational practices within TSH (cessation external purchases, changes in the Hospital shop stock to comply with the Health Care Retail (HRS) Standards, earlier opportunity for physical activity and improved monitoring of such and altered /additional clinical interventions (such as 'Counterweight Plus'). New admissions were presenting with lower admission BMI's, however weight gain within first few years of admission was excessive (11-26% following 3 years of admission).

Levels of being overweight and obesity increased during the first 6 months of 2021 and have recently fallen again.

Table 1 TSH Patient BMI

Date	Jan	Feb	Mar	April	May	June	July	Aug
	%	%	%	%	%	%	%	%
No BMI	7.5	4.8	3.7	3.6	1.8	0.9	1.7	2.6
Normal	8.5	14.4	10.1	7.1	7.2	6.1	11.3	11.3
Over wt	34	36.5	36.7	38.4	38.7	41.2	36.5	32.2
BMI >30	34	26.9	33	33.9	35.1	33.3	33.9	35.7
BMI 35-	13.2	14.4	14.7	15.2	13.5	16.7	13	13

39.9								
BMI >40	2.8	1.9	1.8	1.8	3.6	1.8	3.5	4.3
Total over wt/obe	84%	79.8%	86.2	89	90.9	93	86.9	85.2
Under wt								0.9

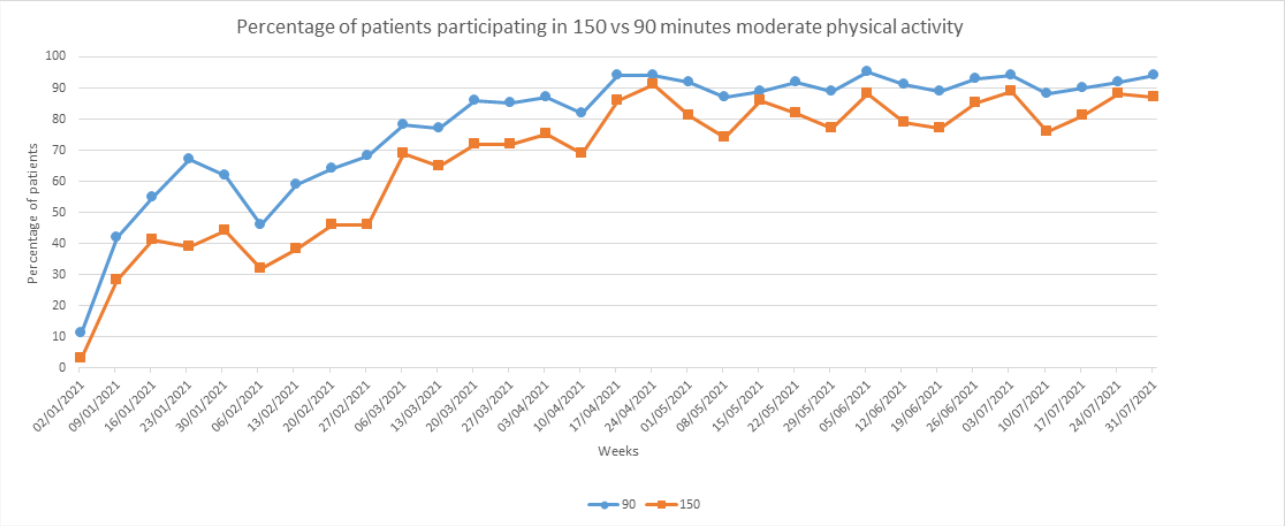
An example of change from May to June can be elaborated on by 1 patient's move from the normal to the Obese 1 category, this patient put on around 6kg from May to June. 6 patients moved from the overweight into the Obese 1 category, 2 patients moved from the Obese 1 to Obese 2 Category. 4 patients moved from the Obese 1 into the Overweight, 1 patient moved from the Obese 3 to the Obese 2 Category and 1 patients moved from the Obese 2 to Obese 1 category.

Of the five admissions; 1 had not data available, 1 fell into the Obese 1 Category, 2 into the overweight and 1 into the Normal Category. There were 2 discharges 1 from the overweight category and 1 from the Obese 1 category. Two patients who did not have their weight completed in May have had them taken in June: 1 fell into the Normal Category and 1 into the Obese 2 category. 1 patient who was on the Obese 1 category in May had no weight data recorded in June for comparison.

Data suggest that the worsening figures from May to June are due to weight gain of patients within TSH rather than variation in patients admitted or discharged. Patients had access again to takeaways, the shop and physical visits from May '21.

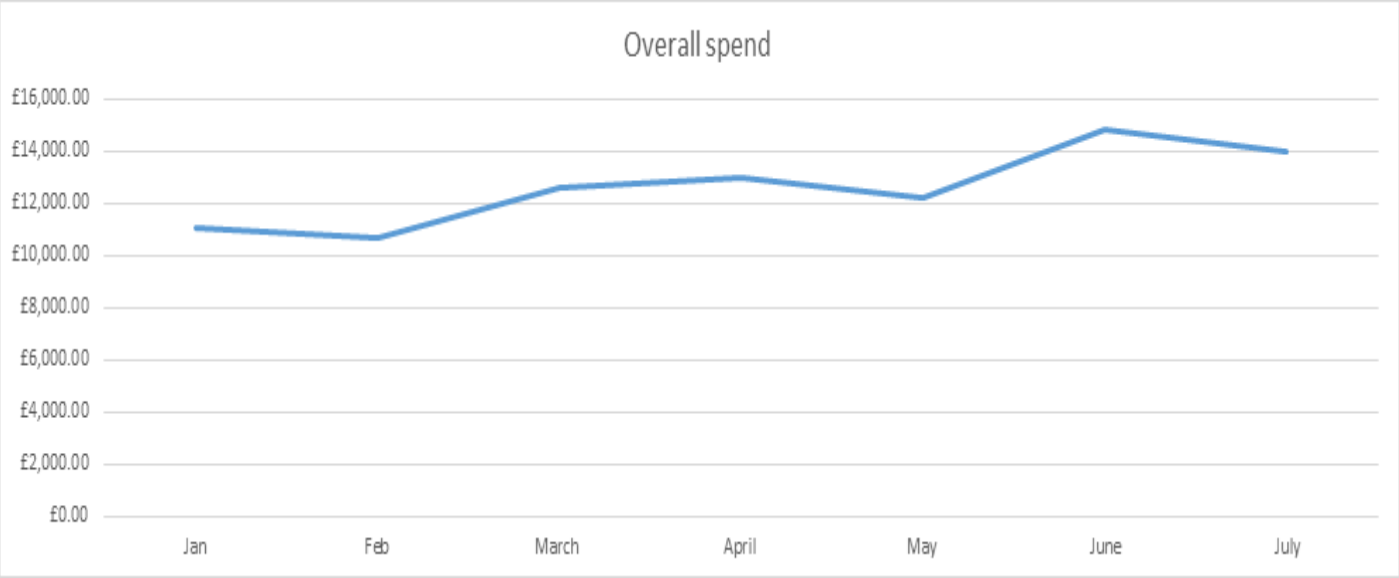
Physical activity data has shown increases during the summer/warmer months with an ongoing increasing trend until the end of July '21.

Fig 1 Physical Activity



and hospital shop spend has varied with the following data we have until July '21.

Figure 2 Patient Shop Spend



During the pandemic until May '21, patients access to the shop was limited to a weekly main shopping list and also a £10 top up, the latter stopped in May, as patients resumed physically visiting the shop again weekly (Mon-Fri only). This is reflected in a spend change of £761.03 (decrease) in May. This could be associated with the cessation of the top up service on the 17th of May 2021. To note, invoices do not always parallel monthly spends.

3 ASSESSMENT

The SHC sub group resumed in February 2020, following the workshop on the 20th January to agree a 2nd phase: agreed terms reference were set including a new SHC plan, a further and updated literature review and a review of outstanding actions from the previous SHC plan.

Work paused due to the COVID-19 pandemic and the group re commenced in September 2020. Public Health England's publication on 'managing overweight patients and obesity in secure settings' (Feb '21) was timely published.

The new draft action plan is based on the workshop's feedback, literature and the principles of realistic medicine. See Appendix 1. The action plan focuses on changes in supporting activity, aspects of daily living, education and training, and food choices; and focuses on the need to monitor data closely.

In 2010 following a legal case against the hospital, Lady Dorian (2011) expressed views were; '*For inmates of the state hospital, the freedom to receive food parcels from visitors and to make purchases from an external source are some of the few areas in which they may exercise some sort of personal autonomy or choice. I have reached the conclusion that a person's right to choose what they eat and drink is a matter in respect of which article 8 is engaged. If that choice is interfered with, it must be justified. In respect of a prisoner or a person confined in a secure hospital, interference to a certain extent can readily be justified. The general restrictions which applied in the State Hospital prior to 29 October 2009 were quite rightly accepted by counsel as being justified. In my view the additional restrictions which the respondent seeks to impose must also be justified. The respondent does not seek to do so on the basis of security or for any other general operational reason. It is specifically not argued that this additional restriction is a necessary, ordinary and reasonable requirement of the petitioner's loss of liberty. The sole basis of*

justification is that it is in the general interest of the health of the patients. It may be that the restrictions can be justified by reference to the risk to health of a substantial percentage of the hospital's population, given the assertion that those suffering from schizophrenia (80% of the hospital population) are at an increased risk of cardiovascular disease and obesity and double the normal risk of developing diabetes'.
Lady Dorian supported ongoing monthly access to takeaways and visitor's food gifts, within the context of above. Due to perceived gaps in consultation other recommendations were not wholly supported. However, '*in the context of inmates of the state hospital, the freedom to receive food parcels from visitors and to make purchases from an external source are some of the few areas in which they may exercise some sort of personal autonomy or choice. I (Lady Dorian) have reached the conclusion that a person's right to choose what they eat and drink is a matter in respect of which article 8 is engaged. If that choice is interfered with, it must be justified. In respect of a prisoner or a person confined in a secure hospital, interference to a certain extent can readily be justified. The general restrictions which applied in the State Hospital prior to 29 October 2009 were quite rightly accepted by counsel as being justified'.*

Consultation on the proposed plan is therefore vital and any interference with article 8 needs to be appropriately considered.

4 RECOMMENDATIONS

The Board is asked to:

- Support the SHC draft action plan
- Support consultation on SHC draft action plan
- Note the recommendation for a new project manager 2 days per week to lead on operationally managing the SHC plan.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	*Priority of supporting physical health and tackling overweight and obesity*
Workforce Implications	*From existing resources, unless highlighted within action plan, as secondment opportunities or within Realistic medicine framework.*
Financial Implications	*New staff posts/secondment role, equipment, activities and resources re patient's day, estates staffing re meal provision, patient mirrors and shopping bags.*
Route to the Committee *Which groups were involved in contributing to the paper and recommendations?*	SHC and PHSG
Risk Assessment *(Outline any significant risks and associated mitigation)*	*Mitigation of obesity forms part of risk register*
Assessment of Impact on Stakeholder Experience	*Potential benefits in health, reduction in co morbidities.*
Equality Impact Assessment	
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).	Action plan in general supports all patients, focus on additional support for higher risk individuals.
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.

Supporting Healthy Choices Development Plan 2021-2024

These recommendations have been prepared by Supporting Healthy Choices Development Group to address the obesogenic environment in The State Hospital. The recommendations are based on the Realistic Medicine Principles and informed by the obesity workshop January 2020 and Public Health England Guidelines (PHE) for 'Managing overweight and obesity in secure settings'. These recommendations require to be consulted upon and approved by The State Hospital Board for Scotland. A SHC Implementation Group will be established to deliver the plan.						
Reduce Harm and Waste						
	Objective	Source -Literature Review Reference - Workshop Recommendation	Aim - Reduction - Prevention	Responsibility/Lead of each individual action	Timescales	Progress
1.	a) Weekly discussion with key worker for all patients who have a BMI over 35kg/m2, new admissions and those who are progressively increasing weight to review shopping plans (in line with Healthcare Retail Standard criteria), healthy eating, physical exercise and activities. Recorded in weekly clinical team meeting report. Monthly discussion for all other patients. To be audited b) Develop adherence agreements with patients who have a BMI over 35kg/m2 and do not comply with agreed shopping plans. For patients with on-going noncompliance with shopping lists or if their weight is not reducing by 5% over 3 months, they will not get access to the shop, and a list or visit will be agreed between keyworker and the patient. c) Review the size of the current shopping bags made available to patients, with a view to reducing the size taking into consideration healthy and non-food items.	Workshop Recommendation PHE 2021 Work shop recommendation	Reduction and Prevention Reduction Prevention	Senior Charge Nurse / Operational Manager (JG) Senior Charge Nurse Skye Centre Team (JG)	(medium goal) 6-9 months (medium goal) 6-9 months (medium goal) 6-9 months	
2.	Change the environmental cues to promote	nPHE '21	Reduction	Senior Charge Nurse	(medium goal)	

	healthy lifestyles at ward level, looking at establishing ward timetables to facilitate placements, escorted walks, meal and specific snack times and facilitated additional activity time. Involve activity co-ordinators in this.		and Prevention	(LL)	6-9 months	
3.	Review access at ward level to, and education of staff and patients around high fat, salt and sugar items such as access to butter and sugar portions in line with FSA guidelines. For those with a BMI over 35kg/m2 and those 'at risk', specific individual guidance re no access to extras will be provided.	PHE Guidelines Prebble 2011.	Reduction	Dietetic Team (FW)	(Long term goal) 12-15 months	
4.	a) Review current practice supporting visitors to bring food / fluids into the Hospital for patients. b) Revisit access for patient gifts of food /fluids by delivery to the Hospital.	PHE 21 Workshop Recommendation Workshop Recommendation	Prevention Prevention	Person Centred Improvement Team (SD) As above	(long term goal) 12-15 months (long term goal) 12-15 months	Forms part of wider visiting experience work streams. PCIT with security deal with this.
Personalised Approach to Care						
5.	Review location of outdoor exercise equipment in collaboration with patients and relocate if required	Haw 2011 Workshop recommendation	Prevention & Reduction	Person Centred Improvement Team (SD)	(medium goal) 6-9months	Pro-forma developed and engagement exercise is underway
6.	a) Carry out audits to ensure that patients have up to date health and wellbeing plans, supported by all the clinical team, with meaningful implementation through the weekly Clinical Team Meeting as well as Care Programme Approach meetings. b) Review content and use of health and wellbeing plans	Workshop recommendations Parity of esteem 2019 Audit recommendations	Prevention and reduction Prevention and reduction	Dietetic Teams (FW) Practice development (CW)	(Medium Goal) 6-9months (Medium goal) 6-9 months.	Current annual audit Commenced with nursing practice development.
7.	Re-explore 2016 recommendation to review	Workshop Recommendation	Prevention	Director of Estates (DW)	(Long Term Goal)	On hold due to current working

	and spread out patients' meal times				12-15 months	patterns.
8.	a) Review, implement and audit the TSH Weight Management Pathway (appendix 1&2) b) Action the use of Clinical Pause in weight management of high risk/hard to motivate patients (BMI >35kg/m2/rapid weight gain, additional comorbidities).	Oakley 2013 Every Palner 2018 PHE '21.	Prevention & Reduction Reduction	Clinical Effectiveness Teams (SS) Clinical Teams	(Long Term Goal) 12-15 months Short term goal (3months)	Work commenced by dietetics to complete this. Ad hoc use currently
9.	a) Delivery of the Healthy Living Group by dietetic, psychology and OT. 2 hubs, max 10 patients/group. b) In addition, offer a variety of weight management groups across the Hospital supported and delivered by Skye centre, AHP, and others annually. Weekly 'slim and trim', Healthy Living Group – 2 groups/year c) Review 9a and b following a formal needs analysis of patients for these groups.	PHE '21 Work shop feedback Consultation 2015.	Prevention & Reduction Prevention and Reduction.	Head of psychology Chair of Physical Health Steering Group Dietetic Team (FW)	(Short Term) 3 months	On hold (Skye centre Qi Activity project)
10.	Review menu format for patients to make these easier for patients to read and identify healthier options and ensure compliance with food, fluid and nutritional care standards	Workshop Recommendation	Reduction	Dietetic Team (FW)	(Medium Term) 6-9 months	Pilot of coloured menus used for ordering June '21
11.	Define role of activity coordinators in promotion of healthy lifestyles and choices		Prevention & Reduction	Operational Manager (JG)	(Short Term) 3 months	Newly recruited to posts.
12.	Review the current role and develop new staff in these roles of Health Champion across the hubs and link with AHP and Skye centre staff (including Activity coordinators) to deliver health promotion messages and facilitate activities.	Rylance 2012. Long 2016. Choudhry 2017. PHE 2021.	Reduction & Prevention	Practice Development Nurse Specialist (CW)	(Long Term) 12-15 months	7 health champions remain.
13.	a) Appoint at least 1 Health Psychologist on a	Psychological	Reduction &	Head of Psychology	(Medium Term)	

	full time basis	perspective on obesity 2019	Prevention	(JM)	6-9 months	
	b) Review and maintain the role and remit of the Trainee Health Psychologist.	Psychological perspective on obesity 2019	Reduction & Prevention	Psychology Team (LK)	(Long Term) 12-15 months	Current 2 year projects
14.	Extend the use of Counterweight plus extending this initiative to more high risk patients within the State Hospital (pre Diabetics).	National Obesity Forum Diabetes Framework 2018.	Reduction	Dietetic Team (FW)	(Long Term) 12-15 months	Maintained during 2020. 4 active patients May '21.
Manage Risk Better						
15.	Explore new national guidelines for limiting patient spending in shop encouraging patients to budget more effectively ensuring this includes patients within the highest risk categories. Patients most at risk (BMI >35kg/m2/new admissions) having an agreed spend on high fat, salt, sugar (HFSS) food items.	Harper 2008 PHE 2021	Reduction	Social Work (DH)	(Long Term) 12-15 months	
16.	Review pre-admission assessment information to include details of physical health conditions, weight, weight history and physical activity history.	PHE 2021	Prevention	Person Centred Improvement Team (SD)	(Long Term) 12-15 months	
17.	Explore the opportunity to develop and link patient health passports with health and wellbeing plans via a 1 year new secondment role to develop and embed this new practice.	PHE 2021	Prevention and Reduction	Occupational Therapy (HC)	(Long Term) 12-15 months	
Become Improvers and Innovators						
18.	Within 3 (or 6) months of admission, all patients will have had a budgeting skills assessment carried out. For those patients with an identified need, budgeting skills will be incorporated within the patients agreed care and treatment plan as a specific objective.	Harper 2008. Workshop Recommendations	Prevention	Occupational Therapy (HC)	(Long Term) 12-15 months	
19.	Explore and develop admissions screening process for disordered eating / eating disorders	Psychological perspectives on	Prevention and	Dietetic Team (FW)	(Long Term) 12-15 months	

	in conjunction with national trauma pathway and Psychology.	obesity 2019.	Reduction			
20.	QI Project outlining staff education/awareness pathway to supporting patients with their physical activity and weight levels	Parity of esteem 2019.	Reduction	Nursing Practice Development (CW)	(Long –Term) 12-15 months	
21.	a) Explore opportunities for a wider range of activities to include: - more structured daily routines for newly admitted patients - more pre planning of seasonal activities with a variety of ward based, weekend and evening options to increase more opportunities for physical activity.- use of scheduled hub and patio activities supported with a 'can do' approach, football, outdoor games. b) Develop guidelines for the prescription of exercise by responsible medical officers c) Timetable activity to meet minimum daily activity such as daily mile for all able patients. d) Increase target for physical activity for 80% patients to achieve min 150 minutes/week in line with national approach.	Cormac 2013 PHE 2017 – Working together to address obesity in AMHSU. SG plan for a 'healthier future' 2018. Work shop recommendations Physical Health Steering Group.	Prevention Prevention Prevention Prevention	Skye Centre (JG) Chair of the Medical Advisor Committee Operational Manager PHSG	(Long-Term) 12-15 months Medium term (6-9 months) Short term 3-6 months (Long term plans in conjunction with revised clinical model)(12-15 months)	New work streams Audit ongoing physical activity.
22.	Make available full length mirrors on ward for patients ensuring this meets with security restrictions	PHE 2021 guidelines	Prevention & Reduction	Security Department (DW)	(Medium Term) 6-9 months	
23.	Designated staff remit (Health Champion/Rehabilitation Instructor) to monthly produce/obtain and present health promotion information on ward physical health boards, promoting health education and key physical health messages.	PHE 2021 guidelines	Prevention	Nursing Practice Development (CW)	(Long-term) 12-15 months.	

Reduce unwarranted variation						
24.	Identify measurable outcomes to monitor progress of action plan (Appendix 3) - Body mass index - Waist circumference - Increase in positive engagement in health improvement behaviours, - - increase in physical activity levels - Reduction in shop spend on un healthy items - reduction in numbers of patients with diabetes and pre diabetes- increase in uptake attending weight management groups and similar.	As per Clinical Effectiveness department measures	Prevention & Reduction	Clinical Effectiveness (SS)	Baseline will be set once finalised plan approved by the Board. SHC implementation group will monitor the success of the action plan through monthly trend data	Develop monitoring flowchart Including increased reporting on weight change within the first 6 months of admission
25.	Ensure that takeaway meals meet the TSH guidance document for ordering and that this is audited annually.	Haw 2011. PHE 2021.	Prevention	Clinical Effectiveness (SS)	(Short Term) 3 months	Ongoing Annual Audit completed and recommendations reviewed
26.	Adapt the TSH3030 (Lewis) project allowing patients access to the Sports and Fitness Department when attending the shop ensuring that it is consistent across the site	Long 2016 PHE 2021.	Prevention	Skye Centre (JG)	(Medium Term) 6-9 months	
27.	Agree SHC objectives are adopted across all hubs with specific guidance for hubs when they move to the new clinical model for admission, treatment and rehab, ID and transition patients to be agreed in the future.		Prevention and reduction	Clinical Model Overview Group (LT)	12-15 months.	
Shared decision making						
28.	Patients' health and wellbeing care plan to be jointly agreed with patients and review at least monthly with any points of concern taken to clinical teams for action.	Workshop recommendation	Prevention and reduction	Nursing Practice development (CW)	6-9 months (medium term)	Review of existing HWP
29.	Refresh and promote current health education available to patients on weight gain following admission with support from clinical team on actioning.	PHE 21	Reduction	Dietetic (FW)	(Medium Term) 6-9 months	Existing information re review and update

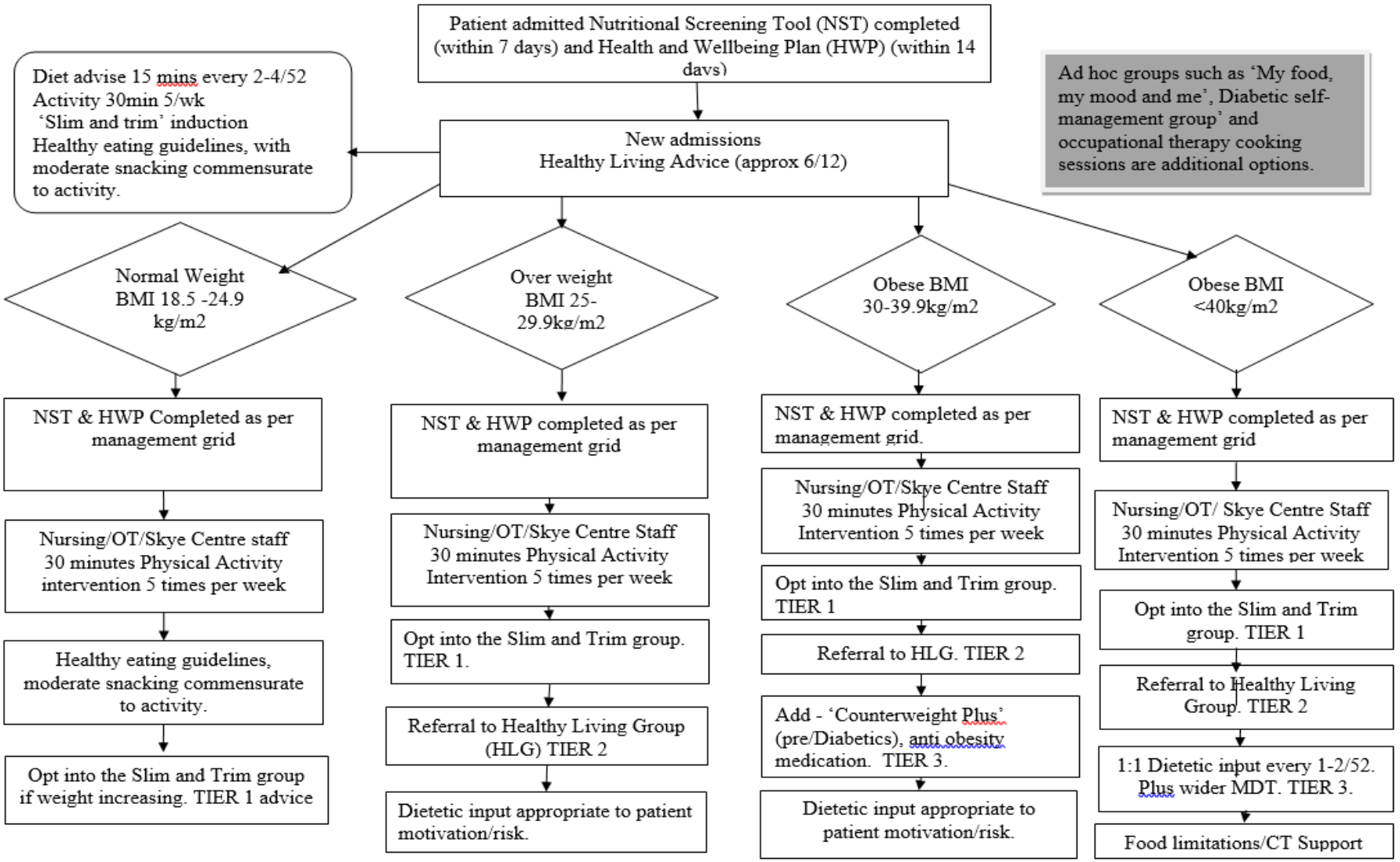
30.	Engage and communicate with relevant stakeholders, adopting a tailored approach to share information in an understandable format	Lady Dorian 2010 recommendations	n/a	Supporting Health Choices Team	(Medium Term) 6-9 months	

Dated: 9th June 2021

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	(i) Improve patient physical wellbeing (ii) Improve patients access to activity (iii) Reduce obesity rates (BMI) (iv) Duty of care to patients (v) Efficient/effective use of resources.
Workforce Implications	See 'recommendations'
Financial Implications	See 'recommendations'
Route To Board Which groups were involved in contributing to the paper and recommendations?	The Supporting Healthy Choices Short-Life Working Group The Senior Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	(i) Unable to resource (ii) Competing priorities (iii) Legal challenge (iv) Risks of not supporting recommendations
Assessment of Impact On Patient Experience	Reduce obesity, improve activity and exercise levels and improve physical wellbeing / life expectancy.
Equality Impact Assessment	EQIA completed at relevant stages of process so far and should continue

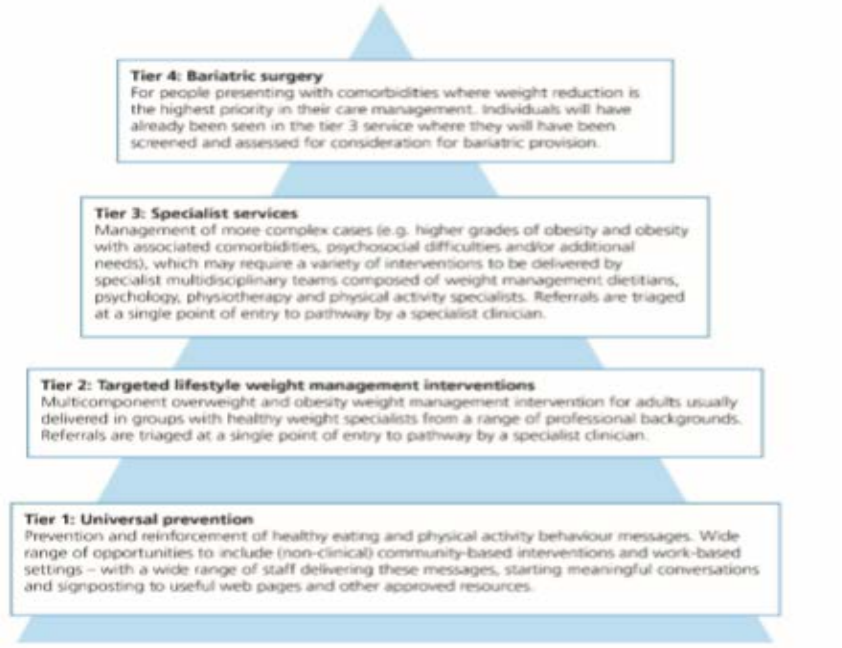
Appendix 1

Weight Management Pathway (WMP)



Appendix 2
Standards for the delivery of tier 2 and tier 3 weight management services for adults in Scotland

Figure 1: Tiered approach to prevention and management of overweight and obesity for adults

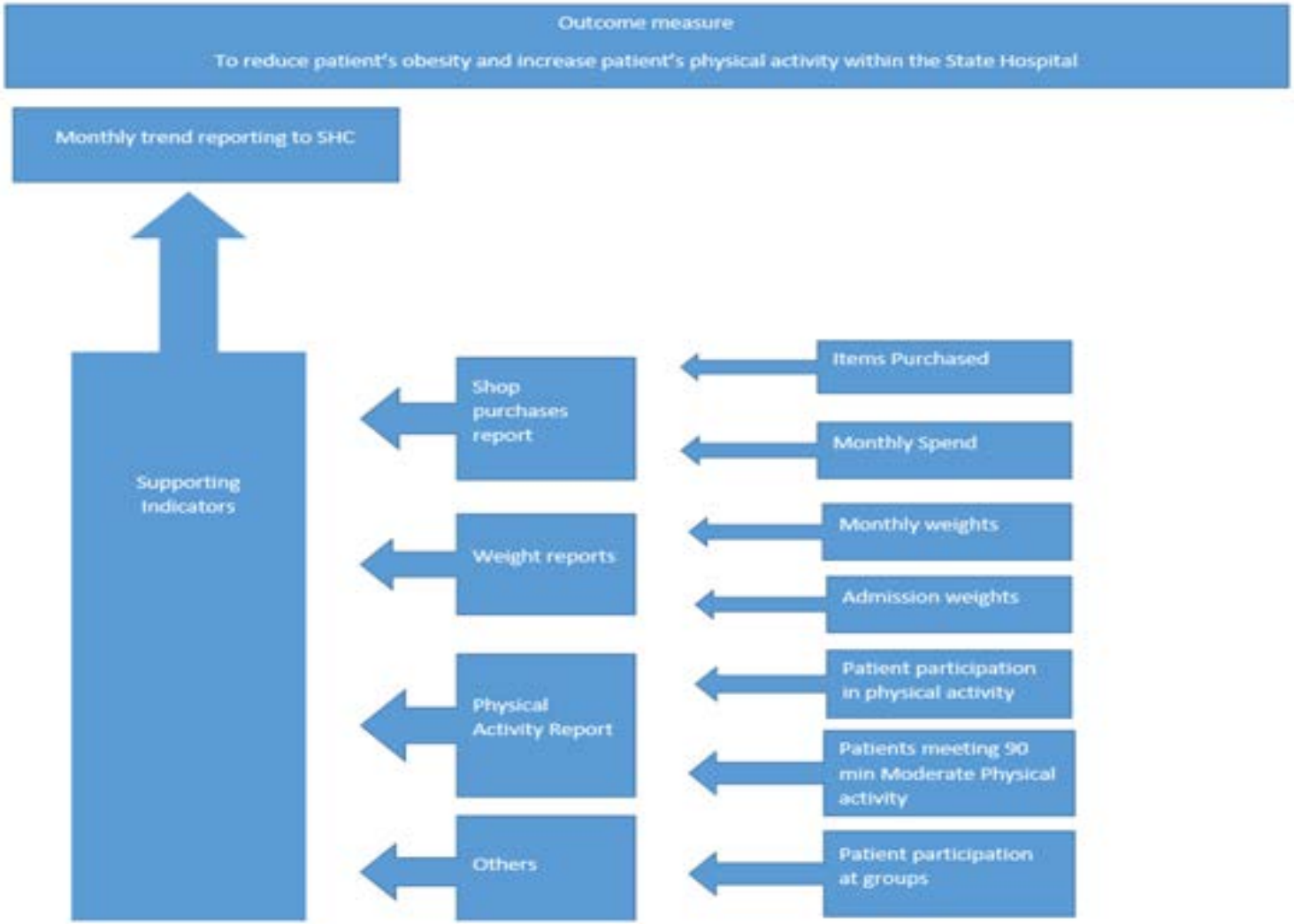


Source: Adapted from *The UK Obesity Care Pathway* (Department of Health, 2013)[20]

The standards are not intended to replace SIGN[31] and NICE[32, 33] guidance on obesity and weight management for adults. These guidance documents should be used to support the implementation and delivery of these standards.

The standards will be reviewed in light of emerging evidence and to reflect any significant changes in NICE, SIGN guidance, or other related national guidance.

Appendix 3 Outcome Measures



THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	Item No: 11
Sponsoring Director:	Medical Director
Author(s):	PA to Medical & Associate Medical Directors
Title of Report:	Approved Medical Practitioner Status
Purpose of Report	For Decision

1 SITUATION

Following the recruitment of 2 Forensic Psychiatry Specialty Doctors, it is necessary for the Board to consider the approval of their Approved Medical Practitioner status.

2 BACKGROUND

In order for the Forensic Psychiatry Specialty Doctors to perform their full role within the Hospital they require to be approved as an Approved Medical Practitioner (AMP).

3 ASSESSMENT

The Forensic Psychiatry Specialty Doctors have completed the pre-requisite Section 22 training in line with the Mental Health (Care and Treatment) (Scotland) Act 2003.

4 RECOMMENDATION

The Board is invited to agree the following recommendation:

The approval of Dr Molly Neville and Dr Gavin Third as Approved Medical Practitioners in line with the Mental Health (Care and Treatment) (Scotland) Act 2003 and that they are formally placed on the TSH Board's list of Approved Medical Practitioners.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To confirm board approval of Approved Medical Practitioner Status
Workforce Implications	As described to support care delivery
Financial Implications	None identified
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)	Required to support care delivery
Assessment of Impact on Stakeholder Experience	No specific implications to be noted.
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not required
Data Protection Impact Assessment (DPIA) See IG 16.	□ **There are no privacy implications.** X There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Paper No. 21/60

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 21
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support
	Clinical Effectiveness Team Leader
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

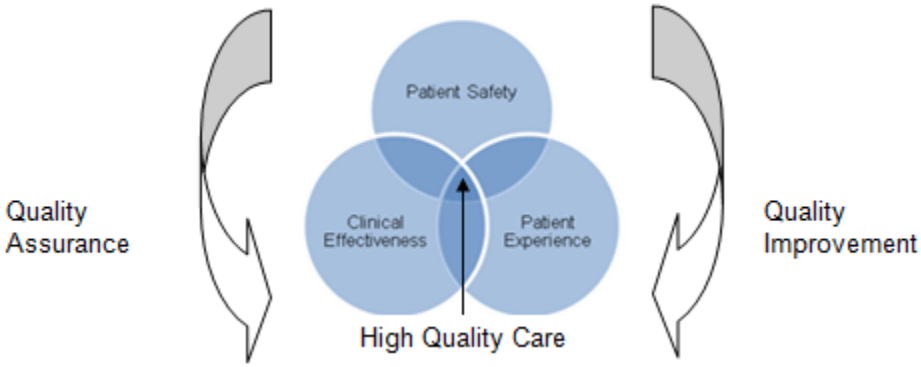
This report provides an update to The State Hospital Board on the progress made towards quality assurance and improvement activities since the last Board meeting in June 2021. The report highlights activities in relation to QA and QI and outlines how these relate to strategic planning and organisational 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

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 CED 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.

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 Audits that have been completed since the last Board Meeting in June are:

- Observation Policy Sub Heading Audit
- Record Keeping Audit (incorporating nurse progress notes for every shift, scanned documents and unvalidated entries)
- Post Physical Intervention Audit

Findings and actions from these included:

Observation Policy Sub Heading Audit
Areas showing improvement:

- For the 35 patients that were placed on Level 2 Observations, 80% of patients had evidence of review discussions taking place. If only the policy directives were audited there would be a negative gap in supporting evidence of 14%, this is a continued reduction in the negative gap of 58%, 23% and 19% in the previous audit periods.
- For the 7 patients on level 3 observations, 100% of patients had evidence found within the note types of review discussions taking place. This has been a maintained improvement remaining at 100% from the previous audit.
- For patients on level 3 observations reviewing only the Medical progress notes where the required note type was used, evidence could be found for 86% of patients that discussions were being held to review those levels. It should be noted that this is a continued improvement from 56%, 50% and 14% in previous audit periods.

Areas requiring further improvements:

- There were 7 (20%) patients on Level 2 increased observation levels where evidence could not be found of observation level review discussions having taken place.
- For the 7 patients on level 3 observations Nursing progress notes were reviewed to find evidence that observation level review discussions had taken place between nursing and medical staff. Evidence was found on 57% of occasions, this is a reduction from 89% in the previous audit period. This shows a rise in the negative gap in data to 29%, this is an increase in gap from 11% in the previous audit.
- For the 5 patients who had been on Level 3 observations for longer than 28 days, 3 (60%) had a minimum of 1 Appendix 4 form available within RiO. This is a reduction from 71% in the previous audit.

Record Keeping

- 100% of patients had a nursing progress entry made on day shift and backshift. 89% had a nursing progress entry made on night shift. On further investigation this was due to email addresses being incorrect in RiO and therefore the automated emails were not being sent. A piece of work has been completed to ensure all email addresses are accurate.
- An issue was highlighted when we looked to ensure that all scanned documents in a patients RiO file pertained to them. Six patients had forms that were not theirs. On further investigation these were all OFT forms. A new process had been implemented that we should rectify this going forward. A further spot check will take place to ensure the change has resulted in an improvement.
- There was an increase in the number of unvalidated entries on RiO. This issue tied in with the incorrect email addresses that have now been rectified. A further spot check will take place to ensure the change has resulted in an improvement.

Post Physical Intervention Audit

Areas showing improvement

- On 7 (87%) occasions there were Post Physical Intervention Assessment (PPIA) forms completed by Senior Clinical Cover on RiO. Of the 7 completed PPIA forms all (100%) had been closed off in RiO
- For the 8 occasions on Datix where physical interventions took place there were 2 (25%) occasions where injuries were recorded, both (100%) of which had a corresponding PPIA form completed

Areas requiring further improvements

- The information on the Post Physical Intervention Assessment Form and Datix should always correspond.
- For all incidents where the patient is taken to the floor, physical observations should be recorded (with a minimum of consciousness level being recorded if the patient is too highly aroused to take BP/pulse/respirations/ temperature) using the NEWS – changes will be made to the Datix form and RiO to make this clear to staff when they are completing the form.
- Posters have been distributed to all wards to all wards to highlight the areas in need of improvement.

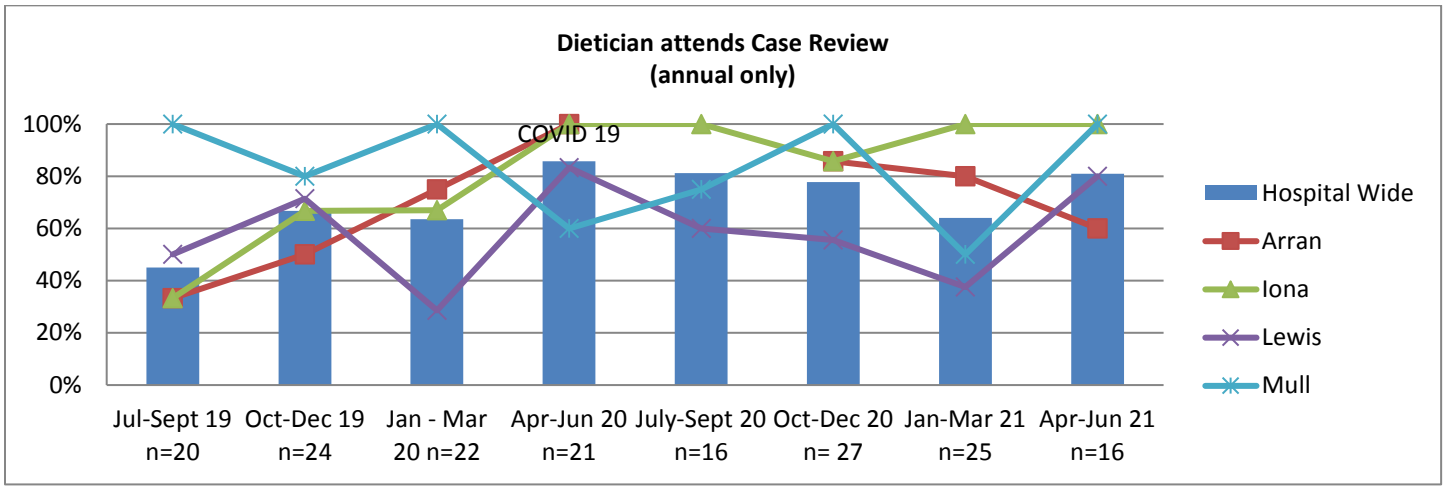
Audits currently underway, or due to commence include IM Haloperidol, PRN Medication, T2/T3 and Physical Equipment.

Variance Analysis Tool Quarterly Report

The quarterly data covering the period 1st April – 30th June was analysed and reported back to Heads of Services.

Areas of good practice included

- Nursing completion of the VAT and carrying out of interventions continues to be good.
- Patient attendance increased from 61% to 76%.
- Medical VAT form completion further increased from 91% to 96%.
- There was further improvement in all Occupational Therapy interventions.
- There was improvement in the Skye Activity Centre report being provided
- There was improvement in Pharmacy attendance.
- Social Work interventions continue to be well completed.
- Dietetic attendance increased from 64% to 81%



Areas for improvement included

- Medical – The PANSS assessment was re-instated in May but completion of the assessment still remains low decreasing from 38% in Q1 to 26% in Q2. No PANSS were carried out on Iona or Lewis during the quarter.
- Medical completion of the Physical Health Summary in the Medical CPA report has decreased from 88% to 80%. CED to investigate further as this may be a definition issue.

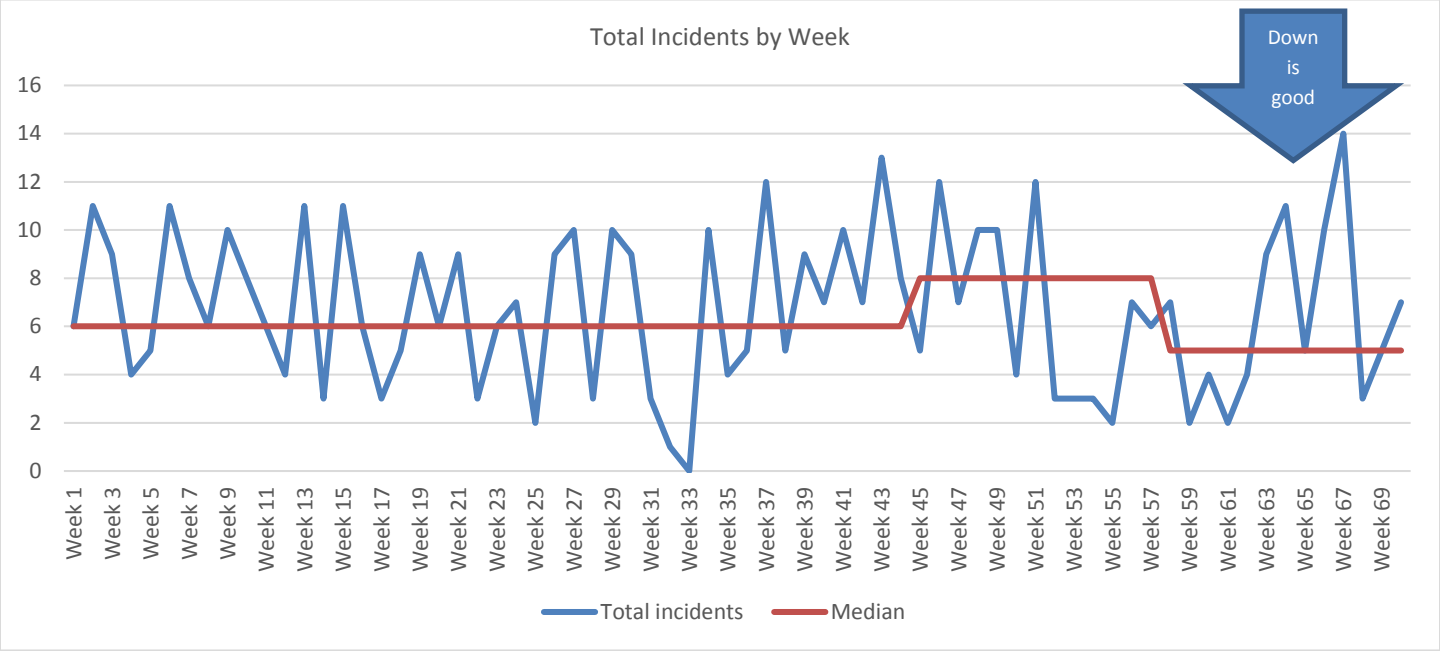
- Nursing - Key Worker/Associate Worker attendance increased slightly from 65% to 69% but still below the 80% LDP target.
- Psychology – Psychology completion remained at 81% - Arran was 97% and Mull 100% however Iona was at 64% and Lewis 72%. It should be noted that Iona had staffing issues during the quarter

Daily and Weekly Indicator Reports

Clinical Effectiveness 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. The full report can be provided on request:

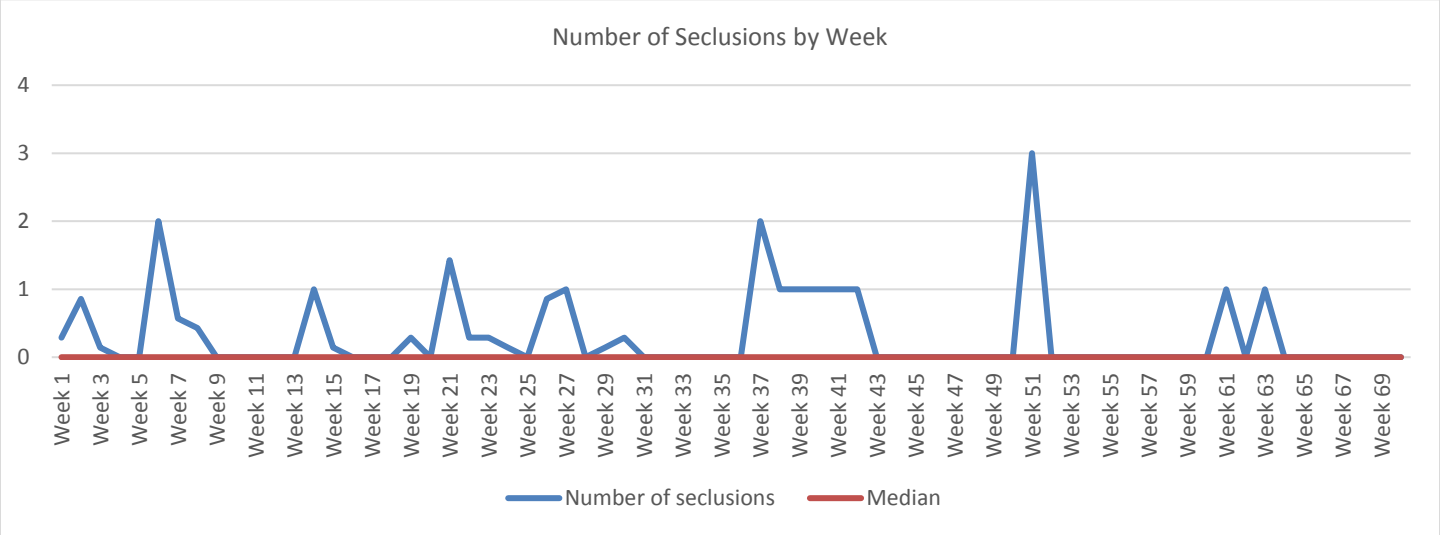
Datix assaults, attempted assaults and behaviour

As can be seen in the graph below, we have seen one positive shift and one negative shift in the data since data collection commenced. A negative shift was seen between week 39 and 44 (22nd December and 1st February) with the median moving from 6 to 8, and then a positive shift between week 51 and 57 (26th March and 6th May) with the median moving from 8 to 5. Since then we have seen random variation. There was a peak at week 67 with 4 incidents: 1 attempted assault; 11 behaviour and 2 self harm.



Seclusions

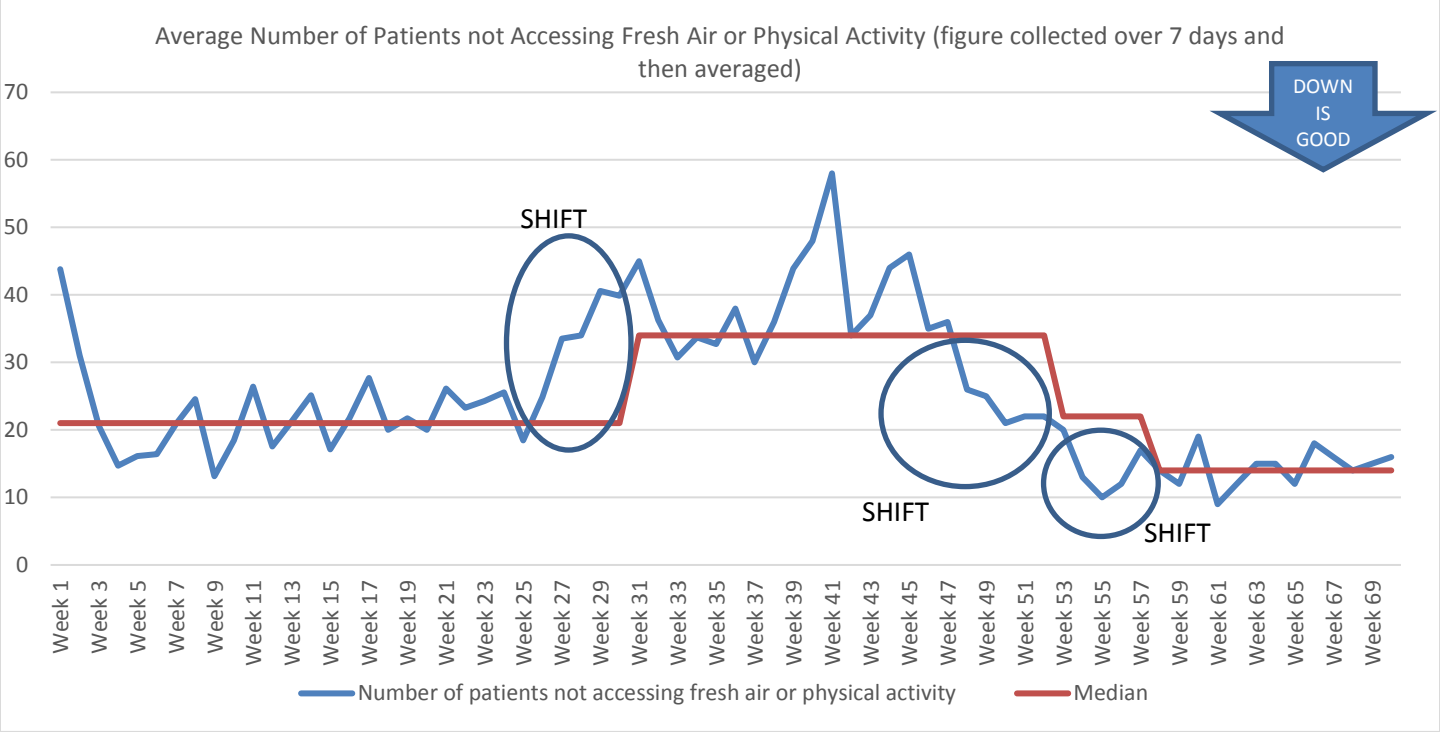
As can be seen the seclusion data continues with random variation. There have been no seclusions since week 64 (18th – 24th June)



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

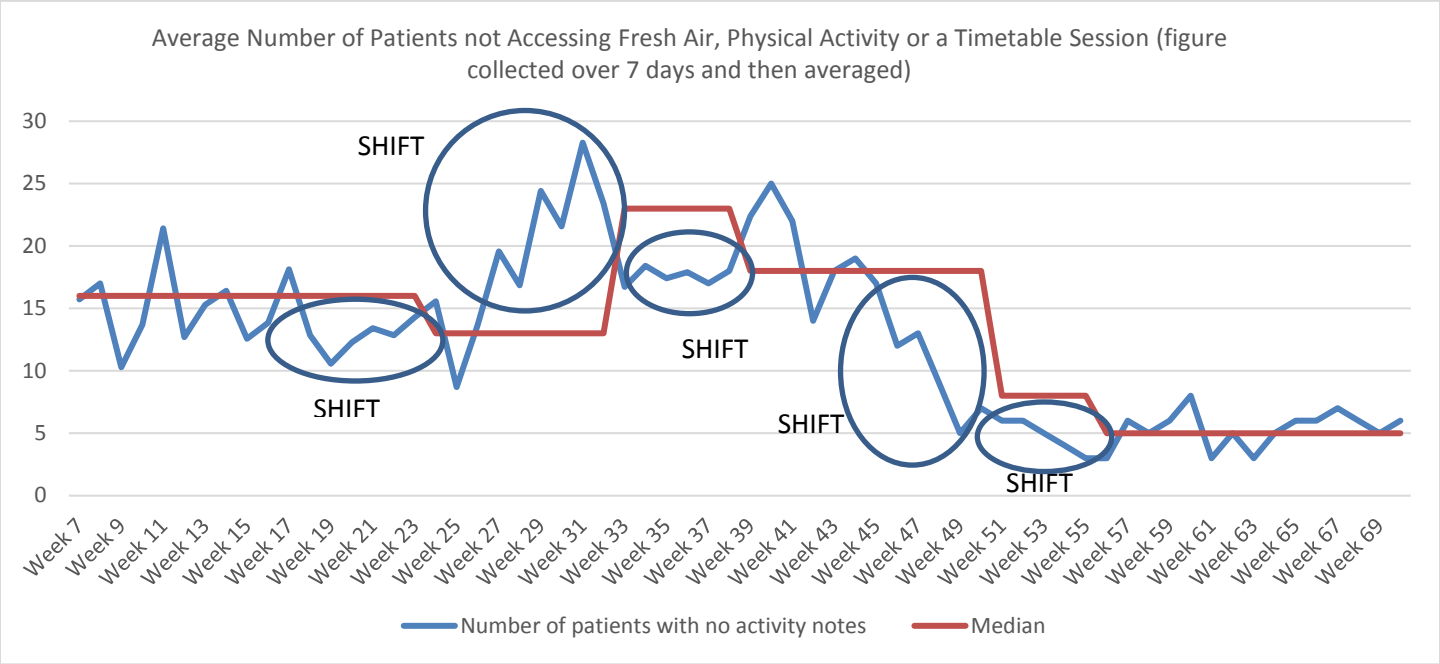
This indicator looks at both the fresh air data from PMTS and timetables and the physical activity data from RiO and highlights the patients that have had no fresh air or physical activity.

As can be seen we have seen one negative shift in the data between week 26 and 31 (22nd September and 2nd November) and 2 positive shifts in the data between week 48 and 53 (26th February and 8th April) and week 53 and 58 (8th April and 13th May). The first positive shift moved the median from 34 to 22 and the second moved it from 22 to 14. This links with the improved weather we have seen since mid-April. We have seen random variation since week 58.



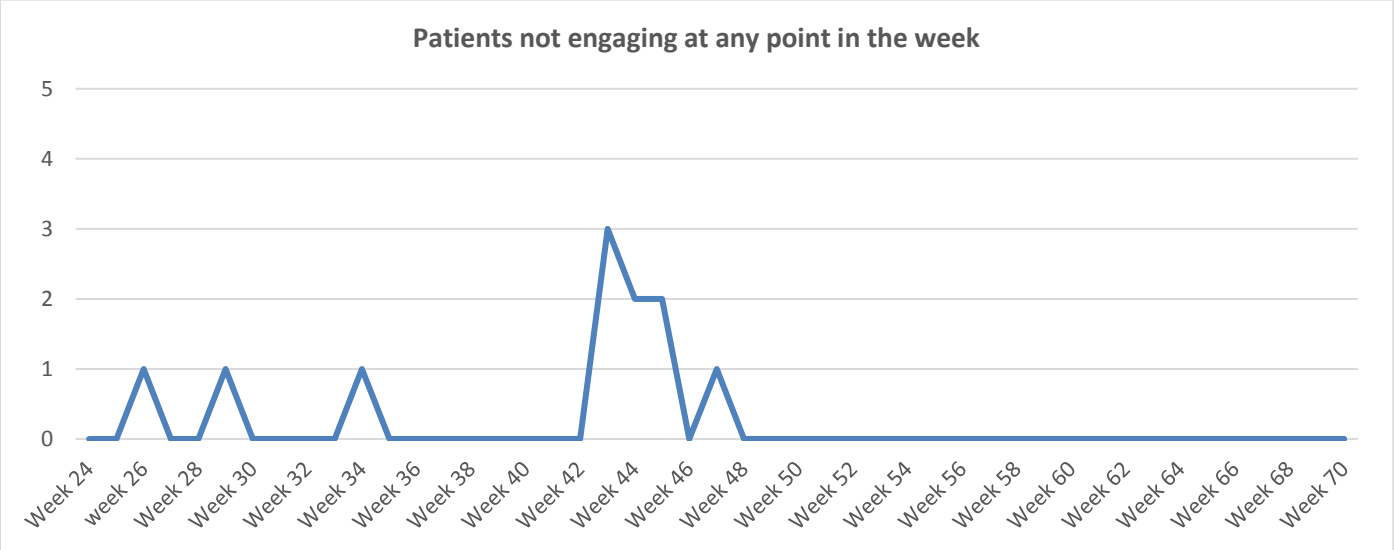
Patients not engaging with fresh air, physical activity or timetable sessions (this is an average daily figure)

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. From week 7, 12th May we started to monitor this. As can be seen, since then we have had 4 positive shifts and one negative shift. The first positive shift came between weeks 17 and 23 (21st July and 7th September); the second between weeks 32 and 38 (3rd November and 21st December) and the third between weeks 43 and 50 (19th January and 18th March) and the fourth between week 51 and 56 (18th March and 29th April). The one negative shift came between weeks 26 and 32 (22nd September and 9th November). Since week 56 we have seen random variation in the data.



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 all patients have engaged with some form of activity at some point in the week since week 48 (26th February – 4th March).



QUALITY IMPROVEMENT

Quality Forum

The Quality Forum meets regularly to champion and lead the quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The Quality Forum continues to support and embed QI approaches to innovation and learning using the model for improvement as a guiding approach. Communication and awareness raising are significant areas of activity for the Quality Forum with recent QI update information being shared across TSH.

Quality Improvement Capacity Building

Developing capacity and capability for individuals and teams across TSH has been a focus of activity for the Quality Forum. National training is available through NHS Education for Scotland (NES), specifically the Scottish Improvement Leaders Programme (ScIL) and Scottish Coaching and Leading for Improvement (SCLIP) training which are particularly useful within TSH. The Quality Forum has engage with these national programmes and support TSH applicants as they progress through the development opportunities.

TSH QI Forum member has been invited to be part of faculty development with the NES Quality Improvement Team. . Specifically, they will be part of the faculty of the Scottish Coaching and Leading for Improvement Programme (SCLIP) Cohort 26, which is likely to commence in Autumn 2021. This opportunity has been put in place to develop links between NHS Boards and NES QI leads.

Scottish Coaching and Leading for Improvement (SCLIP) training recruited to three cohorts in 2020, seven TSH staff were successful with their applications and have completed the programme. From these, six are Senior Charge Nurses and 1 Practice Education Facilitator. The Quality Forum are linking in with these staff and supporting spread and sharing of learning from projects. Recruitment for SCLIP cohorts in 2021/22 has taken place, with 2 TSH staff gaining places

The Scottish Improvement Leaders Programme (ScIL) programme has commenced following a delay due to Covid 19. TSH has 3 staff working thorugh this programme, again the Quality Forum are connecting with participants as they develop their projects. QI Café restarted in May and are being held monthly. TSH were selected to display a poster in the NHS virtual event in June 2021 with the winning team from TSH3030 project in 2019, Lewis 1 Striders describing their project, including ongoing development.

The Quality Forum are currently developing a database of all QI projects across the hospital to enable support and connection as these progress. Table 1 below highlights a range of QI projects that are currently in development across TSH.

TABLE 1 TSH QI PROJECTS

Project Name	Project Description	Lead	Course / Programme Related	Timescales
Tableau Dashboard Use	QI project to support frontline staff to utilise these dashboards for to enhance and devlop data driven decision making	Barry Hill	ScIL	Ongoing
Clinical Audit Results	Improve the communication of audit results to clinical staff.	Sheila Smith	ScIL	Ongoing
Improving Observation Practice	Changing the current policy and developing into engagement.	Josephine Clark	ScIL	Implementation end of 2021.
7 Day Activity	Supporting weekend activity.	Alexandra MacLean	ScLIP	Ongoing
Team Working	Improving teamwork within Lewis Hub.	Linda Reid	ScLIP	Ongoing

Physical Activity Redesign	Creating a patient centred approach to activity.	Brian Paterson Lindsay Tulloch	ScLIP	Ongoing
Staff Transition	Transitioning staff into supervisors.	Marlene Irvine	ScLIP	Ongoing
Striders	Utilising the previous Lewis 3 TSH3030 project hospital wide	Lorna Lawrence	TSH3030	March – July 2021.
CPA Review	Reviewing the process for CPA's.	MHPSG		Ongoing
Grounds Access Process	Looking to utilise QI tools for embedding a form on RiO.	Kelly Watson		Informal discussions taking place currently.
Records Management Project	Use the new national Data Protection toolkit and QI tools for implementation.	Karen Mowbray		Early stages of development.

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

An awareness raising session for all staff on the principles of Realistic Medicine. was delivered by the Clinical Lead through the Seminar Series in May. This was well attended with over 30 participants taking part. Recruitment of a 0.2 WTE Programme Manager to support TSH to continue to embed RM together providing support to Scottish Patient Safety is complete. Collaboration across the wider Forensic Network on Realistic Medicine principles has progressed. Planning is currently underway to host a workshop to be delivered with RM leads.

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 Standards and Guidelines Co-ordinator. During the period 25 May to 31 July 2021, 43 guidance documents have been reviewed. Twelve were recorded for information and awareness purposes and 1 required completion of an Evaluation Matrix – this was for the Scottish Governments Diabetes Framework.

TABLE 2 EVIDENCE REVIEWS

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Mental Welfare Commission (MWC)	8	8	0
Scottish Government	1	0	1
Healthcare Improvement Scotland (HIS)	1	1	0
National Institute for Health & Care Excellence (NICE)	32	2	0
Scottish Public Services Ombudsman (SPSO)	1	1	0

As at the date of this report, there are currently 8 evaluation matrices awaiting 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 ongoing with both. The Osteoporosis guidelines required input from the GP which has proven difficult to access. This guideline is currently under review by the new Practice Nurse. 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 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. The remaining guidelines relating to anaphylaxis, pressure ulcers, diabetes and Rights, Risks and Limits to Freedom have all had gap analyses completed and are awaiting review and sign off by their respective steering groups during August 2021.

TABLE 3 GAP ANALYSIS 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
SIGN	UPDATED: Management of Osteoporosis and the prevention of fragility fractures	PHSG	Currently under review by Practice Nurse	June 2020
NICE	Anaphylaxis: Assessment and referral after emergency treatment	PHSG	Gap analysis completed with 100% compliance achieved. Due to cancelled meetings document will be taken to August PHSG for sign off.	September 2020
HIS	Prevention and management of pressure ulcers	PHSG	Gap analysis completed with 44% compliance achieved. Due to cancelled meetings document will be taken to August PHSG for sign off with outstanding recommendations to be added to Action Plan.	October 2020

PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Awaiting next SHC meeting in order to take document forward.	February 2021
MWC	Rights, risks and limits to freedom	Patient Safety	Gap analysis completed with 92% compliance achieved. Document will be taken to August Patient Safety meeting for sign off with outstanding recommendations to be added to Action Plan.	March 2021
Scottish Government	Diabetes Framework	PHSG	Gap analysis completed with 63% compliance achieved. Due to cancelled meetings document will be taken to August PHSG for sign off with outstanding recommendations to be added to Action Plan.	April 2021

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 6 May 2021 at 9.45am
via MS Teams CG(M)21/02

CHAIR:

Non Executive Director	Cathy Fallon

PRESENT:

Non Executive Director	David McConnell
Non Executive Director	Brian Moore

IN ATTENDANCE:

Senior Nurse – Infection Control	Karen Burnett (Part)
Learning & Development Manager	Sandra Dunlop (Part)
Chief Executive	Gary Jenkins
PA to Medical & Associate Medical Directors	Jacqueline McDade
Patient Learning Manager	Julie McDonald (Part)
Director of Finance and eHealth	Robin McNaught
Head of HR	Linda McWilliams (Part)
Head of Corporate Planning and Business Support	Monica Merson
Board Secretary	Margaret Smith
Clinical Effectiveness Team Leader	Sheila Smith
Core Trainee	Kay Sunderland
Medical Director	Lindsay Thomson
Lead Pharmacist	Morag Wright (Part)

1 APOLOGIES AND INTRODUCTORY REMARKS

Cathy Fallon welcomed those present to the meeting. Apologies for absence were noted from Stuart Currie and Mark Richards.

It was noted that agenda item 6: Infection Control Annual Report would be taken later in the agenda.

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 FEBRUARY 2021

The Minutes of the previous meeting held on 11 February 2021 were amended on page 7, third last paragraph, to remove the second sentence. The minutes were subsequently approved as an accurate record.

4 PROGRESS ON ACTION NOTES

Safe Staffing

Gary Jenkins advised that the Staff Governance Committee meets on 20 May 2021 and will agree the position on alignment on who governs safe staffing; the report will come to Clinical Governance for information. Gary Jenkins will bring an SBAR to the next committee to close the action off.

Action: Gary Jenkins

Learning from Complaints
Margaret Smith advised that a note should be added to the action list that there was a slight misalignment of figures within the report that has now been aligned within the table.

Outstanding Actions from 2019 and 2020
Lindsay Thomson advised that the two outstanding actions that were on hold due to Covid-19 can be removed from the action list as these will be picked back up via the workplan.

Action: Jacqueline McDade

5 MATTERS ARISING

Covid Audit Compliance
Discussed as part of Infection Control Annual Report later on the agenda.

Sandra Dunlop and Julie McDonald joined the meeting at this time

6 INFECTION CONTROL COMMITTEE ANNUAL REPORT

The Committee agreed to take this report later on in the meeting.

7 PATIENT LEARNING 12 MONTHLY REPORT

The Committee received and noted that Patient Learning Service Annual Report which highlighted activity levels and key achievements for the period January to December 2020; the report was summarised by Sandra Dunlop, Learning and Development Manager.

Patient learning activities were significantly impacted during the 12 month reporting period due to a number of factors, including re-prioritisation, redeployment of staff and closure of the Skye Centre and Patient Learning Centre. Despite these challenges, a significant number of activities continued, including:

- Core skill screening is used to identify literacy and numeracy levels and is accredited by the SQA. During 2020 a total of 38 patients were invited to take part in the core skills screening process. During lockdown, this was delivered by outreach within the wards by patient learning staff.
- When open, the PLC is able to deliver 6 vocational programmes, covering 24 vocational qualifications in a number of areas, including creative arts, food hygiene and sports leader
- Bikeability cycling proficiency programme; 18 patients completed the programme and received a certificate
- Patients engaged with a reading group at the beginning of 2020; the group will recommence once group learning can start again.
- Introduction of City Phonics Course which is a literacy programme for people with low level literacy skills; the programme is delivered collaboratively with Allied Health Professional colleagues.
- KPIs on page 14 of the report shows comparison with previous years that patients are engaging in formal or accredited learning
- SQA accreditation for volunteer skills award achieved; this will be delivered when things move back to normal
- Work ongoing with e-Health to progress digital improvement project to enable delivery of more learning at ward and hub based level

David McConnell asked what might be done differently if we ran into the same delivery issues again later in the year or next year. Sandra Dunlop replied that the main focus of the digital improvement project is the roll out of a patient network, which is currently limited to the Patient Learning Centre and will be rolled out to the Skye Centre and hubs to provide access at ward level

and they are seeking to introduce some mobile devices, such as tablets, to increase access to learning options and support; they could also encourage patients to look at open university courses which they cannot do due to limitations of digital inclusion.

Julie McDonald advised that all staff who deliver learning were redeployed to do other duties so maybe we need to look at prioritising availability of technology for them to continue delivering learning.

Brian Moore asked what support is available and how often for patients who do not have English as a first language. Julie McDonald replied that, at the moment, there is only one patient who requires support and there is a requirement for staff to have training to help tutor the patient; patient learning and AHP staff have been identified to attend training. Sandra Dunlop added that the Librarian sources information for patients in different languages.

Cathy Fallon thanked Sandra Dunlop and Julie McDonald for their comprehensive report, which was noted by the Committee.

Sandra Dunlop and Julie McDonald left the meeting at this time
Jamie Pitcairn joined the meeting

8 RESEARCH COMMITTEE 12 MONTHLY REPORT

The Committee **received** and **noted** the Research Committee 12 monthly report, summarised by Jamie Pitcairn, Research and Development Manager.

Jamie Pitcairn advised that the main positive within the reporting period is the Forensic Network Conference which was run using a remote online format for the first time and which attracted a similar level of attendance to the face to face conference. Feedback from participants has been positive and plans are already being put in place for the next conference to be run in the same format on 4 November 2021.

The Research and Clinical Effectiveness Conference has been postponed for the second year and work is ongoing to define what format the conference will take when it returns. Prior to the pandemic, there was falling attendance, particularly from external delegates, and there are plans to reinvigorate the conference and provide this in an alternative format to support the needs of staff.

Research activity has resumed following Covid restrictions with a clear plan as to how methods of study will change to encompass Covid. A number of studies have been undertaken successfully using remote contact methods.

A research portfolio workshop took place on 29 April 2021 to reassess the priority area of research and address how we get better traction in relation to patient involvement at an early stage.

There are links to the Barron review in the role out of the use of the database across the wider Forensic Network which will support aspects of the Barron report in supporting consistent collection and use of data. The wider Research Portfolio review will also aim to address the research related recommendations contained within the report.

Jamie Pitcairn is monitoring the work of the Scottish Governments Coronavirus (Covid-19) Mental Health Research Advisory Group which is developing plans and large scale studies to shape the Scottish Mental Health research agenda.

Brian Moore asked if there is access to external funding or collaborative working with Universities for research. Jamie Pitcairn replied that we do not access external funds through commercial research due to ethical issues and that participating in long term trials requires a high number of patient participants to reach power required for that study. There have been occasions when we

have applied to a number of external funds to support research; an example of this is the wristband study which looks at predicting aggressive behaviour which went to a number of funding bodies to support the expansion of the study.

Lindsay Thomson advised that there are 3 members of staff who have significant roles within Universities and that all will have research funding available from other sources, for example the medical research council, who can provide large or small sums of money. Lindsay Thomson informed the Committee that she is working on a tender on mental health prevalence in prisons which will be taken through the University. Research formally moved under Lindsay Thomson's portfolio on 1 April 2021 and there is a focus on how we might improve what we do using the funding we have and how to grow that funding.

David McConnell asked if there was a planned mechanism and workstream for addressing areas that came out of the Barron Review. Jamie Pitcairn replied that the Forensic Network held a workshop which David Barron attended along with forensic clinical and non-clinical staff to prioritise the recommendations within the report; there was also the development of the State Hospital research strategy, which will soon be due for renewal. Lindsay Thomson advised that the Forensic Network has agreed 10 action areas based on the Barron report; one is on research and the School of Forensic Mental Health, regardless of the Ministers final decision as the importance of research and education is identified within the report. If it continues as a network or if we become one board, this will give us added scale for power research studies to allow for more meaningful research.

Cathy Fallon asked for clarity around the budget and wished to check there was no double counting of spend. Jamie Pitcairn advised that £19,000 has been spent to date from the commitment of £31,000.

The Committee noted and approved the Research Annual Report.

Jamie Pitcairn left the meeting at this time
Morag Wright joined the meeting

9 MEDICINES COMMITTEE 9 MONTHLY REPORT

The Committee **received** and **noted** the Medicines Committee 9 monthly report, presented by Morag Wright, Lead Pharmacist.

During the reporting period, the Committee focused on 3 main areas: Medicines Management, Clinical Effectiveness and Safe Use of Medicines.

Key activities over the last 9 months around medicines include:

Contributing to the Covid-19 vaccination programme - planning commenced in November 2020, with the Hospital receiving both Pfizer and Astra-Zeneca vaccines; supplies came from National Procurement. The Medicines Committee approved the Patient Group Directions to allow trained vaccinators to give vaccines to staff and patients.

Safe Use of Medicines Policy and Procedures update - this has been approved and is on the intranet.

Maintaining medicine supply processes to the wards during Covid-19 - the planning and arrangements to date have resulted in no major medicine supply issues. Monitoring procedures of stock levels are now robust and shared nationally. The hospital now receives weekly notification of low medicine lines.

Falsified Medicines Directive - Implementation of the EU Falsified Medicines Directive to ensure all medicines received into the hospital are bar code validated is no longer necessary following the

UK Exit from EU from 1 January 2021. Morag Wight was seeking approval of the Clinical Governance Committee to have this removed from the TSH Corporate Risk Register. The UK Medicines and Healthcare products Regulatory Agency (MHRA) may review position in future.

Electronic Prescribing – there has been a delay to the implementation of electronic prescribing and this is now rolling into the start of 2022.

Ensuring all patients continue to have a regular review of their mental health and physical health medicines – no concerns of ward medication wastage. Expenditure is still producing savings.

Medication Incident Review Group – the group meet monthly. Frequent incidents being looked at are tablets being found and the focus at the moment is to look at the observation nurse at administration times. Practice Development are involved in taking this forward at induction and through training.

Audit work – continues with 5 local audits reported with no particular concerns. Many are undertaken for QA purposes but if there are any gaps there are action plans for these.

Use of Valporate – a report will go to the Medicines Committee in due course.

Planned activity – a QI project will be taken forward around medicine supply and products from St John's Pharmacy as part of the review of the SLA. This will be added to the report to the Clinical Governance Committee.

Brian Moore asked if there was any learning from the medication incidents as Lewis had 8 incidents. Morag Wright advised that there were no specific concerns with regards to that area.

Lindsay Thomson thanked Morag Wright and her colleagues in Pharmacy and the Medicines Committee as this is an area where there is potential to do serious harm if we get it wrong in prescribing or cannot access what we need. Morag and her team were also thanked for; the continuation of audits throughout Covid-19; the contribution with the vaccination programme and helping with clinical support practice with the establishment of the medical ward and the supply of oxygen. It was acknowledged that Morag Wright was central to much of that work and always comes in on budget.

Cathy Fallon echoed the positive comments made. She asked where we stand in relation to the medicines budget. Morag Wright advised that delivery is through a service level agreement that pharmacy provide, and the medicines budget is comparable with other mental health areas, and very small compared to acute areas.

Gary Jenkins stated that the State Hospital participate in the PoMH audit which gives comparisons on prescribing practice and we always look very good in relation to that.

The committee noted the report and approved the removal of the falsified medicines directive from the risk register.

Morag Wright left the meeting at this time

10 PATIENT MOVEMENT REPORT

The Committee **received** and **noted** the Patient Movement Report, presented by Lindsay Thomson, Medical Director.

There were 25 admissions over the past 6 months and 24 discharges. All of the patients were admitted within the 6 weeks' time limit between referral and admission, except for one which was

due to a court date.

There were three admissions under the exceptional circumstances category.

As at 31 March 2021 we had 114 patients within the hospital; as of today we have 112.

There are 8 patients on the transfer as fully assessed and accepted for transfer; this includes 4 exceptional circumstances patients.

Brian Moore made reference to the 14 ID patients and asked if there is often an occurrence where they are relocated in other wards. He also stated that there are a lot of referrals and admissions from Greater Glasgow and Clyde and asked if this is a recurring issue.

Lindsay Thomson advised that we are slightly over our numbers for patients with ID by two and this is kept under close control. The issue with Greater Glasgow and Clyde, and in particular Rowanbank, is due to bed pressures and this is monitored through the Network Inter Regional Group.

The Committee noted the report.

Linda McWilliams joined the meeting

11 FITNESS TO PRACTICE

The Committee **received** and **noted** the Fitness to Practice Report, presented by Linda McWilliams, Head of HR.

Registration checks for all staff groups that require professional registration are undertaken by the Human Resources Department via national online systems administered by the relevant registration bodies. Checks include pre-employment checks and registration renewal checks.

It is the individual staff member's responsibility to maintain and renew their professional registration in accordance with the requirements of their professional body.

Any registration issues identified by the Human Resources Department are reported to the respective member of staff and their line manager who should ensure that action is taken as necessary to renew the professional registration as soon as possible.

NMC registration and revalidation checks
Annual registrations and 3-yearly revalidation for all registered nurses are checked with the NMC online. An online check is carried out in the middle of each month to ascertain the status of any registration renewals or revalidations that are due by the end of that month. If a member of staff has not yet renewed their registration or revalidated, a reminder letter is sent to both the individual and their line manager.

In the event that the NMC registration is not renewed, or the individual fails to revalidate by the date due, the staff member is no longer authorised to practice. In such circumstances, staff contracts are varied and they are employed as Band 3 Nursing Assistants until they are reinstated on the NMC register.

During 2020/21, there were no lapses in registration. This is a decrease of 2 compared to the previous year.

GMC registration checks
Registrations for all Consultant Psychiatrists, Specialty Doctors and Junior Doctors are checked with the GMC online at commencement of their employment at The State Hospital, and on a monthly

basis thereafter. Should any issues be highlighted the Medical Director/Associate Medical Director would be notified immediately with a follow up letter issued to the Doctor, and a copy sent to their line manager. During 2020/21 there were no occasions when this process had to be followed.

HCPC registration checks
Checks are made on a monthly basis for all members of staff with HCPC registration. As with the other staff groups, a letter would be issued to the member of staff and copied to their line manager if any issues were highlighted. During 2020/21 there were no occasions when this process had to be followed.

Additional registration checks
Staff groups that require professional registration who work in the hospital through a Service Level Agreement (i.e. Pharmacy and Social Work) are also subject to an annual fitness to practice check through the Hospital's Human Resources Department. During 2020/21 there were no registration/fitness to practice issues identified in relation to this group.

The Committee noted the report.

Linda McWilliams left the meeting at this time

12 COVID-19 REPORT AND OPERATING MODEL MONITORING GROUP ANNUAL REPORT

Members **received** and **noted** a paper on the COVID-19 situation presented by Lindsay Thomson, Medical Director, which covers all aspects of the clinical response, together with the annual report from the Operating Model Monitoring Group.

Lindsay Thomson provided an update of the work undertaken since the last meeting around Covid-19.

Incident Command Structure
The Incident Command Structure was re-established on 30/1/21 following a further outbreak and stood down again on 15 February 2021.

TSH Route Map
The route map takes us through what we did in terms of managing the outbreak. Tables 1 and 2 provide the rationale for us moving on and the timetable for doing that. On 19 April we moved to full mixing of wards of 12 people with no physical distancing and the Skye Centre re-opening. This reflected the national route map. Further timescales for the easing of restrictions can be seen in the paper.

Vaccinations
Approximately 90% of staff have had 2 vaccinations and 90% of patients have at least one vaccination.

Test and Protect
We continue to work with test and protect when we have outbreaks and have a line of direct communication.

Number of Patients Tested Positive
14 patients tested positive with Covid; 8 during the first outbreak and 6 in the second.

Patient Flow
Referrals of patients continue to be accepted. There have been 13 admissions over the period of 1 February 2021 – 31 March 2021. There have also been 3 discharges during this period.

Shielding

Shielding was paused by Scottish Government on 26 April 2021. Shielding affected 2 patients and 13 members of staff; all bar one has now returned.

Interim Clinical and Support Services Operational Policy
The Interim Clinical and Support Services Operational Policy has been subject to regular review, based on feedback from patients and staff, and also to ensure as least a restrictive care approach as possible in the face of physical distancing requirements. To date, there have been eighteen iterations of the Policy. The most recent policy (version 21) was implemented on 19 April 2021. This included the re-introduction of single ward households; an update to visiting guidance; an update on mealtimes guidance and updated room search responsibilities.

TSH Covid-19 Clinical Care Support Documentation
This document was fully updated to Version 4 on 21 April 2021 following publication of NICE Guideline: COVID-19 rapid guideline: managing COVID-19 and the decision to close the medical ward.

General Medical Ward
The TSH COVID-19 ward was stood down on 31 March 2021. It can be reinstated if required. It would be used for patients who are COVID positive and physically unwell. It has never been required and modelling shows no shortage of general medical or ITU beds.

Personal Protective Equipment
Retesting of fit masks is currently ongoing due to supply and design changes.

Visiting
Personal visiting recommenced on 26/4/21 and visitors are invited to carry out a lateral flow test. Professional visiting will recommence on 17/5/21 again utilising LFTs.

Scientific & Technical Advisory Group (STAG)
STAG continues to meet on a weekly basis and have been instrumental in pushing forward timescales.

Lateral Flow Testing
Currently 22% of expected test results are being recorded weekly on the national portal. This is similar to or slightly lower than other NHS Board areas. Use of LFTs continues to be actively promoted but is voluntary. There is an issue with the recording of results on the national portal; more staff may be using the test but are unable to record results.

David McConnell advised that this is a national issue and our position is no different to other boards; this is being looked at by the Scottish Government and Board Chairs and Chief Executives across the country.

Operating Model Monitoring Group Annual Report
Lindsay Thomson advised that the Operating Model Monitoring Group (OMMG) was established as a result of Covid-19 to ensure models put in place were safe for our patients. The report gives an overview of the data collected and monitored via the OMMG initially on a weekly basis, but now fortnightly. The model has changed over time in response to outbreaks. Where data exists, Sheila Smith has compared 2019-20 data against 2021 data. This can give the Committee assurance that the model for these factors being measured has not caused harm.

Cathy Fallon expressed her thanks to Sheila Smith for the work that has gone in to preparing this very comprehensive report.

Brian Moore stated that the report did provide assurance to the Committee. He had a query regarding patient information being available to the clinical team and asked how do we get vital information into single care plans that is accessible by clinical and support staff. Lindsay Thomson advised that the care plan has one aim and this is what they need to do each week around clinical

team meetings in following data for an individual patient. Sheila Smith advised that when key workers are putting together weekly reports for patients they are using these tables so data is all in one place now; in time they will be looking for this to be on the tableau dashboard along with timetables and physical activity.

Cathy Fallon suggested that the OMMG annual report be included as an area of good practice.

Action: Jacqueline McDade

Lindsay Thomson asked the Committee to consider the system Sheila Smith had developed on feedback of data to clinical teams.

The Committee noted both reports.

13 CLINICAL GOVERNANCE COMMITTEE STOCK TAKE

The Committee **received** and **noted** the Clinical Governance Committee Stock Take, presented by Lindsay Thomson, Medical Director.

The Clinical Governance Committee Annual report outlines the wide range of activity overseen by the Committee during 2020/21. The stock take also includes the Committee's Terms of Reference, Reporting Structures and Work Programme.

David McConnell advised that the report gives assurance to the Board of the work undertaken and expressed his thanks to Lindsay and her team for this.

Cathy Fallon noted that leadership walkrounds have not been undertaken. Lindsay Thomson advised that these will be reinstated as we move back to normalisation. Gary Jenkins advised that once we start to replan and mobilise non-Executives will undergo PMVA training and then the SPSP leadership walkrounds can resume.

Lindsay Thomson expressed her thanks to Sheila Smith and Jacqueline McDade for their support to the Committee throughout the year.

The Committee noted the report and agreed the workplan and practice.

A minor amendment is required to the Terms of Reference to reflect the Chair and Chief Executive are "in attendance" and not ex-officio. If the meeting is not quorate then the chair may be asked to step in as a member, if agreed by the Committee.

Action: Jacqueline McDade / Sheila Smith

Brian Moore asked if there was sufficient emphasis on realistic medicine, given the presentation at the last meeting. Lindsay Thomson suggested this is just an issue of timing of the report but will check and see if anything needs to be added.

Action: Lindsay Thomson

14 LEARNING FROM FEEDBACK

Members **received** and **noted** the Learning from Feedback report summarised by Lindsay Thomson for the period 1 January to 31 March 2021.

81 pieces of feedback were processed during this quarter
47 suggestions/comments/general enquiries, 5 compliments and 8 areas of concern were shared
Patient Partnership not meeting directly but meeting with members individually

Cathy Fallon stated that the triangulation of information within the report is very helpful.

The Committee noted the report.

15 LEARNING FROM COMPLAINTS

Members **received** and **noted** the Learning from Complaints report, summarised by Margaret Smith, Board Secretary. The report covers the period 1 January to 31 March 2021.

During this quarter, 7 complaints were received and 6 complaints were closed. Four complaints were resolved at Stage 1 of the MCHP and two investigated at Stage 2, with both of these cases escalated from Stage 1. The Patients' Advocacy Service provided support to patients in 2 cases.

The report shows that Communication and Clinical Treatment accounted for the majority of issues raised, and details the outcomes in each case, as well as the timescales for concluding cases. One enquiry into a complaint was received from the SPSO in this quarter, and the documentation in this regard was supplied. There has been no further follow-up from the SPSO in this respect.

The report also describes particular areas of improvement, wherein action was taken to improve service delivery directly, following the expression of dissatisfaction through the complaints process.

Brian Moore asked for details around the job advert closing before the specified closing date. Gary Jenkins advised that this was for a driving post and he will obtain further information and this will be sent via e-mail to Brian Moore and Cathy Fallon.

Action: Gary Jenkins

Cathy Fallon asked if there needs to be a separate complaints report in terms of the MCHP. Margaret Smith advised that this report is for the final quarter of the year and this will be looked at and considered for the next quarter.

The Committee noted the report.

16 INCIDENT REPORTING AND PATIENT RESTRICTIONS

Members **received** and **noted** the Incident Reporting and Patient Restrictions report summarised by Lindsay Thomson, Medical Director.

- Handcuffs were used on 3 occasions during March when patients were attending clinical appointments.
- 239 incidents were reported in Q4. This is an increase of 8 on the 231 incidents reported in the previous quarter.
- There were no 'High' graded incidents.
- Total incidents are down from 1435 to 942 year on year, a decrease of 493.
- 114 incidents reported related to health and safety, an increase of 17 on the previous quarter.
- In 2020/21 412 Incidents were reported, down 300 from 2019/20. Most categories showed large decreases across the board.
- 'Behaviour' made up the majority of Health and Safety Incidents with 60; this is an increase of 31 from the 29 incidents reported in the previous quarter.
- 36 incidents were recorded as "Threatening/Intimidating Behaviour" 16 as "Other" and 8 as "Destructive. 23 of these incidents took place in Arran 1, 16 from 1 patient and 4 from another. 19 incidents came from a mix of patients and wards in Iona Hub, 10 in Mull and 7 in Lewis.
- 'Verbal Aggression/Abuse' remained similar with 10 incidents in Q4 . 9 were 'patient to staff' and 1 was 'patient to patient'.
- 'Assault' incidents decreased from 8 to 4. 2 incidents were 'patient to staff' and 2 were 'patient to patient'. 2 incidents came from a patient in Lewis 1.
- 'Attempted Assault' decreased from 18 incidents to 14. All 14 incidents were recorded as 'patient to staff'. 5 Incidents came from 1 patient in Lewis 1. The rest of the incidents came from a mix of patients.

- 'Sexual' Incidents decreased from 7 to 4 in Q4. 3 Incidents recorded as 'Inappropriate Conversation came from 1 patient in Arran 1.
- No patients met the criteria on the Patient Assault Tracker
- Self-Harming Behaviour' increased from 22 to 25: 6 different patients were reported as having self-harmed in this quarter down from 8 in Q3. 11 occurred in Mull 1 from 1 patient, 8 from a patient in Iona 2 and 3 from a patient in Mull 2. The 3 others were isolated incidents.
- 'Medicine Administration' Incidents increased from 2 to 5 in Q4. 3 incidents involved secreted medication, wrong patient attending surgery resulting in patient being given another patients medication and medication admin error resulting in patient receiving injection 3 days late.
- 1 'Patient Death' occurred in Q4. Incident involved patient calling nurse buzzer as he was unable to breath. Patient had choked on an item of food and died as a result. Category 1 Investigation 20/03 was commissioned on 2 February 2021, findings are due 27 April 2021.
- Equipment Malfunctions' decreased from 16 to 7 in Q4: the incidents reported related to; PAA issues (1); faulty bedroom door locks (1); TOA Failure (1); Coretech error (1), PIDS failure (1), Airlock malfunction (1), delivery cage collapse (1).
- 'Media Article' incidents increased from 1 to 3. 2 of the articles contained information that could have been potentially leaked from staff. Both articles covered the story regarding positive LFT test staff member.
- Cat 1 20/03 Patient Death is underway, report is due 27 April 2021.
- There were a total of 5 seclusions involving 4 patients.

Brian Moore stated that this is a very important and detailed report. He asked if staff are comfortable with the DATIX system and if we are meeting deadlines in terms of adverse events. Lindsay Thomson advised that it is our view that staff are well trained in the DATIX system and following up on incidents reported. There were some challenges with timescales for Cat 1 and 2 events due to limited staffing within the risk management department. Gary Jenkins advised that there was an external Cat 1 investigation and some relate to capital work that should have been closed off; these are tracked by CMT and he expects these to come down.

Cathy Fallon asked about the wrong patient attending surgery and being given the wrong medication. Lindsay Thomson advised that each ward has a small room referred to as the "surgery" where medications are kept and dispensed from a stable type door. This was a dispensing error and will be included in the Medicines Committee annual report.

The Committee noted the report.

17 SAFE STAFFING REPORT

Members **received** and **noted** the Safe Staffing report presented by Lindsay Thomson, Medical Director.

Lindsay Thomson advised that the Safe Staffing Legislation has not yet been put in place by the Scottish Government due to Covid-19.

There are some vacancies within nursing and sickness absence is currently 6.23%. Recruitment is underway for registered nurses. Resources issues are discussed at a daily meeting with the Operations Manager and Senior Clinical staff.

There were no occasions in the last quarter when business continuity arrangements required to be implemented.

The Committee noted the report.

Karen Burnett joined the meeting at this time

6 INFECTION CONTROL COMMITTEE ANNUAL REPORT / HAND HYGIENE COMPLIANCE

Members **received** and **noted** the Infection Control Committee Annual Report, together with a paper on hand hygiene compliance, summarised by Karen Burnett, Senior Nurse for Infection Control.

Karen Burnett advised that since November 2020 the existing hand hygiene audits were amended to include the monitoring of Covid secure practice as a direct requirement from the Chief Nursing Officer Fiona McQueen, to ensure safe practices, including the wearing of PPE and physical distancing were adhered to. The audit was fit for purpose between November and early December 2020 when the model of care changed and restrictions were relaxed for patient. Since the beginning of March 2021 Karen has tried to push compliance of hand hygiene but due to resource issues this has not been possible. Sheila Smith and Karen Burnett will do some work towards the end of May / June to review the audit toll and make it fit for purpose. An update report will be available in August 2021.

Sheila Smith sought the views of the Committee on whether a report was required to come to the Committee or if it could be tracked through the Clinical Governance Group and any issues escalated to the Committee. Cathy Fallon thought this suggestion was appropriate.

Karen Burnett went on to summarise the Infection Control Committee Annual Report, which covers the period April 2020 to March 2021.

The focus for this review period has been to reduce the risk of Covid19 within the hospital through various stages of the pandemic and to manage Covid19 outbreaks effectively to ensure there is not wider spread of infection across the site. In addition to this the roll out of the Covid19 vaccinations and lateral flow device testing has dominated the last quarter. Government guidance/instruction with short timescales has influenced the routine infection control activities, these are outlined in the report.

The Infection Control Annual report is positive; however, it is not able to capture or reflect on the significant pressure placed on State Hospital staff and patients during the last 12months. 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.

Funding was agreed to recruit for an additional support post to assist with audits etc but recruitment has not been successful as yet. Informal support has been provided by various members of staff and Infection Control Committee members.

There have been some slippages in terms of audit submissions not being chased up as they should have been; clinical waste is an ongoing issue due to safe management of linen and items not being segregated and labelled correctly.

Flu vaccination uptake increased from the previous year. Peer vaccinators were introduced which proved to be beneficial.

Covid outbreaks were successfully managed and there have been no positive patients identified between 4 April 2020 and 18 January 2021.

Peer vaccinators were utilised to provide Covid vaccinations and it is hoped that they will take on this role going forward.

In January 2021 voluntary lateral flow device testing was introduced for staff who have direct/social interactions with patients. The uptake of the lateral flow device testing is monitored on a weekly basis by the Scientific and Technical Advisory Group (STAG). From 3 May 2021 this has been rolled out to all staff coming on site.

Gary Jenkins wished to note on behalf of the executive team his thanks to Karen Burnett and colleagues as we could not have got to the position we were in without their expert advice and support during this period from an infection control perspective.

Cathy Fallon suggested that this be included as an area of good practice.

Action: Jacqueline McDade

The Committee noted the report.

Karen Burnett left the meeting/

18 DISCUSSION ITEM

There was no item for discussion at this meeting due to Covid-19 update paper.

19 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee noted two areas of good practice:

OMMG Annual Report
Infection Control Annual Report

20 WORKPLAN

The Committee **noted** the Clinical Governance Committee Workplan.

Lindsay Thomson advised that a new format for reports was introduced last year and that she would like to recommend that this year we encourage more brevity and that reports are up to 12 pages in length, but can include appendices.

Cathy Fallon stated that 12 pages is very helpful and we can see how this will work out.

21 ANY OTHER BUSINESS

Gary Jenkins expressed his thanks to Lindsay Thomson for covering reports that were normally presented by Mark Richards.

22 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on Thursday 12 August 2021 at 9.45am via MS Teams

The meeting concluded at 12.40pm.

THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL FORUM **CF(M)21/02**

Draft Minutes of the Clinical Forum held at 10.00am on Tuesday 25 May 2021 via Microsoft Teams

Present:

Alan Blackwood	*Lead Nurse*
Fraser Breed	*Dietician*
David Hamilton	*Social Work Team Leader*
Dr Sheila Howitt	*Consultant Forensic Psychiatrist (**Chair**)*
Dr Kerry Jo Smith	*Clinical Psychologist*
Sheila Smith	*Clinical Effectiveness Team Leader*
Fiona Warrington	*Clinical Pharmacist*
Carolin Walker	*Professional Nurse Advisor*

Apologies:

Dr Aileen Burnett	*Consultant Clinical Psychologist*
Jim Irvine	*Clinical Liaison Security Manager*
Marcus Topping	*Practice Nurse*
Dr Jana De Villiers	*Consultant Psychiatrist*

In Attendance:

Sandie Dickson	*Person Centred Improvement Lead*
Gary Jenkins	*Chief Executive Officer*
Julie Warren	*Corporate Services (**Minutes**)*

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

The Forum Chair, Sheila Howitt, welcomed everyone to the meeting and apologies were noted as detailed above.

Fraser Breed and Kerry Jo Smith were welcome to their first meeting of the Clinical Forum.

NOTED.

2 CONFLICT(S) OF INTEREST

There were no conflicts of interest declared.

NOTED.

3 APPROVAL OF PREVIOUS MINUTES

The minutes of the previous meetings held on 23 March 2021 and 20 April 2021 were approved as an accurate record.

APPROVED.

4 URGENT MATTERS ARISING

There were no urgent matters which have arisen over the preceding seven days.

NOTED.

5 REVIEW OF ROLLING ACTIONS LIST

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

NOTED.

6 TSH REMOBILISTION PLAN 2021

Monica Merson joined the meeting at this time.

Monica Merson offered a presentation and provided an overview of the hospitals Version 3 Remobilisation Plan in light of the request from Scottish Government which was submitted in February 2021. She advised that the Scottish Government were content with the plan though it was not published due to purdah arrangements for the Scottish Parliament elections. The Remobilisation Plan followed guidance and a template issued by Government and it would be anticipated that a further plan would be requested with guidance issued in Summer 2021 though the exact date remained unknown.

There were no specific queries raised by the members of the Clinical Forum. However, Sandie Dickson asked a point of information around stakeholder engagement; and Monica Merson provided assurance within the context of the planning cycle for remobilisation of NHS Scotland supporting recovery from the Covid-19 pandemic.

The Clinical Forum welcomed this update on planning for remobilisation, and members were content to note it. Given the ongoing cycle of planning, the Clinical Forum agreed this item would remain on the agenda. To sum up, the Clinical Forum Chair welcomed the plan and was pleased to see that it the prominence given to staff wellbeing and digital inclusion.

Action: All / Julie Warren

NOTED

Monica Merson left the meeting at this time.

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

(a) Nursing and Allied Health Professions Advisory Committee

Members **received** and **noted** the approved Minutes of the Nursing and Allied Health Professions Advisory Committee held on 28 April 2021.

In relation to Student Nurse placements, it was recognised that there were no longer mentors, alternatively, supervisors were now in place.

NOTED.

(b) Medical Advisory Committee

Members **received** and **noted** the approved Minutes of the Medical Advisory Committee held on 8 March and 12 April 2021.

The Chair advised that Dr Kay Sutherland has expressed in interest in undertaking an audit exploring the progress of grounds access forms and timeframe for processing and authorising these application.

NOTED.

(c) Psychology Professional Practice Meeting

The Forum recognised Psychology Professional Practice Meetings were not taking place at this time, however Kerry Jo Smith offered a brief update of key topics of discussion within the directorate. Of note were that the Mentalisation Based Therapy programmes commenced today and the department were looking forward to returning to service wide priorities. Alan Blackwood advised that he would be keen to hear feedback from patients on how the groups were progressing with the electronic nature of the groups. Kerry Jo Smith and Alan Blackwood agreed to discuss out with the meeting on the best approach to capture patient's views and report back at the next forum.

Action: Kerry Jo Smith / Alan Blackwood

Also of note was that the department had their own remobilisation plan of a service wide approach. No concerns were raised from the Psychology directorate.

NOTED.

(d) Update Report from Dentist, General Practitioner and Optometric

Members received and noted the written update from Skye Centre Manager dated 20 May 2021. No concerns were raised.

NOTED.

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

The Forum Chair advised that the Area Clinical Forum Chair's Group were scheduled to meet on 2 June 2021. Key topics of focus remain on staff wellbeing and the actions taken by Health Boards along with individual action plans. Both the Chair and Vice Chair agreed to discuss the action plan outwith the meeting and report back at the next meeting.

Action: Sheila Howitt / Carolin Walker

NOTED.

9 UPDATE ON IMPROVING OBSERVATION PRACTICE POLICY

Members received and noted the proposed roll out plan on Improving Observation Practice.

Carolin Walker advised that in line with previous discussions with Mental Health Nurse Leads across Scotland, thought was given to more input in from medical and multidisciplinary colleagues, however, positively, this was not felt the case for The State Hospital which Carolin Walker fed back on our behalf.

NOTED.

10 CEO UPDATE

Gary Jenkins joined the meeting at this point.

Mr Gary Jenkins advised that due to prior commitments, the Chairman was not able to be present at today's meeting and would therefore attend the Forum in July 2021. Mr Jenkins provided a brief

overview of key concerns and work in progress to address management structures and partnership interface. A Hospital Management Team Development Session was scheduled to take place on 16 June 2021 to reflect on layers of authority and accountability and how this related to interface within each layer of management structure to ensure staff feel they were able to make decisions with autonomy. HMT members were welcomed and invited to attend this meeting to aid and define the latitude of decision making.

In terms of partnership engagement and in a cohesive partnership collaboration, Mr Jenkins advised that work was underway to streamline at what level potential issues were raised, discussed and resolved.

It was noted that a Short Life Working Group would be established to help support the discussion around nursing shift patterns. It was hoped that this work would commence in approximately 6 weeks time to ensure the correct staff were available to input and participate.

Mr Jenkins advised that TSH had received notification that the European Commission for the Prevention of Torture (CPT) would shortly be visiting the U.K. and may visit TSH as part of this.

He noted that the new Cabinet Secretary for Health and Social Care, Mr Humza Yousaf, had met recently with NHS Chief Executives – it would be helpful for TSH to support a visit from the Cabinet Secretary and/or the new Minister for Mental Wellbeing and Social Care to visit the hospital and understand how the dynamic and interface would work with the organisation going forward.

Mr Jenkins appraised members on the current work on the Security refresh project which was progressing well.

He noted that six Activity Coordinators were recently recruited to help overall support with patient activity.

In line with the Barron review into the forensic estate nationally, there was a debate on the position of admission of female patients to TSH, as well as the wider recommendations of the report. However, work would continue within TSH to ensure the system worked within the current landscape.

Lastly, Mr Jenkins advised that a debrief of the Incident Management Team outputs was held recently. On reflection, the group considered potential foreseeable challenges of the pandemic and which different actions may be taken in future. The group were content that resources were in place via the Scientific Technical Advisory Group, Infection Control Committee and Covid-19 Support Team should the pandemic situation worsen in future.

NOTED.

Gary Jenkins left the meeting at this point.

11 REVIEW EQUALITY OUTCOMES WORKSHOP REPORT

Members received and noted the Equalities Outcomes Update Report 2017-21 and 2021-25 including Workforce Monitoring and Non-Executive Board Member Gender Profile dated April 2021. Sandie Dickson advised that a quarterly update on each outcome would be taken forward by the Person Centred Improvement Steering Group meeting with individual leads.

The Forum advised they would welcome this and offered support where required.

Sandie Dickson agreed to advise Julie Warren how and when this would be incorporated in to the Forum workplan.

Action: Sandie Dickson / Julie Warren

NOTED.

12 REVIEW OF CLINICAL FORUM WORKPLAN

Members **received** and **noted** the 2021 Forum Workplan.

The Chair submitted apologies for the meeting in July; Vice Chair agreed to lead the meeting in her absence.

Members agreed to move the following from July to September;

- Triangle of Care update
- Reflection on Annual Review 2021
- Audit of Grounds Access Policy

An invite would be extended to the Chair to attend in July 2021, therefore a CEO update would hopefully be received in September.

Monica Merson would be invited to the meeting in July in order that the Forum feedback thoughts on remobilisation planning as noted under item 6 and to provide a verbal update on the clinical model.

Action: Julie Warren

Also for discussion in September would be the update from the Digital Inclusion Group as noted under item 13.

AGREED.

13 DIGITAL INCLUSION WORKPLAN

Jacqueline Garrity joined the meeting at this point.

The Terms of Reference and Workplan were received at the last meeting of the Clinical Forum. The updated workplan remained a work in progress and was not finalised at this time in order to share with the group, however Jacqueline Garrity provided a brief overview on the activities on the horizon and progress in these areas.

Of note was video conferencing to provide patient group work though governance issues were being explored by Microsoft Teams. A DPIA was in progress by Security colleagues to explore risks and the delivery of projectors was awaited.

The patient shop browsing experience action plan was completed and would be piloted within Arran hub in the first instance.

Patient Education project was progressing well with procedures in place. Equipment was ordered and Wi-Fi locations would be reviewed.

With the above progress being made, thought would be given to looking at other projects to take forward, for example the cash flow system for bank and patients, as well as digital media solutions i.e. music and smart televisions.

The Digital Inclusion Group are scheduled to meet on 27 May 2021.

Jacqueline Garrity advised that she was now a member of the eHealth Sub Group and therefore had access to this budget going forward.

Sandie Dickson advised that in line with the Equalities Act, guidance for patients on the above actions

would be drawn up and individual assessments would be carried out for any patient who had a barrier to communication.

The Forum agreed that they wished to capture sight of the updated digital inclusion workplan following the meeting on 27 May 2021 which Jacqueline Garrity agreed to provide.

Action: Jacqueline Garrity

The Forum also agreed to review this work on a quarterly basis and that Jacqueline Garrity would be invited to the Forum in September 2021 to provide a further update. Julie Warren agreed to extend this invite and ensure this was included in the workplan and September Agenda.

Action: Julie Warren

Jacqueline Garrity left the meeting at this point.

14 ANY OTHER COMPETENT BUSINESS

Nil.

NOTED.

15 DATE AND TIME OF NEXT MEETING

The next meeting of the Clinical Forum would take place at 10am on Tuesday 27 July 2021 via Microsoft Teams.

Meeting concluded at 1210 hours.

Paper No. 21/61

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	Item No: 14
Sponsoring Director:	Interim Director of HR and Wellbeing
Author(s):	Head of Human Resources
Title of Report:	Attendance Performance Summary
Purpose of Report:	For Noting

1 SITUATION

This report provides information on sickness absence within the State Hospital for the period up to 30 June 2021. It should be noted that this update is the board level performance summary, a further level of detail is provided within the Staff Governance Committee attendance report (Quarterly) which is also reviewed by the Human Resources and Well-Being group and Corporate Management Team (both monthly).

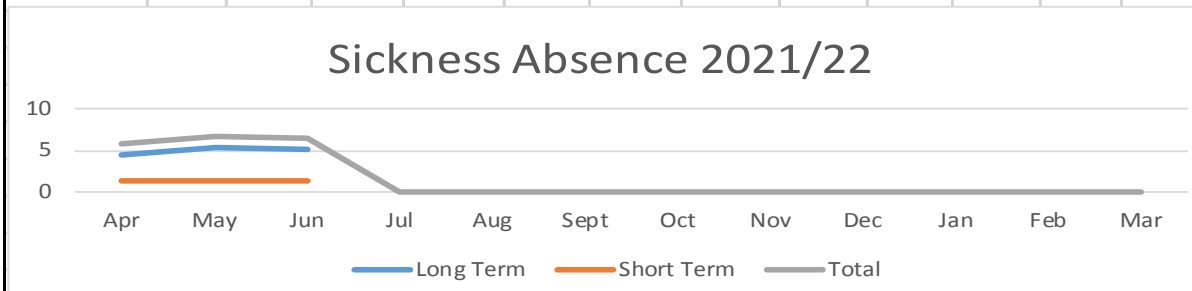
2 BACKGROUND

The State Hospital is required to achieve a sickness absence rate no higher than 5%. The data used is extracted from, SWISS (the national repository) and SSTS (the Board time recording system).

3 ASSESSMENT

The sickness absence figure from 1 June 2021 to 30 June 2021 is 6.58% with the long/short term split being 5.14% and 1.44% respectively.

Table 1 A 2021/22 Performance



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Long Term	4.52	5.35	5.14									
Short Term	1.35	1.29	1.44									
Total	5.87	6.64	6.58	0	0	0	0	0	0	0	0	0

Table 1 B 2020/21 Performance

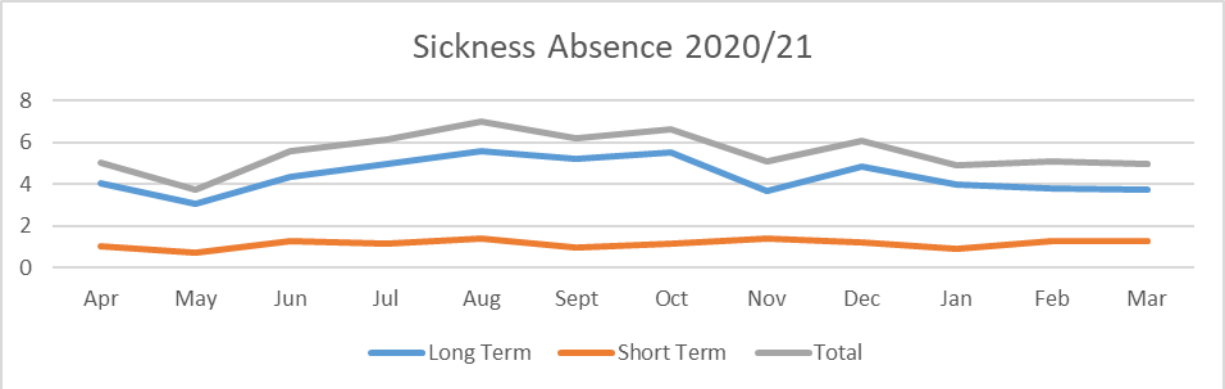
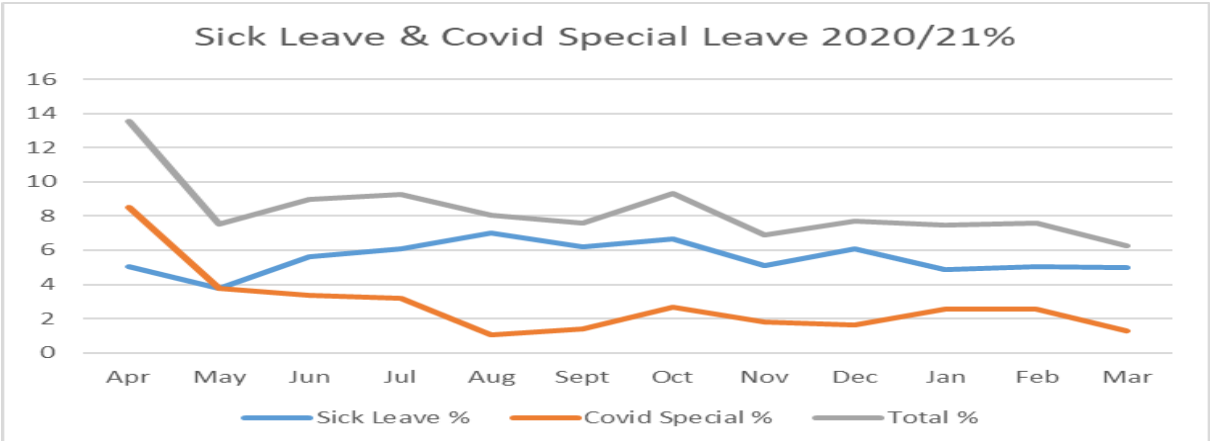


Table 2 A Combined sickness absence and COVID-19 related special leave 2021/22

Sick Leave	5.88	6.64	6.58									
Covid Spec	2.08	1.02	1.54									
Total %	7.96	7.66	8.12									

Table 2 B Combined sickness absence and COVID-19 related special leave 2020/21



Total %	13.55	7.5	9	9.28	8.05	7.59	9.34	6.89	7.68	7.45	7.59	6.24

Table 3 National Performance Comparator
June 2021

		Total	Long Term [1]	Short Term [2]
Scotland		**5.42**	**3.65**	**1.77**
NHS Ayrshire & Arran		5.15	3.61	1.54
NHS Borders		4.69	2.80	1.89
NHS National Services Scotland [4]		3.63	2.22	1.41
NHS 24		7.71	5.13	2.57
NHS Education For Scotland		1.36	1.10	0.26
Healthcare Improvement Scotland		2.49	1.74	0.75
NHS Health Scotland [4]		-	-	-
Public Health Scotland [4]		2.62	1.73	0.90
Scottish Ambulance Service		7.82	5.62	2.20
The State Hospital		**6.58**	**5.14**	**1.44**
National Waiting Times Centre		5.21	3.05	2.17
NHS Fife		5.66	4.10	1.56
NHS Greater Glasgow & Clyde		5.98	4.23	1.75
NHS Highland		5.13	3.37	1.75
NHS Lanarkshire		6.16	4.51	1.65
NHS Grampian		4.13	2.37	1.76
NHS Orkney		4.50	3.07	1.43
NHS Lothian		4.96	3.01	1.95
NHS Tayside		5.58	3.56	2.03
NHS Forth Valley		6.04	4.35	1.70
NHS Western Isles		5.85	4.04	1.81
NHS Dumfries & Galloway		5.61	3.58	2.03
NHS Shetland		3.38	1.74	1.64

4 RECOMMENDATION

Board members are invited to note the contents of this performance update and confirmation of the wider circulation and review of attendance management information.

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 set by the Scottish Government
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.	Staff Governance Committee Partnership Forum, HR and WB Group
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
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

Date of Meeting:	26 August 2021
Agenda Reference:	Item No: 16
Sponsoring Director:	Interim Director of HR and Wellbeing
Author(s):	Interim Director of HR and Wellbeing
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

The Scottish Public Services Ombudsman (SPSO) previously advised that the role of the Independent National Whistleblowing Officer (INWO) would be implemented with effect from the 1st of April 2021.

2 BACKGROUND

This new role provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing case. The rescheduled launch date of 1 April 2021 was in recognition of the risk of pressures on Health Boards over the winter period. 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.

3 ASSESSMENT

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. A key requirement of the revised standards is notification of case incidence to the board and staff governance committee. This is the second report of this nature and confirms that 1 case has been raised during the period 1 April 2021 to date. This case is currently subject to investigation at stage 2 within the standards.

4 RECOMMENDATION

Board members are invited to note the information and confirmation of compliance with the National Policy.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the National Guidance for Whistleblowing set by the Scottish Government
Workforce Implications	Positive measure in support of Staff Governance Standards.
Financial Implications	N/A
Route to Board Which groups were involved in contributing to the paper and recommendations.	Via HR and Wellbeing Group
Risk Assessment (Outline any significant risks and associated mitigation)	N/A
Assessment of Impact on Stakeholder Experience	Failure to adopt would undermine the principles of Partnership Model and Employee Engagement.
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.	**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

Minutes of the meeting of the Staff Governance Committee held on Thursday 20 May 2021 at 9.45am via MS Teams, The State Hospital, Carstairs. **SG(M)21/02**

Present:

Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
Employee Director	Tom Hair
Non-Executive Director	Brian Moore
Non-Executive Director	Pam Radage ***(Chair)***

In attendance:

Organisational Development Manager	Jean Byrne
Training and Professional Development Manager	Sandra Dunlop
Interim Board Chair	David McConnell
Chief Executive	Gary Jenkins
Head of Corporate Planning & Business Support	Monica Merson
UNISON Staff-Side Representative	Michelle McKinlay
RCN Staff-side Representative	Jacqueline McQueen
POA Staff-side Representative	Richard Nelson
Clinical Operations Manager	Brian Paterson
Board Secretary	Margaret Smith
Professional Nurse Advisor	Carolin Walker
Director of HR and Wellbeing	John White
PA to Director of HR and Wellbeing	Rhona Preston (minutes)

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Pam Radage welcomed everyone to the meeting, no apologies were noted.

2 CONFLICTS OF INTEREST

There were no conflicts of interest raised.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 18 FEBRUARY 2021

The Committee approved the Minutes of the previous meeting held on 18 February 2021 as an accurate record.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

Health, Safety and Welfare Committee
Gary Jenkins explained that he has discussed with the Chair or H&S the route for this through the revised structure now in place. Some refinement is required and it has been agreed to take to next week's Partnership Forum for further discussion. A paper will be presented to a future Staff Governance Committee that will allow this action to be closed.

ACTION: G JENKINS

5 EMPLOYEE WELLBEING

Carolin Walker, Professional Nurse Advisor / Wellbeing Champion provided an overview via a presentation of work undertaken to date and planned work moving forward. She advised this has been a joint effort between herself, Gayle Scott and a team of people. At the beginning of the pandemic the Scottish Government were looking for a Wellbeing (WB) Champion and due to Carolin already taking forward work she was nominated to be the WB Champion.

Carolin Walker summarised what has been done to help staff and help boost morale across the organisation including the set-up of the WB centre in Islay located initially within Islay and thereafter in its permanent location within Harris, this has provided many staff groups with invaluable support.

Funding was secured from Charities Together, totalling 35k. A group was established to consider the needs of all staff across the hospital and to monitor the spending of the funding received. The three areas where monies could be spent where across; Staff, patients and volunteer's.

Also very early on local businesses donated a substantial amount of goods, that were either distributed or raffled.

Carolin summarised some of the key areas of work undertaken and were the monies have been used;

For those staff who were shielding, virtual tea-breaks were held which proved to be successful.

Tea Boxes were distributed across the site on Mental Health Nurses Day to those staff on duty. Care packages were also supplied to all kitchen spaces together with a note of appreciation. The response to this was phenomenal. There was a focus on promoting the national campaign of Mental Health Awareness Week. It would have been preferred to have organised a target event however it was felt this was not the right time to organise events.

Gratitude badges were attached to payslips which also coincided with the Covid Bonus payment for staff, the timing of all these things was noted as a real boost to morale for staff.

Utilisation of the WB Centre currently is very good however during these restricted times the WB team are not over promoting this space but it is being used regularly by a broad range of staff groups including student and other staff inductions.

Discussion are taking place with Lanarkshire to introduce an independent person who will lead on Spiritual and Pastoral service for staff.

Discussions continue around confirming a garden space for staff, it is anticipated this will be located at the Family Centre.

The Leadership development reading group was established with a book by, Brene Brown Dare to Lead. This involved a cross section of staff within the hospital at all levels who held a read-along of the book based on Brene's development hub. This was very well received. It was noted that Sandra Dunlop, Training and Professional Development Manager is using as part of the Clinical Nurse development programme. Both Gayle Scott and Carolin Walker are considering how they can use this style within the hospital.

The WB Centre also ran a Christmas Appeal and Easter Egg Appeal, allowing staff to give something back to local communities through these difficult times. Carolin and members of the WB team were totally enthused by the support these appeals received from the State Hospital staff.

Jean Byrne, Organisational Development Manager will now take forward future plans of the Staff Wellbeing Centre including the National Wellbeing Calendar through Healthy Working Lives group. A paper will be presented to the Corporate Management Team requesting ongoing financial and resourcing support associated to retain this service for staff. It is hoped this cost is supported as the feedback from staff has been very positive and a definite boost to their morale. The aim moving forward is for staff to continue feeling supported through this service and to embed into the culture of the Hospital.

Pam Radage thanked Carolin Walker for her enthusiastic presentation and for all the work that has already taken place and agrees this is an area that is required to be embedded into the culture of the Hospital.

Stuart Currie also thanked Carolin for her presentation and agreed it cannot just be a one-off experience in response to the situation we were faced with but it now needs to be embedded and continued moving forward. He reiterated the importance of contact between staff and that they can sit in an environment with a colleague, a friend or by themselves. He hopes the WB centre is now in place to stay. Carolin Walker advised that Scottish Government are now expecting this to remain and to embed. Focus needs to remain therefore it is now about deciding how best to manage and resource.

Stuart Currie also asked how this fits into other areas ie sickness and recruitment. Carolin confirmed it is now being utilised in Student Inductions and is being used as a de-brief area for staff if and when required, she believes staff have now seen that Gold Command were behind this and is being further supported now through the new structure of CMT, HMT and OMT.

Gary Jenkins advised the Committee that at yesterday's CMT they reviewed the option to enhance with 1 wte and it was agreed to review the needs of this service every 3 months with the key message being it is important to sustain. On a personal note, Gary Jenkins thanked Carolin and the team for their incredible work.

Jean Byrne provided reassurance to the Committee that HWL will take over the mantel and have already been involved in certain areas. Work will continue and this has been incorporated into the HWL action plan and with the established HR and Wellbeing Group this will ensure all workstreams are aligned and kept on track.

David McConnell agreed with everything already discussed and thanked Carolin for a very informative and enthusiastic presentation. He agreed there has been a great level of work undertaken and has previously visited the WB Centre which he advised other members to visit as soon as they can. He advised members this is being well supported by Scottish Government and is being discussed at Board forums.

Cathy Fallon thanked everyone involved and was pleased to hear how active the WB centre is however raised concerns around the 3k budget mentioned under HWL but was encouraged to know the service will be reviewed every 3 months and will hopefully assist in ensuring an enhanced budget is put in place.

Gary Jenkins is aware of monies available through the Scottish Government and has spoken with Robin McNaught, Director of Finance and eHealth in supporting this facility as 3k is not a lot and as a Board we do need to look at investment and will do what we can to support.

Brian Moore thanked Carolin and team for their work and advised that Charities Together are still providing funding under their staff recovery fund that could be worth exploring further. Tom Hair advised that UNISON will be donating some funding to the WB Centre however focus needs to be given to recurring monies for long-term achievements.

Members thanked Carolin Walker and the team for the fantastic efforts and achievements to date and look forward to this work continuing under HWL. All members are in agreement that future funding is key to ensure the sustainability of the WB Centre.

STANDING ITEMS

6 ATTENDANCE MANAGEMENT REPORT

Members of the Committee received and noted the report up to 31 March 2021, as presented by John White, Director of HR and Wellbeing, who advised members that this report is very well signposted through other sources across various meetings. He advised members that the national target is 4% however following recognition of the working environment here the target is 5%.

The reports were summarised advising members that the sickness absence figure from 1 March 2021 to 31 March 2021 is 5.56% with the long/short term split being 4.27% and 1.29% respectively. The total hours lost for this period is 5,394 which equates to 33.14 WTE.

The monthly absence figure has increased by 0.59% from February 2021 figure of 4.97%. The February 2021 long/short term split was 3.67% and 1.30% respectively.

Members were advised of the difficulties in receiving the EASY compliance figures following the introduction of a new system at NHS Lanarkshire. The cohort platform is experiencing difficulties in extracting the data from the new system. John White advised there is an expectation that the compliance sits around 80-90% due to being a Monday-Friday service and the drop can be as a result of weekend absence, he is not concerned about this as it is not impacting on the short-term absence.

It is hoped at the next meeting to share the revised format of this report with information drawn from tableau. The tableau information will also be available via the intranet which will allow Managers to see their Sickness Absence and the live information in their areas rather than wait on reports.

The HR Department are also working on taking forward a refreshed approach to Attendance Management training following the launch of the policy which was now one year ago. Therefore, it was felt this is a good time to re-look and refresh.

John White explained that work is ongoing in preparing an overall Workforce Report that will include PDP, Recruitment, ER Activity and Attendance Management, it is hoped this can be brought to the next meeting.

Clarification was sought on Table 3 and what ‘Other’ includes, it was advised that this could be special leave / bereavement etc.

Pam Radage thanked John White for his report and update and acknowledged the positive absence rates however continued focus is required to help maintain the figures recorded.

Members noted the report.

7 HR PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

Members of the Committee received and noted the Employee Relations Activity Report to 30 April 2021 as presented by John White, Director of HR and Wellbeing. John White summarised the report, advising members that during April one new case was raised.

Members were updated on the reason associated with the lengthy delay being reported within the grievance table, however John White provided assurance to the Committee that there is an understanding of the people involved behind cases and that these need to progress in line with policies with a fair approach.

The particular case that remains outstanding at more than 9 months relates to waiting on guidance

regarding national terms and conditions from SWAG, Scottish Workforce Advisory Group. This delay will also be replicated across a number of Boards. It was noted that considerable progress has been made with the historic cases.

Stuart Currie acknowledged the report looks excellent in terms of the numbers involved however he asked if that is a true reflection on the ground. John White advised he is not aware nor gets the feeling there is an under-current within the Hospital that causes alarm or concern and does not get the sense that this report is not capturing everything. Tom Hair confirmed he is not surprised by the figures being reported and also acknowledged the work that has been undertaken to improve on earlier reports. Historically these figures were too high but is now confident that processes are being followed timeously.

Following a comments from Brian Moore, it was agreed that future reports will also include the months between these meetings, therefore at the August meeting this report will outline figures covering 1 May – 31 July 2021.

ACTION: J WHITE

Richard Nelson stated that recently partnership working has struggled however this is being discussed at length at the Corporate Management Team and he is hoping that some of the difficulties are being worked through.

Gary Jenkins provided assurance to the Committee that partnership working has progressed however there is always ways to improve to embed into our ways of working. Following a recent meeting of the Partnership Forum there was agreement for a development session to take place that will assist with improving the way forward with staff side and partnership working.

The Committee noted the report and welcomed the assurances given.

8 PERSONAL DEVELOPMENT PLAN REPORT

Members of the Committee received and noted the Personal Development Planning & Review (PDPR) update report, presented by Sandra Dunlop, Training and Professional Development Manager.

As at 30 April 2021:

The total number of current (i.e. live) reviews was 545 (89.3%) - an increase of 8.7% from 31 January 2021.

A total of 50 staff (8.2%) had an out-of-date PDPR (i.e. the annual review meeting is overdue) – a decrease of 8.4% from 31 January 2021.

A further 15 staff (2.5%) had not had a PDPR meeting - a decrease of 0.3% from 31 January 2021. Staff in this group are predominantly new staff with an initial set-up review meeting overdue.

There has been an incremental improvement in overall compliance since January 2021. This is likely to be due in part to a reduction in staff absence levels and the gradual lessening of the impact of the COVID-19 pandemic and associated resumption of previous work routines and practices.

Members asked what follow-up procedures take place with staff. Sandra Dunlop advised that random follow-ups take place with staff and a survey approach is carried out. She has been encouraged with a change in staff across the site who have a more positive mind-set in relation to the PDPR process to make it more meaningful with much less resistance than previously received.

Members noted the report acknowledging the encouraging compliance levels.

9 WHISTLEBLOWING

Members received and noted the Whistleblowing update as presented by John White, Director of

HR and Wellbeing. 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.

A key requirement of the revised standards is notification of case incidence to the board and staff governance committee. This is the first report of this nature and confirms that no cases have been raised during the period 1 April 2021 to date.

Members noted the update.

ITEMS FOR DISCUSSION

10 STAFF GOVERNANCE COMMITTEE DRAFT ANNUAL REPORT TO 31 MARCH 2021

Members received and noted the draft Annual Report to 31 March 2021 as presented by John White, Director of HR and Wellbeing. Members were advised that despite the pandemic the report clearly shows it was business as usual in line with the workplan.

Margaret Smith will review to ensure contents are accurate prior to submission.

Members noted the report.

11 STATUTORY AND MANDAOTRY TRAINING COMPLIANCE (OCT-MAR)

Members received and noted the compliance update as presented by Sandra Dunlop, Training and Professional Development Manager.

Compliance levels for both statutory and mandatory training have marginally increased since the previous update in September 2020, however, have both decreased when compared to compliance at 31 March 2020. This is due primarily to the impact of the COVID-19 pandemic, and most significantly the associated suspension of all non-critical face-to-face training courses from March to September 2020 and from January to March 2021.

- Statutory Training – 92.6% compliance
- Mandatory Training – 85.1% compliance

It is evident from the data presented in the report that although compliance levels in some areas of statutory and mandatory training have reduced slightly over the past 6 months, overall compliance remains generally high.

The COVID-19 pandemic, and associated restrictions on face-to-face training delivery has had an impact on compliance, however, the introduction of alternative delivery methods has helped to limit the impact and enabled a high level of overall compliance to be maintained.

Work will continue to be progressed to further embed the use of web conferencing technology to support remote delivery of statutory and mandatory training where viable and appropriate. This will enhance delivery options and help build resilience and ‘future-proof’ against the impact of face-to-face training restrictions having to be reintroduced due to COVID-19.

Members noted and acknowledged the good work achieved during the difficult period.

12 HEALTHY WORKING LIVES (HWL) UPDATE

Members received and noted the HWL update at May 2021 as presented by Jean Byrne, Organisational Development Manager.

This year, submission for the Gold Award is on pause. No advice has come from Public Health Scotland on what criteria might be applicable so that workplaces can recognise the impact of COVID-19. The Hospital have been advised not to submit a report at this time. However, we have been informed that nobody will be adversely affected in terms of awards. When things return to normal, the HWL Group will be ready for submission of the report and is hopeful of maintaining the award at that level.

The HWL Group continue to meet regularly every two months. The members are representative of various sections of the State Hospital community – nursing, Infection Control, Occupational Health, Catering, Dietetics, Psychology, Practice Development, L&D, OD, e-Health, HR, Sports, Medical Records, Staffside and OD.

Jean Byrne provided a summary of the numerous initiatives and activities detailed within the report that have and are continuing to take place across the organisation.

Members noted and recognised the full and concise report and acknowledged the important work being carried out.

ITEMS FOR INFORMATION

13 FITNESS TO PRACTICE REPORT

Members received and noted the Fitness to Practice Report as presented by John White, Director of HR and Wellbeing who advised this paper outlines the process for monitoring professional registration status at The State Hospital. This report was presented to the Clinical Governance Committee on 6 May 2021 to provide assurance that all members of staff hold current professional registration.

Members were advised that during 2020/21, there were no lapses in registration. This is a decrease of 2 compared to the previous year.

Members noted and recognised the work that takes place to ensure all registrations remain current.

14 WORKFORCE PLANNING UPDATE

Members received and noted the Workforce Planning Update and Plan 2021/22 as presented by John White, Director of HR and Wellbeing. Members were advised that due to the submission requirement of Scottish Government and TSH Board and Committee scheduled, the plan was approved at the April Board meeting prior to submission on 30 April 2021.

Members noted this report and its submission date.

15 APPROVED MINUTES FROM PARTNERSHIP FORUM FROM 23 FEBRUARY 2021

Members received and noted the approved minute.

16 APPROVED MINUTES FROM HR AND WELLBEING GROUP FROM 13 APRIL 2021

Members received and noted the approved minute.

ANY OTHER COMPETENT BUSINESS

17 ANY OTHER BUSINESS

Safe Staffing

Gary Jenkins advised that there has been a debate in relation to this report either going to Clinical Governance and/or Staff Governance. Gary Jenkins advised he will take forward with Margaret Smith to correlate.

ACTION: G JENKINS

18 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 19 August 2021 at 9.45am via MS Teams**.

Paper No. 21/63

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	Item No: 18
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For Decision

1 SITUATION

Following Board self-assessment in March 2019, an improvement plan was developed to support key corporate governance priorities as part of the NHS Scotland Blueprint for Good Governance. The Board submitted its improvement plan to Scottish Government in April 2019, and submitted a six-month progress report in November 2019.

At the outset of the Covid-19 pandemic, this workstream was necessarily paused as part of The State Hospital's resilience response. However, work has now progressed across a range of workstreams encapsulated in the plan, and a summary is set out herein.

2 BACKGROUND

The five key areas of the improvement plan are outlined as follows:

- Setting the Direction
- Holding to Account
- Assessing Risk
- Engaging Stakeholders
- Influencing Culture

The Improvement Plan (attached as Appendix A) sets out the relevant workstreams under each of these five key areas.

At its meeting on 15 April 2021, the Board considered the following areas as being essential areas of development in the coming year:

Item 2	Effective rostering within the nursing directorate
Item 7	Review of the performance metrics framework
Item 9	Risk reporting
Item 15	Defining TSH culture
Item 18	Digital platforms for leadership engagement with staff

In addition, progress updates can be made in relation to the following:

Item 6	Implementation and compliance with Once for Scotland HR policies
Item 12	Encourage attendance at Public Board Meetings
Item 13	External Board Meetings as NHS Board with national remit
Item 19	Coordinate senior team visibility at hospital events
Item 21	Non- Executive Director visibility and connection

3 ASSESSMENT

Item 2 – Effective rostering within the nursing directorate:

Work with National Workforce Team is continuing, and will be taken forward in line with safe staffing legislation. A one-year workforce plan for 2021/22 was approved by the Board in April 2021, and submitted to Scottish Government.

Dedicated reporting in this area is being routed through the Staff Governance Committee focussed on staffing issues and implementation of the legislative component. The Clinical Governance Committee received updates in relation to Staffing and Care in respect of any potential impacts to the delivery of safe and effective care.

The Director of Nursing, AHPs and Operations and Director of Workforce will meet with the National Workforce team on 6 September and will be able to provide a further update to the Board at its next seminar session on 23 September 2021. A progress will then be submitted through this plan.

Item 6 - Implementation and compliance with Once for Scotland HR policies

The State Hospital is well prepared for the continuing roll out of national policy.

The HR and Wellbeing Group is now well established and firmly support links with the Partnership Forum as well as the Staff Governance Committee to ensure appropriate governance. Updates or any issues of concern can be escalated to the Board if required. Given this strengthened governance route, and the assurance for the implementation of policy, the Board is asked to consider that this item is completed within this plan.

Item 7 – Review of the performance metrics framework:

The Board received newly formatted reporting at its meeting in February 2021, to give greater clarity on performance in reporting of Key Performance Indicators (KPIs) as well as to highlight the key areas for improvement. Work is being progressed in respect of a data map to describe

reporting routes across governance and management groups. A pilot was taken forward with the Human Resources department to support alignment of performance reporting and improvement priorities, and this methodology has now been rolled out to eHealth.

The Strategic Planning and Performance Group has now been established with responsibility in this area, reporting to the Corporate Management Team. Work will continue to be linked to the national agenda on active governance. A development session is expected to be led by the board development team at NHS Education for Scotland in the second half of this year.

Therefore, the Board is asked to consider if this item can be considered as closed as part of this improvement plan.

Item 9 – Risk reporting:

Significant work has been progressed well in reviewing the risk reporting framework at both local and corporate levels and linking these to provide cohesion in the reporting framework overall. The Board received a full update in this area at its meeting on 15 April, as well as considering this further in the seminar session in May 2021 taking assurance from the progress made.

The Corporate Risk Register is embedded in the Board's workplan and is closely monitored by the Corporate Management Team, supported by the Organisational Management Team. A framework is now in place to monitor local risk registers across the organisation. The Board is asked to consider if this item on the improvement plan can now be considered as completed.

Item 12 – Encourage public attendance at Public Board meetings

Item 13 – External Board Meetings

These items on the improvement plan are intrinsically linked. In the past, the State Hospital has taken forward a number of initiatives to facilitate public attendance, including holding Board meetings outwith the confines of the hospital itself.

Clearly, the pandemic has placed constraints on the ability to hold in person meetings. At the same time the shift to virtual meetings has brought unintended consequences that can be viewed as positive in supporting attendance through digital connectivity. This is especially relevant to The State Hospital as a national board serving the populations of both Scotland and Northern Ireland. With COP26 taking place in Glasgow in November, it is also timely to consider the positive impact on emissions that a shift to digital ways of working can have**.**

Therefore, the Board is asked to consider that a return to "business as usual" may not be optimal in this regard and that continued use of digital meetings should be tailored to a hybrid model. This would enable in person attendance in part for some, as well as digital connectivity into the meeting. There are tools available to enable this (e.g. virtual owl within the meeting room) and this model is the simplest logistically and is now being used widely across NHS Scotland. This model would be closely monitored to ensure compliance with any change to national guidance or restrictions relating to Covid-19

Should there be public interest in attending the meeting, this can be considered through in person and /or the digital connection, and managed through the Board Secretary. A digital connection is managed through linking to the meeting only as an unidentified guest viewer and without access to wider functionality e.g. MS Teams chat function. The meeting would not be recorded or used as live stream. No personal details would be recorded or published, ensuring appropriate practice in

terms of personal data. This practice has been benchmarked to other NHS Scotland Boards and now be regarded as common practice.

As a courtesy, the Chair may offer guidance to the public that, whilst they are welcome to view the meeting, they will not be invited to contribute.

Finally, the State Hospital should also consider the patient group itself and the possibility of viewing the meeting through a digital connection. The Person Centred Improvement Team have been asked to consider this in the wider context of patient engagement, and how best to facilitate links with the Board. For example, this may be linked to Non-Executive Director attendance at the Patient Partnership Group.

Item 15 – Defining TSH culture:

The Board received detailed reporting in this area on 15 April 2021, through the Recovery and Innovation agenda and noted that developments would continue to be progressed through the HR and Wellbeing group. This group commenced in December 2020, through the new management structure and has developed as a strongly supportive mechanism within the organisation. It is well attended across departments and staff cohorts, providing an arena for discussion and consideration across all areas affecting the workforce, and is key to supporting staff wellbeing and defining culture within TSH. The Board receives reporting specific to staff wellbeing as part of the continuing response to the Covid-19 pandemic, and thereafter will receive dedicated reporting on staff wellbeing as part of overall workforce reporting.

The Board is asked to consider if this item can now be considered completed as part of the improvement plan.

Item 19 – Senior Leadership connection to hospital events

Item 20 - Non-Executive Director visibility and connection

These two items have for the most part been necessarily paused during the pandemic. Whilst on site or in person events may now be possible, this will need to kept under close review and aligned to the national position in terms of public health and infection control.

Therefore, a hybrid model of engagement is proposed as the way forward, for leaders within the hospital as well as enabling connectivity for Non-Executive Directors. For example, the staff awards are planned through a digital platform, whilst it is more beneficial for Leadership Walkrounds or attending the Patient Partnership Group to take place in person.

The Corporate Services Team is continuing to develop as part of the business support framework in the hospital and can support coordination of leadership visibility. This should be progressed and in place for October 2021.

4 RECOMMENDATION

The Board is asked to:

- Consider and discuss the updated improvement action plan, noting the key areas of development this year, and agreeing to the items now considered to be closed.

- Provide further input on any further areas of improvement or any additional actions that should be included in this plan to support the remobilisation of The State Hospital.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	In support of the Corporate Governance Blueprint, and development of a Once for Scotland approach for cohesive governance across NHS Scotland
Workforce Implications	None identified to date
Financial Implications	None identified to date
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board requested as part of workplan – to enable reporting to Scottish Government
Risk Assessment (Outline any significant risks and associated mitigation)	None identified to date – this report supports good governance and considers overview whilst each workstream provides reporting and risk are outlined therein.
Assessment of Impact on Stakeholder Experience	Implementation will benefit stakeholder engagement through the workstreams indicated in the improvement plan
Equality Impact Assessment	Not required to be formally assessed
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	No impact identified
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One □ There are no privacy implications. X There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	Reconfirm the Board's strategic direction, and communicate this through the Strategy Map and development of strapline statement for corporate documents.	CEO	CMT	June 2019	**Completed:** Strapline finalised following hospital wide competition. Strategy Map reviewed as part of review of Corporate Objectives.
	2	Review of effective rostering system within nursing as component of focus on effective workforce utilisation and safe staffing legislation.	Director of Nursing, AHPs and Operations	CMT	New: **December 2021**	**December 2019:** Work to ensure effective rostering is in place with the support of electronic systems. Testing of SSTS eRostering module in one ward with wider rollout planned. Restrictions on effective rostering remain due to fixed shift pattern; alternative, flexible shift pattern introduced for all new appointments to ward nursing posts which increased capacity Internal Audit planned for Jan 2020. **Update: February 2020** RSM undertook audit 6th to 10th January 2020, range of actions linked to this point accepted for progression. **Update: December 2020** Work restarted - further planning and review underway in conjunction with interim management structure.

						Update April 2021: Work with the National Workforce Team has generated several pieces of work to streamline processes including potential adaptations to rostering and shift patterns to improve rostering, create capacity and reduce overtime. This workstream will continue to be progressed in Partnership during 2021. Full update to Board Seminar in May 2021 (deferred). **Update August 2021: Dedicated reporting to Staff Governance Committee on implementation of legislation, dedicated reporting to Clinical Governance Committee in respect of staffing inked to impact on care. Meeting with the National Workforce Team in September 2021, and presentation to Board as part of seminar in September.**
	3	Development of more robust processes to compare planned and actual spend and to account for any variance.	Director of Finance and eHealth	CMT /Board	September 2019	**Completed:** Process in place- Planned and actual £ spend per budget line reviewed with each individual budget holder on a line-by-line basis from the 2019/20 mid-year 6-month reviews (30/9/19) – a summary of any significant or material

						variances is collated to be reported as appropriate.
HOLDING TO ACCOUNT	4	Ensure compliance with new national guidelines in management of Executive pay and performance through remuneration Committee approval for annual ESM pay and performance cycle.	Chair /Interim HR Director	Remuneration Committee	Ongoing	**Completed**
	5	Ensure implementation of attendance management policy through support from HR to line managers help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).	Interim HR Director	CMT	Ongoing 2019/20 – revised and completed	**Completed:** Once for Scotland Workforce Policy Implemented. Training for Line Managers and HR Managers delivered. Update presented on attendance management to each Board Meeting. Improvement activity now directed by the HR and Wellbeing Group.
	6	Implementation and compliance with Once for Scotland HR policies within TSH. Focus on policy awareness through completion of metacompliance / staff bulletins/ staff training in Single Investigatory process.	Interim HR Director	Partnership Forum/CMT	New: **April 2022 national target**	**Phase 1 On Track** – to align with roll out of the national guidance. **Update: March 2021** Workstream continues to be paused with phase 2 policies, due to Covid-19. National Implementation to be confirmed August 2021 for planned implementation of phase 2 for April 2022. **Update August 2021: HR and Wellbeing Group is now well established and will support**

						links with Partnership Forum/ Staff Governance Committee to ensure appropriate governance, with updates to the Board if required. Board to consider whether to close item as completed.
	7	Review performance framework and assurance information systems to support review of performance.	Head of Corporate Planning	CMT	New: June 2021	**On Track -** Strategic Review of Performance underway with draft performance framework in development based on balanced scorecard approach of better health better care, better value and better workforce. Operational definitions for suggested KPI's being developed with associated data sources identified. **Update: December 2020** Presentation to Board in November 2020, work progressing with oversight through CMT **Update April 2021**: Format of KPI report changed to provide clarity on KPI's performance and describe the areas for improvement. Data map developed to illustrate where data is reported across governance and management

						groups. PuMP pilot being taken forward with HR to support alignment of performance improvement and reporting of KPI's in line with Organisational priorities and linked to departmental priorities. **Update August 2021. PuMP rolled out to EHealth following the HR programme, and underway. Performance Workbook created across directorates and linked to governance. Strategic Planning and Performance Group set up and met for first time in August 2021, reporting line to the CMT. Link also made to Active Governance workstream for board development session planned for November 2021. Board to consider closing this item on this plan.**
	8	Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK	9	Further development of risk management with focus on risk register to ensure this is clearly defined with set of mitigating	Director Security, Resilience and Estates	Audit Committee / Board	New: June 2021	**December 2019:** Review underway through closer Risk Register monitoring and review process (managed by Risk Team

		measures against each risk which also have a focus on improvement actions.				Leader). Board Workplan 2020 agreed to include regular updates on Corporate Risk Register. **Update: December 2020** Board requested reporting developed to ensure tracking of risk more clearly. Work progressed on local risk registers and link to corporate risk register. Change in leadership through interim management structure, and link to resilience framework. **Update: April 2021** Work progressed to review the Corporate Risk register and link to development of local registers throughout TSH. Update to Board April 2021, as well as to next Board seminar 31 May 2021. **Update August 2021: Board presentation took place. Regular reporting of Corporate Risk Register to Board and tracked through monthly reporting at CMT and quarterly at OMT. Local Risk tracked and link made to CRR. Board to consider whether to close this item on the plan.**

ENGAGING STAKEHOLDERS	10	Review and develop the Communications Strategy to include proactive engagement with aim of addressing dissonance between strategic aims of the hospital and public perception of these aims.	CEO	Board	New: **Roll out over June to December 2021**	**December 2019 -** Review of media strategy in progress with regular updates to the Board. **Update: December 2020** Presentation to Board seminar November 2020, and re-engagement of workstream at start of 2021. **Update April 2021-** Work being progressed January to June 2021 in preparation for roll out.
	11	Promotion of The State Hospital as an employer in the local area. Increase number of modern apprenticeships. Participate in local school careers events, local and university recruitment fairs.	Interim HR Director	CMT	New: August 2021	**Completed** Full range of recruitment activity in place.
	12	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	New: June 2021	**On Track** – through promotion of external Board Meetings /Annual Review session in 2020. **Update: December 2020** Reviewed in Board Seminar November 2020, and awaiting national guidance. Local review

						to be taken forward to engage virtually. **Update: February 2021**: Board agreed value of digital means of engagement and further work to be take forward to enable this to be taken forward linking to attendance by patients as well. **Update August 2021: Board to consider hybrid of in person and digital meetings**
	13	Hold two Board Meeting each year at external locations to promote role as national Board.	Board Secretary	Board	Paused due to Covid-19 restrictions	**Update: February 2020:** Board Meeting 27 February in Lanark Memorial Hall, digital participation under review. **Update August 2021: Board to consider hybrid of in person and digital meetings**
	14	Annual Review - Public Meeting to be held outside of the hospital to help engage public engagement and attendance.	Board Secretary	Board	Paused due to Covid-19 – awaiting national guidance	**Update: December 2019:** Plan to be progressed as part of Annual Review. The review in 2020 was redesigned due to Covid-19. Awaiting national guidance for the current year. **ON HOLD**
INFLUENCING CULTURE	15	Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	New: August 2021	**Update: February 2020** Progressed in conjunction with response to Sturrock and Clinical Model Review – Culture, Values & Behaviours, Leadership workstream led by CEO.

						Update: December 2020 Workstream re-formulated and developed more widely under Recovery and Innovation Group during Covid. Planning in place for development of this framework in spring 2021, and reporting to come to Board as part of workplan. **Update: April 2021** A programme of work, from the themes identified through the staff engagement activity has been taken forward. Oversight of the Recovery and innovation group is through CMT, and updates to all staff through bulletin. Future developments will connect through the staff HR and Wellbeing group **Update:August2021:** **Workstream led through HR and Wellbeing. Staff wellbeing reporting comes to Board as part of covid reporting, with dedicated reporting to replace this at end of pandemic as part of overall workforce reporting/ workplan. Board to consider closing this item as completed on plan.**

	16	Implement a Staff Recognition Scheme for long service as well as individual contribution to the organisation.	Interim HR Director	CMT	September 2019	**Completed**- first ceremony 24 October 2019.
	17	Embed a culture of quality across the organisation through initiatives such as TSH3030, Quality Forum and sharing our work more widely.	CEO	CMT	February 2020	**Completed and Board now gets full updates at each meeting.**
	18	Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of events to ensure regular engagement.	CEO	CMT	New: **December 2021**	**Update: December 2019** wider engagement across TSH – progressed in conjunction with response to Sturrock and Clinical Model Review. **Update: December 2020** This agenda has been developed throughout the incident command structure period, with strengthening of layers of leadership. Key learning has been taken and progressed through to interim management structure. **Update: April 2021** Review of digital means of connection under development with software procured. Training and development to be progressed for rollout
	19	Senior Team / RMO presence at key events in hospital calendar e.g. patient learning awards/ sportsman dinner.	CEO / Medical Director	CMT	New: **October 2021**	**Update: December 2019** Coordination of central diary of events to help facilitate attendance.

		Promote this through management structures.				**Paused due to Covid-19 Update August 2021: Covid restrictions depending event planning through hybrid of in person and digital means with coordination of diary to be led through Corporate Services Team and in place for October 2021.**
	20	Link in with Scottish Government once appointment of the Independent National Whistleblowing Officer and Board Champion has been appointed.	Change to Interim HR Director	Board	March 2021	**Completed**
	21	Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	New: **October 2021**	**February 2020** - Schedule in place for patient and staff engagement with NXD attendance at PPG meetings. **Paused due to Covid-19 Update: December 2020** Restart may be possible in 2021. PPG meetings have, in part re-commenced virtually, explore possibility of NXD attendance at these meeting virtually. Digital agenda being progressed including online staff engagement for Exec Team. This should be progressed to include NXDs. **Update April 2021:**

						PPG meetings taking place in person for ID population, and new video conferencing equipment under procurement for wider patient group. Non-Executive attendance to be kept under review for 2021 when possible. **Update August 2021: Covid restrictions depending, non – executive presence on site now being taken forward as per hybrid model of engagement. Workplan Including PPG/ Leadership Walkrounds planned for October 2021 onwards. Link to hospital events such as staff awards through digital means.**

THE STATE HOSPITAL BOARD FOR SCOTLAND

Date of Return:	26 August 2021
Agenda Reference:	Item No: 19
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 June 2021
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 monthly to Scottish Government (SG) along with the statutory financial reporting template. It is also reported internally to fit in with the new Management Structure.

2 BACKGROUND

Scottish Government are provided with an annual Operational Plan and 3-year financial forecast template, the draft version of which was submitted at the end of February. This process has now been complemented by the Board Remobilisation Plan.

TSH have asked for six months funding for Covid based on half of last year's funding. We have now received Q1 monies. There are potential delays in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be quantified for consideration within the Covid cost impact.

The base budgets have been established and forecast a breakeven year end positon, set on achieving £1.249m efficiency savings, as referred to in the table in section 4.

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £39.537m is primarily the forecast Scottish Government Revenue Resource Limit allocation, and anticipated allocations.

The Board is reporting an under spend of £0.019m to 30 June 2021.

AFC pay has been accrued (from the reserve set aside) for the arrears due to be paid in August.

3.2 Key financial pressures / potential benefits.

Revenue (RRL):-

Office 365

An accrual was set aside March 2021 to help the licence costs pressure, which will be monitored with the Head of eHealth.

Covid-19

50% of 20/21 funding has been requested for the first six months of this financial year, this will be closely monitored in year, and in liaison with SG. We did however receive Q1 only in the June Allocation.

Clinical Model review

The review of the clinical model identified potential recurring savings in ward nursing - values to be confirmed – which would have been beneficial from early 2020/21. However, this is on hold due to the ongoing Covid crisis. This is expected to commence mid/late-year, possibly September 21.

Patient Visiting

There will be a Business Case put forward to CMT for the additional staff needed to cover patients visitors service (changes re covid).

Travel

Benefits arising due to most meetings and courses now being virtual, through the Covid crisis.

Capital (CRL):-

Additional funding has been requested over and above the recurring £0.269m, specifically for MSR and KeySafe priority works, amounting to an estimated £0.500m.

3.3 Year-to-date position – allocated by Board Function / Directorate

Further tables/detail below on first two Directorates – i.e. those with the highest budgets.

Directorates	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 3	Budget WTE	Actual WTE
Nursing And Ahp's	22,112	5,528	5,474	54	400.63	412.63
Security And Facilities	6,457	1,614	1,566	49	120.64	116.68
Medical	2,925	731	726	5	21.70	23.02
Chief Exec	1,819	455	402	52	22.07	17.16
Human Resources Directorate	937	234	227	8	14.05	14.42
Finance	2,557	639	650	(10)	29.02	29.01
Cap Charges	2,857	714	655	59	0.00	
Misc Income	(600)	(269)	(356)	87	0.00	0.00
Central Reserves	472	(136)	149	(285)	0.00	0.00
	39,537	**9,511**	**9,492**	**19**	**608.11**	**612.92**

Medical – Clinical Effectiveness & Risk change forms still outstanding – this should be resolved for July payroll.

CE – Corporate change forms still outstanding – this should be resolved for July payroll. Social Work SLA savings to be reviewed once invoices received for the new financial year.

HR – No issues.

Finance – Legal fees and compensation payment pressures, also eHealth strategic funding pending.

Capital Charges – Awaiting forecast for 2021/2022, this budget is carried forward from previous year meantime.

Misc. Income – The budget now recognises income for exceptional circumstance patients. There are some delays in their payment, for which pursuit at senior level and CLO continues.

Central reserves
Savings unidentified are phased as twelfths. Pay accrual charged here until arrears paid August.

Nursing & AHPs

Nursing And Ahp's	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 3	Budget WTE	Actual WTE
Advocacy	148	37	37	0	0.00	0.00
AHPs & Dietetics & SLAs	719	180	130	50	13.33	11.42
Hub & Cluster Admin & Clinical Operations	862	216	172	44	24.97	20.48
NPD & Infection Control & Clin Gov	443	111	89	21	5.80	4.75
Psychology (but PA's actuals £74k still included)	1,337	334	404	(69)	18.50	23.76
PCI & Pastoral	228	57	52	5	3.40	3.60
Skye Centre	1,794	448	419	29	37.33	34.53
Ward Nursing	16,581	4,145	4,171	(26)	297.30	314.14
	22,112	**5,528**	**5,474**	**54**	**400.63**	**412.63**

Highlights from Nursing & AHP's: -

Ward nursing overtime equates to actual WTEs, with Nursing currently under establishment – resulting in overspend in month.

Vacancies for many of the other departments –
There have been many changes within the Management structure and some change forms are still outstanding so budgets and actuals still not in sync this month, the remaining change forms are expected to be finalised in July payroll.

Security & Facilities

Security And Facilities	Annual Budget £'k	Year to Date Budget £'k	Year to date Actuals £'k	YTD Variance (budget less actuals) for period 3	Budget WTE	Actual WTE
Risk & Resilience	128	32	19	12	2.00	2.00
Facilities	4,575	1,144	1,091	52	78.87	73.83
Security	1,754	439	454	(15)	39.77	40.85
Perimeter Security	0	0	1	(1)	0.00	0.00
	6,457	**1,614**	**1,566**	**49**	**120.64**	**116.68**

Highlights from Security and Facilities:-

Risk & Resilience – New start not in post from 1st April so providing a saving against budget.

Facilities – Housekeeping vacancy savings and holiday pay budget not fully utilised.

Security – some of the overtime and on-call pressures will be met from covid monies – Quarter 1 pressures will be matched in the July accounting period. Other overtime is for high sickness levels and is being monitored.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(143)	0	(143)
Finance	(26)	8	(18)
Nursing & AHP's	(392)	96	(296)
Human Resources	(15)	0	(15)
Medical	(20)	10	(10)
Security & Facilities	(215)	50	(165)
Unidentified (phased 1/12ths ytd)	(438)	(107)	(544)
Total	**(1,249)**	**58**	**(1,192)**

While an improved level of the proportion of recurring savings is a national focus that has been highlighted by audit, it should be noted that of the Hospital's budget nearly 85% of costs are pay/staff-related. The remaining non-pay cost element from which recurring savings are being pressured is therefore only 15%. By comparison, many territorial boards have a non-pay cost element of around 65%; other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.; and certain boards treat vacancy savings, or a proportion thereof, as recurring savings. Budget base adjustments slightly increased the unidentified base savings. Further review will take place at the end of quarter 1 i.e. for July accounting period.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working.

There continues to be pressure on the collective boards due to the £15m challenge not yet being fully identified. The recurring level which the Board agreed for 2019/20 and 2020/21 remains at £0.220m.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for the year is £0.269m. Over and above this is additional funding requested (as noted in paragraph 3.2), and the perimeter fence project allocation, for which this shows Year 2 of 2.

CAPITAL CRL 2021/2022 AS AT JUNE 2021	ANNUAL PLAN	YTD PLAN	YTD SPEND	under/ (over)
	£'k	£'k	£'k	£'k
PERIMETER SECURITY				
STANLEY SECURITY SOLUTIONS LTD		677	677	0
SECURITY CONTRACTING SERVICES LTD		0	0	0
DOIG & SMITH		0	0	0
THOMSON GRAY LTD		48	48	0
TSH STAFFING APR - MAR'22		38	38	0
ATUS		0	0	0
SENSTAR CORP		25	25	0
PERIMETER SECURITY TOTAL (Yr 1 of 2)	**2,879**	**789**	**789**	**0**
CAPITAL				
IM&T		0	0	0
OTHER		2	2	0
CAPITAL	**269**	**2**	**2**	**0**
Total CRL	**3,148**	**790**	**790**	**0**

6 RECOMMENDATION

Revenue
Year to date position is £0.019m underspend, with breakeven anticipated for the year-end.

Capital
Spend may not be in even twelfths through the year, so this table will show plan and spend matching, with breakeven anticipated for the year-end.

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.

Paper No. 21/65

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	Item No: 21/65
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 Q1 2021/2022
Purpose of Report:	To provide KPI data and information on performance management activities.

1. SITUATION

This report presents a high-level summary of organisational performance through the reporting of Key Performance Indicators (KPI's) for Q1: April – June 2021. Trend data is also provided to enable comparison with previous performance. The national standards directly relevant to the State Hospital are as follows: 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 for 2020-21 which was submitted to Scottish Government to outline the priority areas of development.

The Board is asked to note that this report covers the unprecedented period of operation due to the Coronavirus pandemic. During this period, an Interim Clinical Operational Policy (ICOP) was introduced in March 2020 to ensure infection prevention and control measures are prioritised. The ICOP is supported by daily and weekly monitoring of key data to review the impact of the care model on the health and well-being of patients. 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.

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 Q1 and highlight any areas for improvement in the next quarter through a deep dive analysis for KPI's that have miss their targets.

There are eight KPI's which have reached and / or exceeded their target this quarter.

There are four KPI's which are off target this quarter, these are:

- Patients 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 rate (National HEAT standard is 4%)

Performance Indicator	Target	RAG Q2 20/21	RAG Q3 20/21	RAG Q4 20/21	RAG Q1 21/22	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	G	A	A	92.40%	This indicator remains in the amber zone for quarter 1.
Patients will be engaged in psychological treatment	85%	G	G	G	G	90.26%	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%	R	G	G	G	94%	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%	G	R	R	R	0%	13 patients were due their annual physical health review however none were offered this.
Patients will undertake 90 minutes of exercise each week	80%	G	A	R	G	90%	A 25% increase in this indicator during Q1. This indicator is now within the green zone.
Patients will have a healthier BMI	25%	R	R	R	R	8%	The amount of patients within the hospital with a healthy BMI has remained the same during this quarter.
Sickness absence rate (National HEAT standard is 4%)	** 5%	R	A	G	A	5.68%	April's figure was 4.57%, May's was 5.75% and June's was 6.74%
Staff have an approved PDR	*80%	G	G	G	G	90.70%	This indicator has been within the green zone March 2019.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	7 patients were transferred during this quarter all using CPA.
Patients requiring primary care services will have access within 48 hours	*100%	G	G	G	G	100%	This indicator remains 100% in Q1.
Patients will commence psychological therapies <18 weeks from referral date	**100%	G	G	G	G	99.70%	1 patient waited beyond the specified wait time.
Patients have their clinical risk assessment reviewed annually.	100%	G	G	A	G	95.13%	As at 30 June 2021, there were 114 patients in the hospital. Thirteen were new admissions and two patients had out of date risk assessments
Attendance at CPA Reviews (Refer to Appendix 1)							

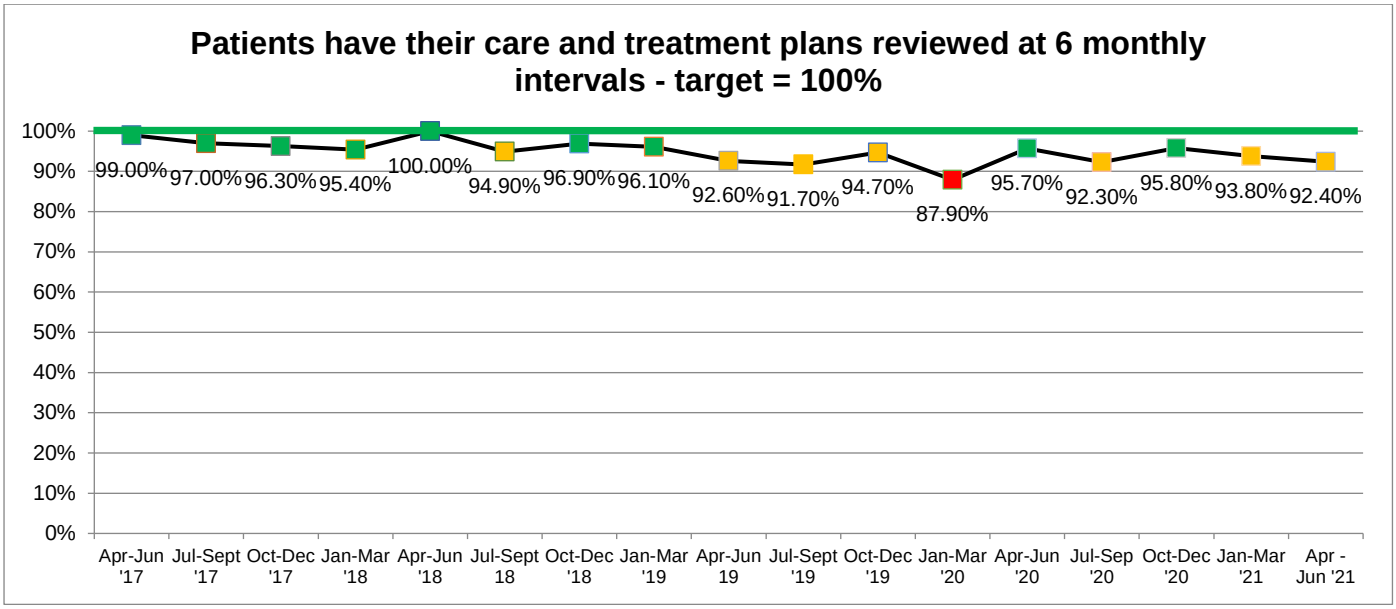
No 1: Patients Have their Care and Treatment Plans Reviewed at 6 Monthly Intervals

Target: 100%

Data for current quarter: 92.40%

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.



On 30 June 2021 there were 114 patients in the hospital. Thirteen of these patients were in the admission phase. Five CPA documents had not been reviewed within the 6-month period, or within the agreed admission phase. All of these five CPAs have been held with no documents being uploaded to RiO – one had been moved to fit with the annual renewal date, however this was over 7 months since the previous CPA.

All dates are set in line with the relevant date of an annual review or renewal followed by a 6 monthly review after that.

Key areas of improvement for implementation, which are ongoing, are as follows:

- Health Records Manager is going to provide monthly updates for the next rolling 6 months to ensure CPA's are being held within their timescales and completed fully; including the uploading of documentation onto RiO.
- Additional support is being provided for RMO's and medical secretaries regarding CPA documentation and timescales in liaison with the Business Support Manager.
- The KPI definition is undergoing a review to ensure it wholly encompasses national guidelines and realistic timescales for completion of the entire process.
- Health Records Manager is liaising with Clinical Effectiveness and MHPSG regarding the current review of the CPA process. This could, in turn, produce the need to revise the current CPA guidance.
- A review of current checklists to aid this process may be undertaken to provide further assurance every patient receives either an intermediate or annual review.

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.

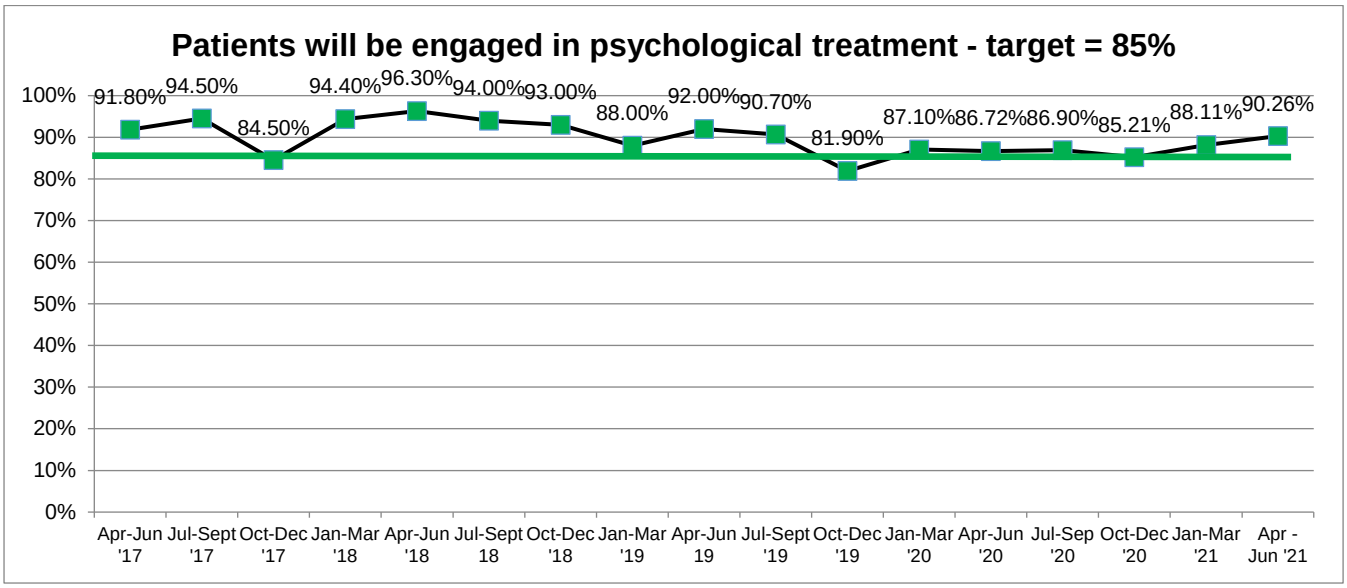
No 2: Patients will be Engaged in Psychological Treatment

Target: 85%

Data for current quarter: 90.26%

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.



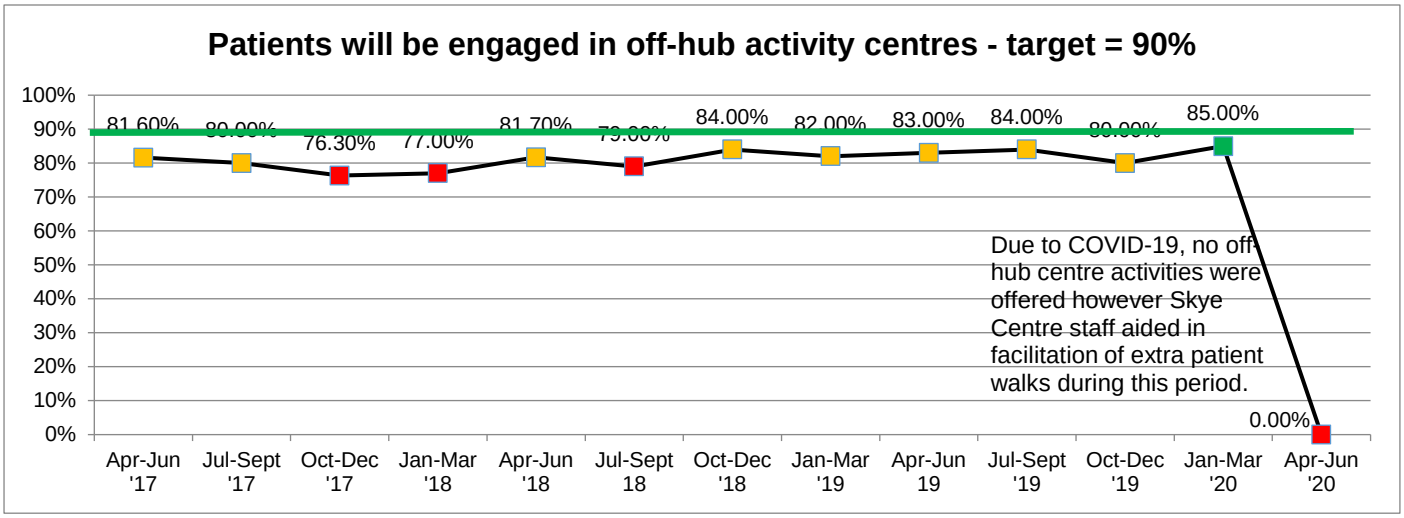
No 3: Patients will be Engaged in Off-Hub Activity Centres

Target: 90%

Data for current quarter: -

Performance Zone: -

This is a local priority linking with patient objectives within their care plans and measures the same.



*This indicator was closed off in June 2020 to accommodate the changing nature of engagement in off-hub activity centers during the coronavirus pandemic as all scheduled / timetabled sessions were paused.

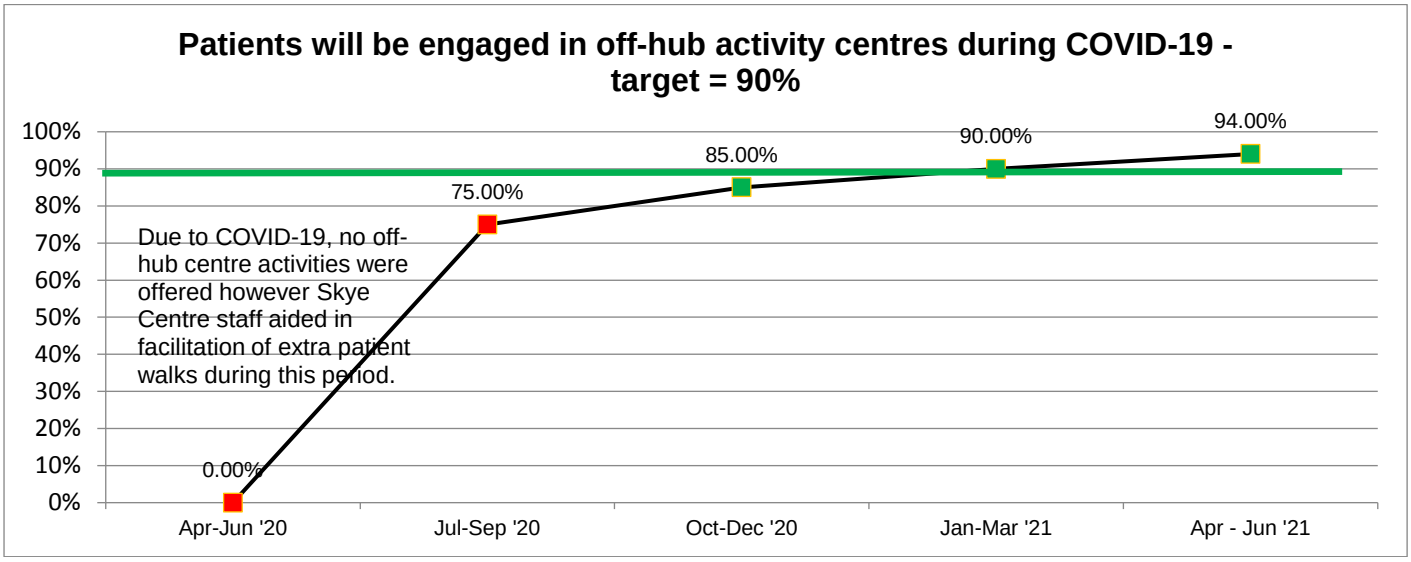
No 3.1: Patients will be Engaged in Off-Hub Activity Centers during COVID-19

Target: 90%

Data for current quarter: 94%

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).



*This indicator includes data gathered pertaining to non-timetabled sessions and drop-in rates at the Skye Centre from July 2020 onwards.

Patients continue to access off hub activities through drop-in services. Since the last quarter, there has been a 4% increase in the average percentage of patients who chose to participate in off-hub activities.

A weekly timetabling group has been established with members of professional services including Psychology, Skye Centre, Nursing and Occupational Therapy. This group discusses patient activity on a weekly basis, new activities being introduced as well as identifying gaps and staff deficits that could prevent patients participating in activity.

Due to the COVID-19 pandemic, the recording of patient activity has changed slightly. The e-Health Department and the Skye Centre Secretary are currently adapting the RiO timetables to ensure the continued accurate recording, as we did pre-COVID-19, and it is hoped to move back to recording planned activities in the near future.

This indicator is currently under review to be redeveloped into a more accurate indicator which relates to any timetabled sessions and activity for every patient.

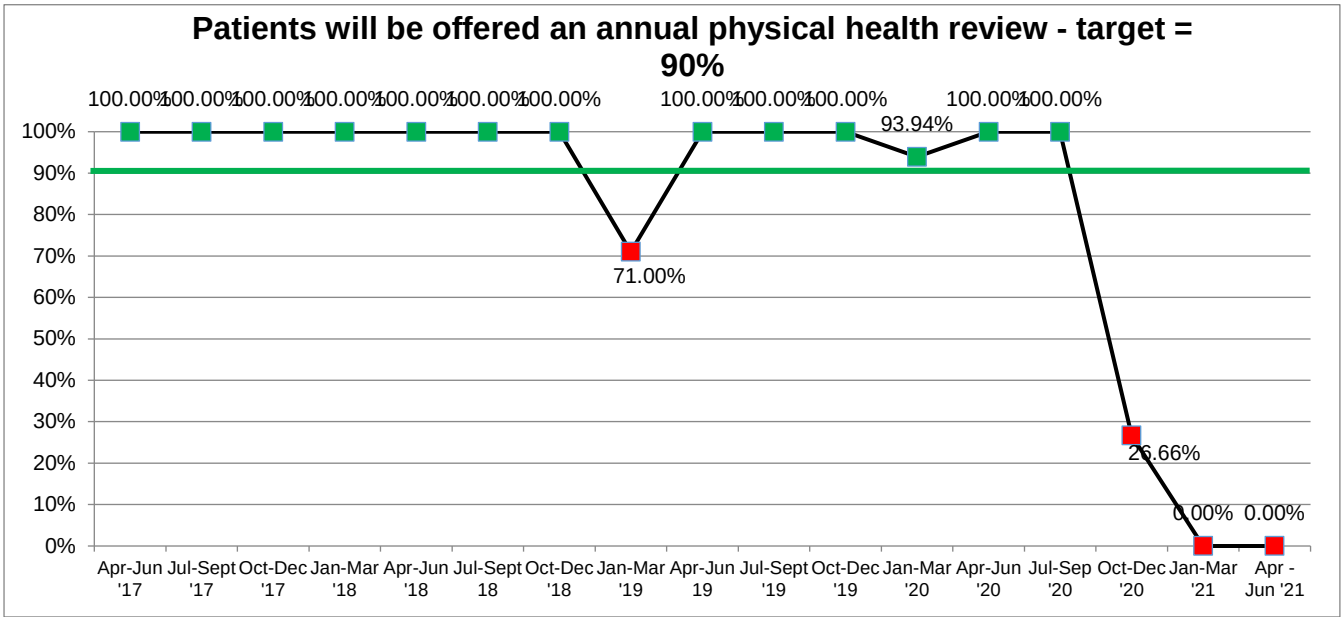
No 4: Patients will be Offered an Annual Physical Health Review

Target: 90%

Data for current quarter: 0%

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.



This indicator has fallen into the red zone for three consecutive months. A total of 13 patients were due an annual physical health review during this quarter however no patients were offered this review. This gives a 0% compliance for Q1. This was due to absence of the General Practitioner (GP) due to long term sickness which meant that letters inviting attendance at Annual Health Reviews to see the GP were not issued.

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. Locum Doctors from the Medwyn Practice were contacted for guidance during this period as the current GP for TSH is absent through long-term sick.

The Health Centre will re-establish the offering of the annual physical health reviews in the coming weeks and discussions are already in place regarding this; albeit in line with Government guidance and restriction levels. Work has progressed regarding the amendment of this KPI to reflect the uptake and quality of the physical health care provided. Moreover, the appointment of the new Practice Nurse will contribute to the KPI accurately reflecting standards in addition to tailoring the KPI to be more results based.

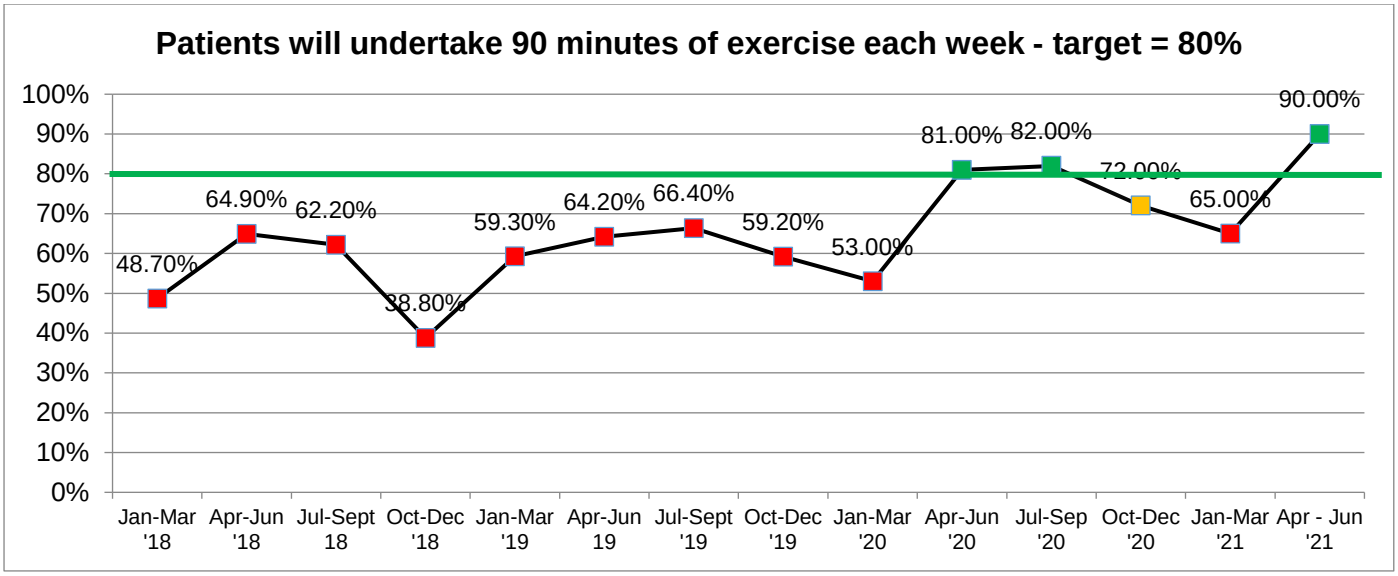
No 5: Patients will be Undertake 90 Minutes of Exercise Each Week

Target: 80%

Data for current quarter: 90%

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.



This has been an exceptional year due to the impact of the pandemic on physical activity.

There has been a significant increase since the last quarter (65%) in the average percentage of patients undertaking 90 minutes of exercise per week and this figure is the highest percentage for Q1 for physical activity over the last 3 years.

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.

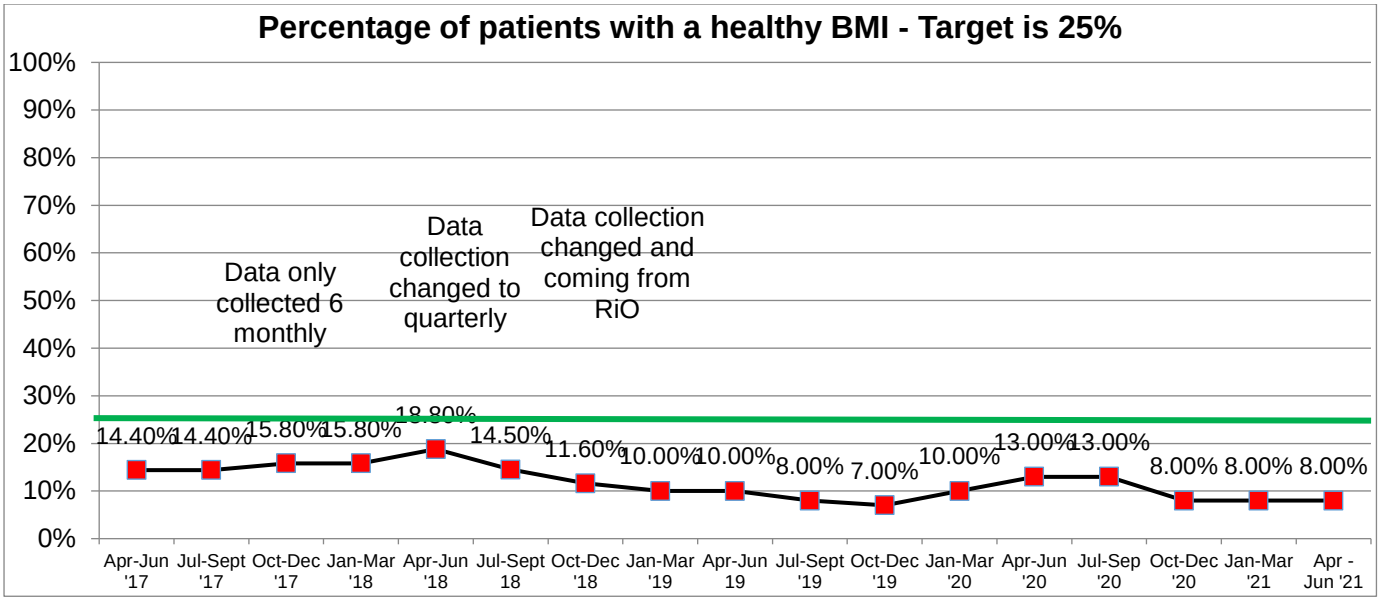
No 6: Patients will have a Healthy BMI

Target: 25%

Data for current quarter: 8%

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.



The RiO reports show that 8% of patients have a healthy BMI; this remains the same as last quarter. This indicator remains in the red zone. The data is a snap shot per month of the population, taken on the 12th of the month.

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. The SHCG draft plan of work adopting a QI approach to prevention, reduction and the management of obesity has been submitted to the Board. Options to consider how groups and ward-based weight loss interventions may be delivered have been included within the plan of work.

The PHSG has requested monthly monitoring of Shop purchasing to ascertain the percentage of items purchased which fall in the healthy / unhealthy category and devise ways in which we can promote healthier purchases.

Weight Range BMI	**Q1 Apr-Jun 2021 N=112**	**Q4 Jan-Mar 2021 N= 96**	**Q3 Oct - Dec 2020 N=106**	**Q2 Jul - Sep 2020 N=111**
<18.5 Underweight	0%	0%	0%	1%
18.5-24.9 Healthy	8%	8%	8%	13%
25-29.9 Overweight	42%	40%	35%	43%
30-34.9 Obese (Class 1)	36%	34%	38%	26%
35-.39.9 Obese (Class 2)	12%	16%	15%	15%
>40 Obese (Class 3)	3%	2%	3%	2%

*N.B. The N number equates to how many patients we hold BMI data for during the specific quarter. Missing data relates to those patient who refuse or are too unwell to undertake a BMI check.

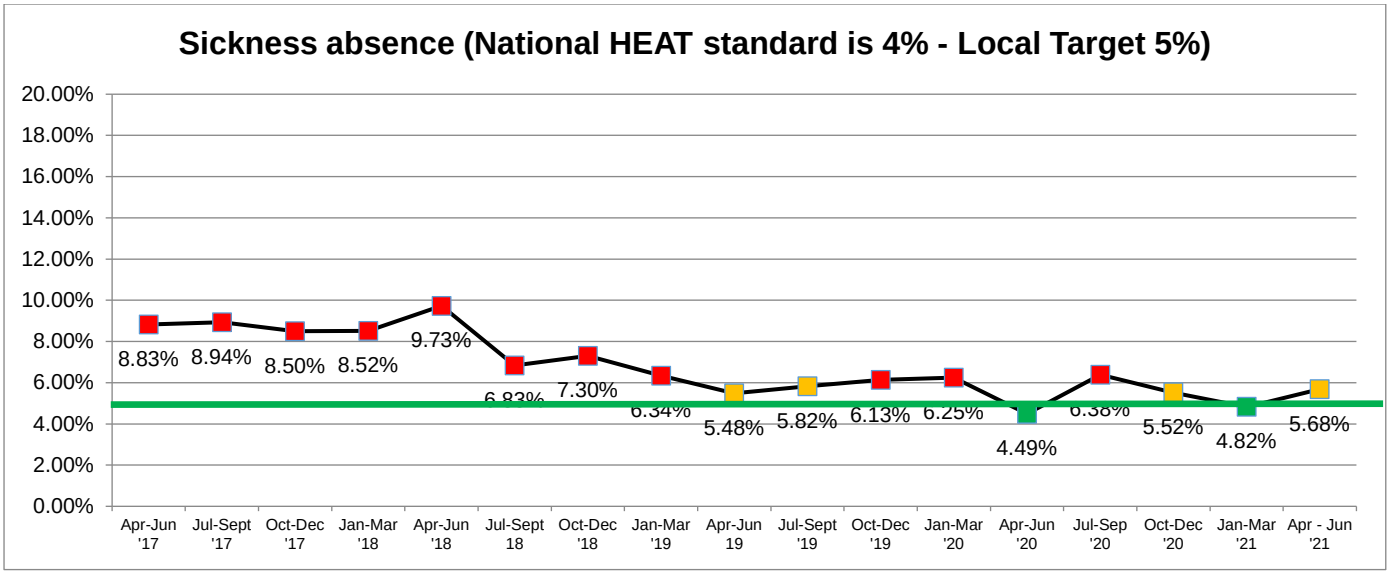
No 7: Sickness Absence (National Heat Standard is 4% - Local Standard Is 5%)

Target: 5%

Data for current quarter: 5.68%

Performance Zone: Amber

This relates to the National Workforce Standards and measures how many staff are absent through sickness. This excludes any COVID-19 related absences which are measured / reported separately.



COVID-19 RELATED SPECIAL LEAVE

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. Details of working hours lost due to COVID-19 related special leave expressed by the monthly totals, are provided below.

Source: SSTS

< 5% Green
5 - 7% Amber
> 7% Red

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%

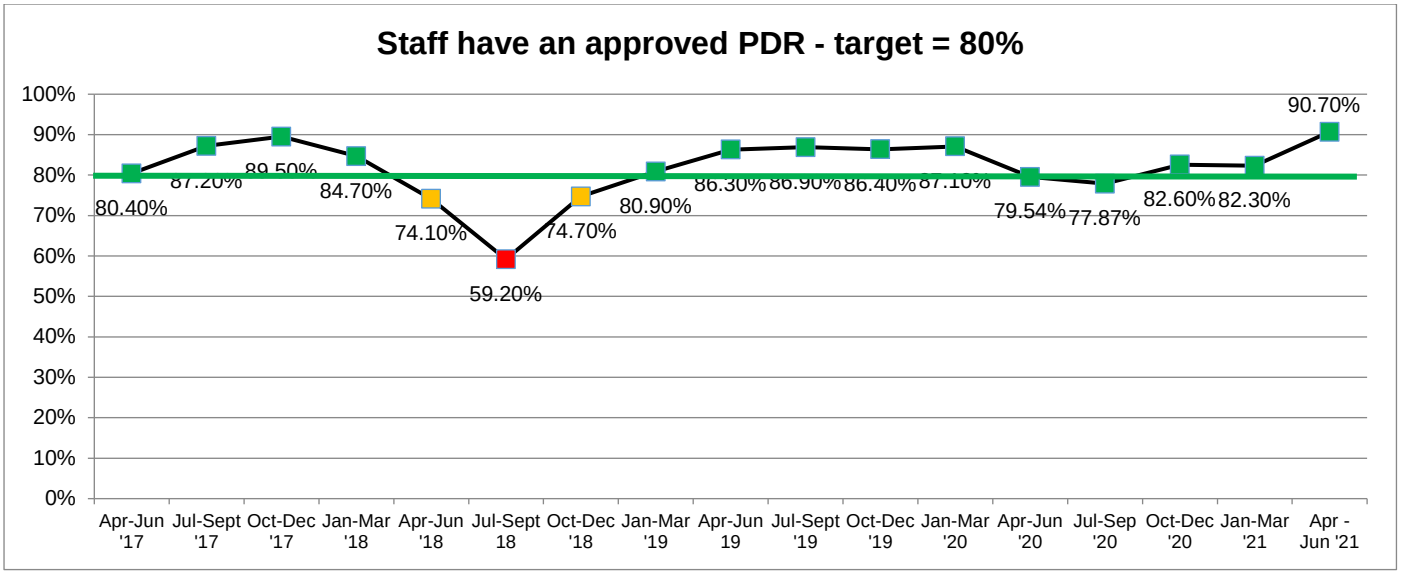
No 8: Staff have an Approved PDR

Target: 80%

Data for current quarter: 90.70%

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.



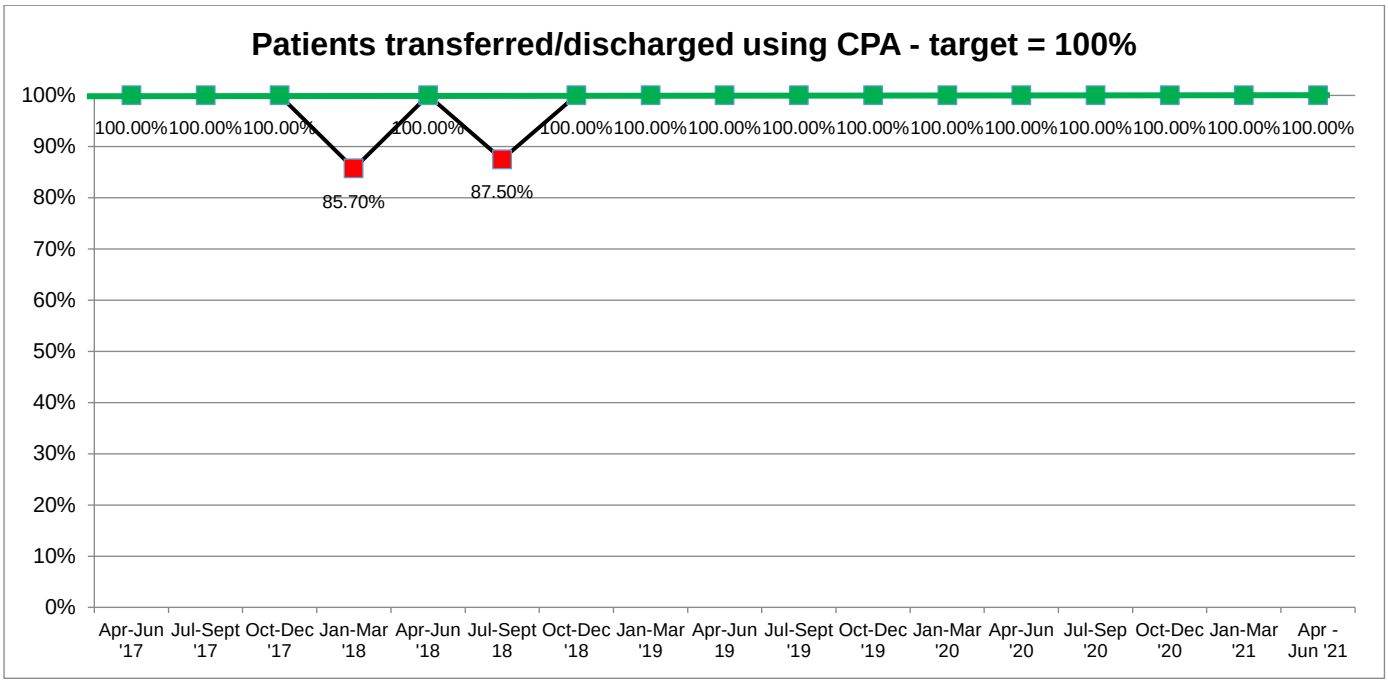
No 9: Patients are Transferred/Discharged using CPA

Target: 100%

Data for current quarter: 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.



7 patients were admitted / discharged via the CPA process.

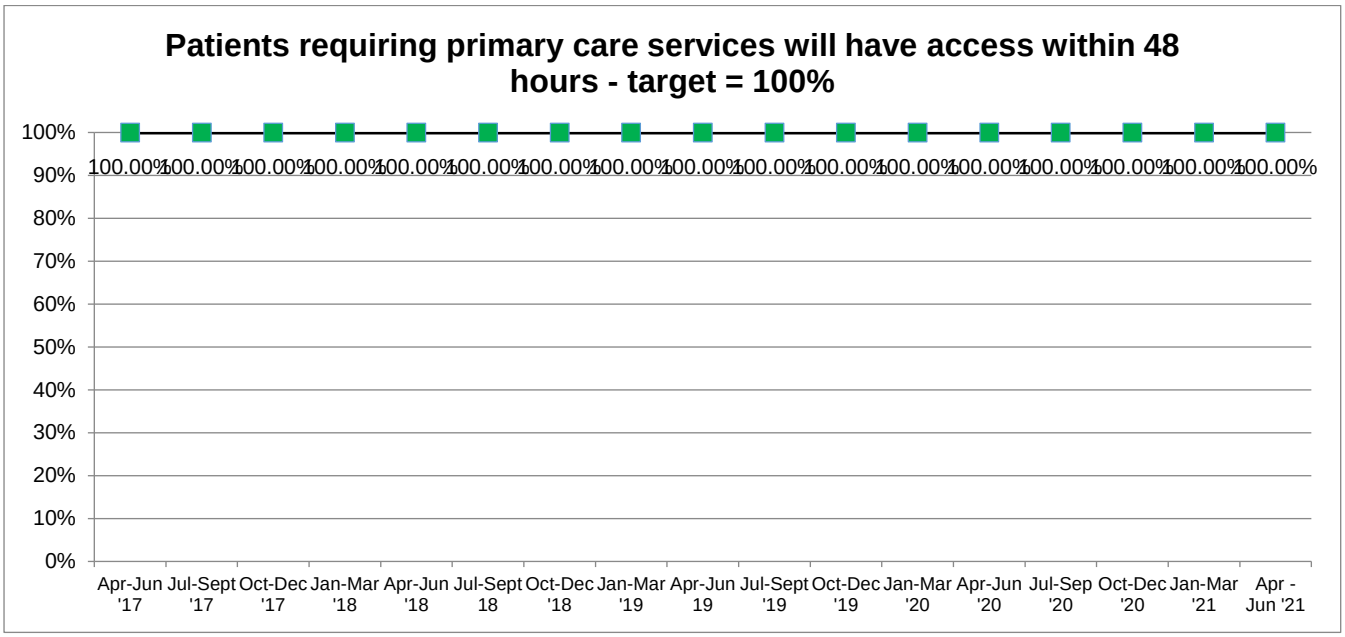
No 10: Patients Requiring Primary Care Services Will Have Access within 48 Hours

Target: 100%

Data for current quarter: 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.



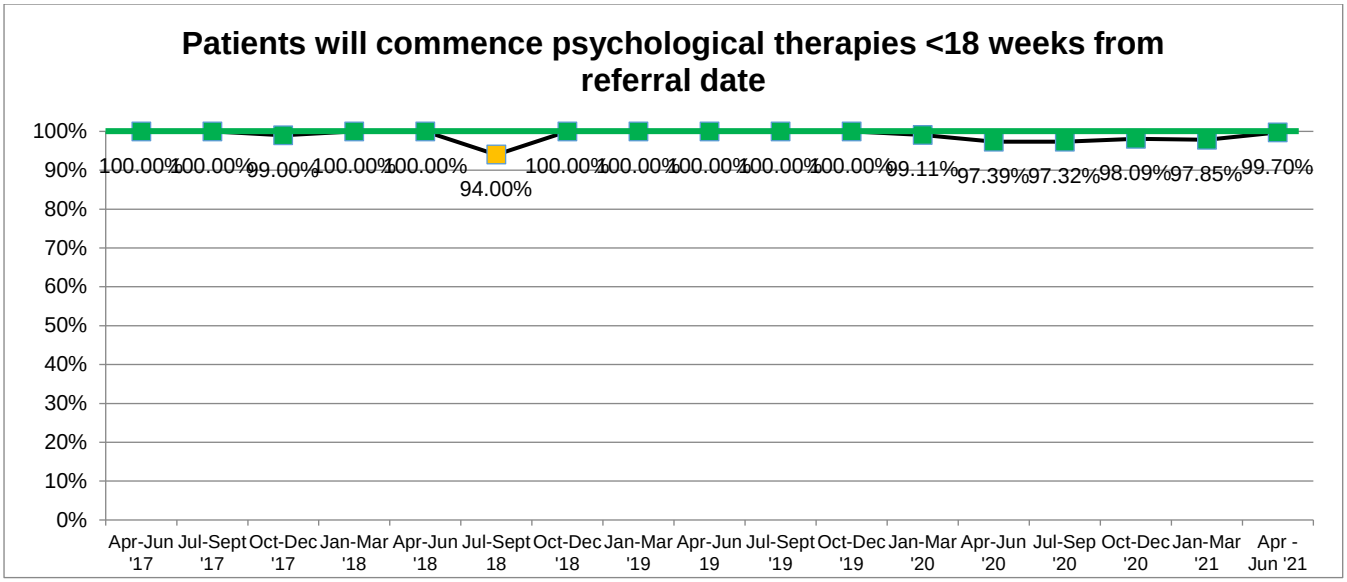
No 11: Patients will Commence Psychological Therapies <18 Weeks from Referral Date

Target: 100%

Data for current quarter: 99.70%

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.



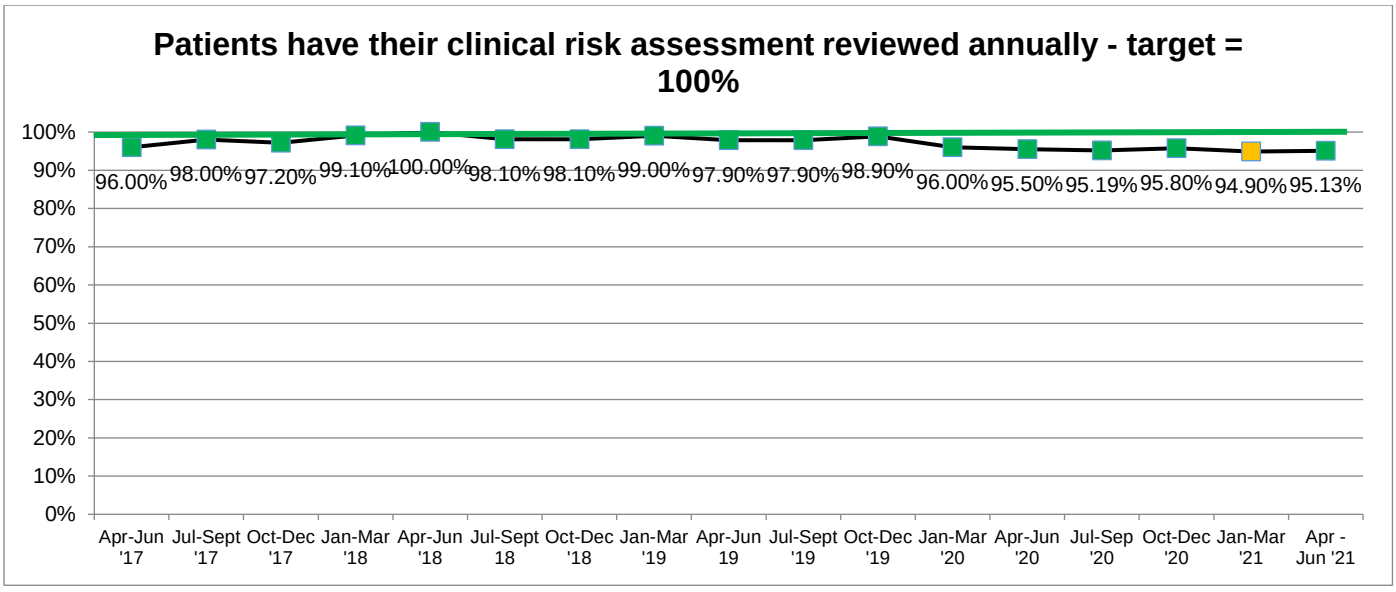
No 13: Patients have their Clinical Risk Assessment Reviewed Annually

Target: 100%

Data for current quarter: 95.13%

Performance Zone: Green

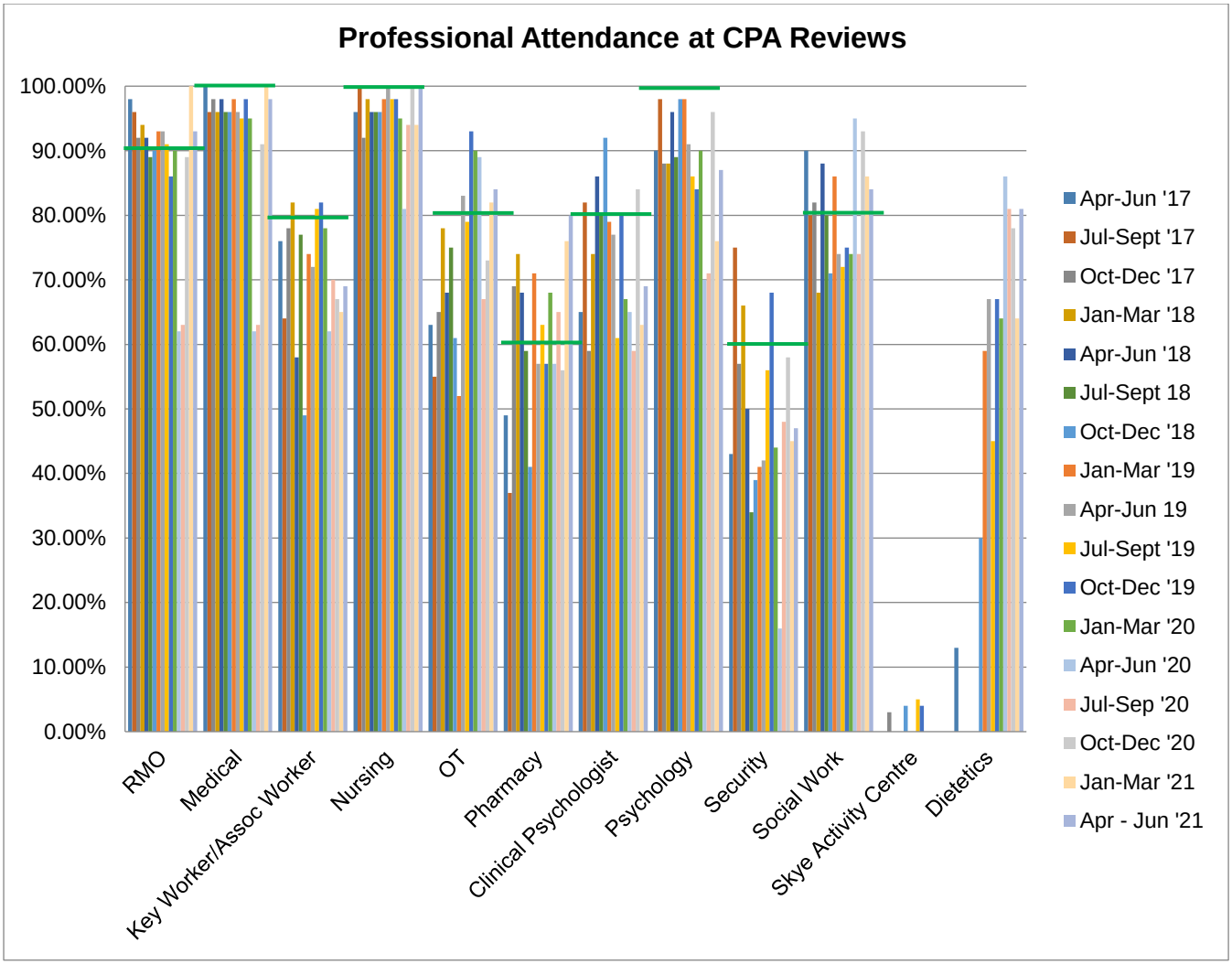
The indicator links with the Mental Health Care and Treatment Act Scotland, 2003. Examples of clinical risk assessments would be a HCR20 / SARA.



No 15: Professional Attendance at CPA Review

Target: Individual for each profession

Local priority area set out in within CPA guidance. The reasoning behind this indicator is that if patients have all of the relevant and important professions in attendance, then they should receive a better care plan overall.



Attendance at case reviews was recorded as both physical and virtual attendance.

RMO – attendance for this profession has fallen slightly to 93% in Q1. This indicator remains in the green zone.

Medical – this profession remains in the green zone for this quarter, with a slight drop from 100% to 98% in Q1.

Key Worker/Associate Worker – attendance figures increased to 69% in Q1 from 65% in Q4. This profession remains within the red zone. When a Key Worker/Associate Worker was unable to attend, a nursing representative attended in their place.

Nursing – during Q1, nursing attendance increased to 100%; thus moving the profession from the amber into the green zone.

OT – attendance has risen during Q1 to 84% from 82% in Q4. OT remains in the green zone for this quarter.

Pharmacy – attendance for this quarter has risen from 76% to 80%. This profession remains within the green zone.

Clinical Psychologists – this profession's attendance has increased in Q1 to 69%. This indicator remains in the red zone for this quarter. 8 instances where the VAT form was not completed and a combination of annual leave, staff not available and other staff attending in their place made up this percentage.

Psychology – this professions attendance has risen in Q1 to 87% from 76% in Q4. This profession remains in the red zone. On 8 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place, 5 instances where the VAT form was not completed and on 1 occasion no member of Psychology attended.

Security - attendance from security has increased in this quarter – from 45% to 47%. Security remains in the red zone for this quarter. Staff off duty and annual leave comprises this figure.

Social Work – attendance has slightly fallen in Q1 from 86% to 84%. This profession remains in the green zone.

Dietetics – during Q1, attendance from dietetics has risen to 81% from 64% in Q4. There is no target for this profession as of yet.

4. RECOMMENDATION

The Board is asked to **note** the contents of this report and the unprecedented period that the report covers.

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 Q4	RAG Q1	Overall attendance Apr – Jun 2021 (n=45)	Overall attendance Jan – Mar 2021 (n=49)	Overall attendance Oct – Dec 2020 (n=45)	Overall attendance Jul – Sep 2020 (n=46)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	G	93%	100%	89%	63%
				Medical **(LT)**	100%	G	G	98%	100%	91%	63%
				Key Worker/Assoc Worker **(MR)**	80%	R	R	69%	65%	67%	70%
				Nursing **(MR)**	100%	A	G	100%	94%	100%	94%
				OT**(MR)**	80%	G	G	84%	82%	73%	67%
				Pharmacy **(LT)**	60%	G	G	80%	76%	56%	65%
				Clinical Psychologist **(JM)**	80%	R	R	69%	63%	84%	59%
				Psychology **(JM)**	100%	R	R	87%	76%	96%	71%
				Security **(DW)**	60%	R	R	47%	45%	58%	48%
				Social Work **(KB)**	80%	G	G	84%	86%	93%	74%
				Skye Activity Centre **(MR)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(MR)** (only attend annual reviews)	tbc			81% (n=16)	64% (n=25)	78% (n=27)	81% (n=16)

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	Item No: 21
Sponsoring Director:	Director of Security, Estates and Facilities
Author(s):	Programme Director / Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
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 Board meets monthly, with an interim internal meeting taking place between full meetings. The POB last met on 19th August 2021 and is scheduled to meet again on 16th September 2021.

The Programme Director provided an update on the current status on the project and the financial details. The Risk Register was reviewed.

3. ASSESSMENT

a) General Project Update:

This current phase of the project is proceeding according to plan. Quality targets are being met, project costs are projected to overspend by a small amount (See Finance – Project Cost at (f) below) and project timescales have been reviewed and adjusted (See “Project Timescale” at (e) below). A summary of planned and completed works during the period of February 2020 to date include:

b) On-site works Completed:

Item	Completion
Installation and testing of Fibre Network across site	June 2020
Tubestile replacement	July 2020
Installation of CCTV in Skye Centre	July 2020
Installation of CCTV in Arran Hub	October 2020
Installation of CCTV in Mull Hub	December 2020
Installation of CCTV in Family Centre	December 2020
Installation of CCTV in Tribunal Annex	December 2020
Installation of CCTV in Lewis Hub	March 2021
Installation of CCTV in Lewis Hub	June 2021
Moling under perimeter & additional CCTV Columns	May 2021
Factory Acceptance Test	June 2021
Installation of Car Park CCTV	August 2021
Contingency Gate Fence & Gate works	August 2021

c) Works underway:

Item	Due date
Replacement of Fence detection systems	September 2021
Grounds and Patient Walkways CCTV	September 2021
Outer Perimeter CCTV installation	TBC

d) Offsite works:

Production and review of:

- Detailed design packages
  The project requires 27 Design packages; two remain to be completed and approved.

- Risk Assessments and Method Statements for all elements of the project. These contain the detailed methodology of how the contractor will approach the task in order to ensure that Health, Safety and TSH requirements are met.

e) Project Timescales:

As previously reported, the project's planned completion date moved from mid October 2021 to December 2021 due to the impact of COVID, delays on approval of Design Packages and Risk and Method Statements. A mid programme strategic review took place and Stanley recast the programme to reflect the outcomes of that meeting, with a revised completion date of 21st February 2022 and a revised Contract end date of 13th April 2022. The completion date has now been adjusted to 2nd March 2021 and the Contract end date remains unchanged.

This reflects the previously identified issues and the additional days accrued due to COVID delays (30 days) and the inclusion of the Running Track CCTV (5 days). Additional days have also been incurred due to the changes to the Perimeter CCTV and Grounds and Patient Walkways CCTV design (22 days).

f) Finance – Project cost

The project is proceeding according to the current projected cost plan, though detail below (g) of contingencies available, including estimates, quotes and commitments and other adjustments such as VAT reclaim, COVID recharges and other minor changes result in a potential overspend (exclusive of VAT) of £123k.

All quality targets are being met.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	February 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):	£10,479,927
Total costs to date (Inc. VAT) at 12th August 2021:	£ 08,352,500

The expenditure to date is in line with the 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.

Actual spend to date at 12th August 2021 is in line with Stanley planned schedule of works

Breakdown of actual spend to date –

Stanley	£ 6.111m (Certified Value, 5% retention not applied)
Thomson Gray	£ 0.610m
Doig & Smith	£ 0.007m
VAT	£ 1.345m
Staff Costs	£ 0.280m
	£ 8.353m

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.

Paper No. 21/67

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	26 August 2021
Agenda Reference:	Item No: 22
Sponsoring Director:	Director of Security, Estates and Facilities
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 risk registers.

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 See appendix a.

All risk assessments are in date. Details of the risks are available in Appendix A and those requiring action plans have them in place.

3.2 Proposed Risks for inclusion on Corporate Risk Register

N/A

3.3 Medium/High/Very High Graded Risks

The Register currently has 4 HIGH graded risks:

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
MD30 Failure to prevent/mitigate obesity
ND71 Failure to assess and manage the risk of aggression and violence effectively
ND70 Failure to utilise our resources to optimise excellent patient care and experience

The following 21 risks are graded as Medium:

*CE10 Severe breakdown in appropriate corporate governance
*CE11 Risk of patient injury occurring which is categorised as either extreme injury or death
CE12 Failure to utilise appropriate systems to learn from prior events internally and externally
MD32 Absconsion of patients
*MD33 Potential adverse impact arising from clinical presentation out of hours with no doctor on site (5pm - 6pm)
*MD34 Lack of out of hours on site medical cover
*SD50 Serious Security Incident
SD51 Physical or electronic security failure
SD52 Resilience arrangements that are not fit for purpose
*SD53 Serious security breaches (eg escape, intruder, serious contraband)
SD54 Climate change impact on The State Hospital
SD55 Negative impact of EU exit on the safe delivery of patient care within The State Hospital
SD56 Water Management
ND73 Lack of SRK trained staff
FD90 Failure to implement a sustainable long term model
*FD91 IT system failure/breach
FD93 Failure to complete actions from Cat 1/2 reviews within appropriate timescale
*FD96 Cyber Security/Data Protection Breach due to computer infection
*FD97 Unmanaged smart telephones' access to The State Hospitals information and systems.
HRD110 Failure to implement and continue to develop the workforce plan
*HRD111 Deliberate leaks of information
HRD112 Compliance with mandatory PMVA Level 2 refresher training.

*target risk met

CE = Chief Executive
MD = Medical Director
SD = Security Director
ND = Nursing Director
FD = Finance Director
HRD = Human Resource Director

These risks are reviewed by risk owners (Directors) monthly and have action plans in place to assist reduction to their target level. All other risks fall into the review cycle detailed below:

Low risk	6 monthly
Medium risk	Quarterly
High risk	Monthly
Very High	Monthly

3.4 Risk Updates

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: The Risk Management Facilitator met with the Senior Nurse for Infection Control to review the current risk assessment. The risk assessment has been updated to reflect the latest guidance. CMT made a decision to keep the risk at High.

ND70 Failure to utilise our resources to optimise excellent patient care and experience has been increased from Moderate x Unlikely (Medium) to Moderate x Likely giving a High grading. This is due to the current staffing pressures being faced at TSH. ND70 will be monitored monthly going forward. The action plan has also been updated in response to this increase.

3.5 Risk distribution

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70	MD30	
Possible			CE12, SD50, SD54, ND73, FD91, FD93, HRD112	ND71, CE14	
Unlikely			MD33, MD35, SD52, SD55, FD90, FD96, HRD110	MD34, SD56, HR111, SD51	
Rare			FD95, CE13, FD94	MD32, FD97	CE10, CE11, SD53

4 RECOMMENDATION

The Board are invited to review the current Corporate Risk Register, and decide if any further amendment or addition should be made.

Paper No. 21/67
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	CMT/ Board Workplan
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

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	31/10/21	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	31/10/21	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	31/10/21	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	31/08/21	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 Unlikely	Minor x Possible	Chief Executive	Chief Executive	12/08//21	CMT	Y/Y		Fortnightly	-
Corporate MD 30	Medical	Failure to prevent/mitigate obesity	Major x Likely	Major x Likely	Moderate x Unlikely	Medical Director	Lead Dietitian	31/08/21	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	31/10/21	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	31/10/21	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	31/10/21	CMT	Y/Y	N/A	Quarterly	-

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Moderate x Possible	Moderate x Possible	Security Director	Security Director	31/08/21	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	31/08/21	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	31/08/21	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	31/08/21	Audit 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	31/08/21	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 55	Service/Business Disruption	Negative impact of EU exit on the State Hospital	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Chief Executive	Security Director	31/08/21	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Major x Unlikely	Major x Unlikely	Major x Rare	Security Director	Head of Estates and Facilities	31/08/21	Infection Control Committee	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	31/08/21	CMT	Y/Y	Y/Y	Quarterly	Likelihood ↑
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	30/09/21	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	30/09/21	PMVA Group and CMT	Y/Y	N/A	Quarterly	-
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	31/08/21	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	31/08/21	Information Governance Group & CMT	Y/Y	N/A	Quarterly	-

Corporate FD 93	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	31/08/21	CMT	Y/Y	N/A	Quarterly	-
Corporate FD 94	Service/Business Disruption	Inadequate data centre	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	31/08/21	CMT/ Risk and Resilience Committee	Y/Y	N/A	Quarterly	Likelihood ↓
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Rare	Moderate x Unlikely	Finance and Performance Director	Head of eHealth	01/12/21	CMT/Risk and Resilience Committee	Y/Y	N/A	6 Monthly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Possible	Major x Unlikely	Finance and Performance Director	Head of eHealth	31/08/21	Information Governance Group & CMT	Y/Y	Y/Y	Quarterly	Likelihood ↓
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	31/08/21	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	31/08/21	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Possible	Major x Rare	Interim HR Director	Training & Professional Development Manager	31/08/21	H&S Committee	Y/Y	N/A	Quarterly	Impact ↓

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date:	26 August 2021
Agenda Reference:	Item No: 23
Author(s):	Board Secretary
Title of Report:	Board and Committee Membership
Purpose of Report:	For Noting

1 SITUATION

The tenure of the previous Chair of State Hospitals Board for Scotland ended on 31 December 2021. An Interim Chair, Mr David Mc Connell acted as Interim Chair, to allow a recruitment process to be completed.

2 BACKGROUND

This recruitment exercise concluded in July 2021, and confirmation was then received from Scottish Government that a new Chair had been appointed for a two-year term. Mr Brian Moore took up this appointment on 6 July 2021. Given this, Mr David McConnell's tenure as Interim Chair has concluded and he has reverted to his role as Vice Chair of the Board.

The Board has confirmed membership of the Board's standing governance committees in light of these changes. Given the timing this was completed electronically, and this now requires to be formally noted.

3 ASSESSMENT

Mr Moore's appointment as Chair leaves a vacancy on the Board for a Non-Executive (Whistleblowing Champion). Further advice in this respect is currently awaited from the Public Appointments team, as this is an appointment made by Scottish Government directly.

In addition, it should be noted that the current Employee Director will retire on 1 September 2021, and a new Chair of Joint Staff Side, Mr Allan Connor, has been elected. Scottish Government have confirmed Mr Connor's appointment as Employee Director for the period 1 September 2021 until 31 March 2023.

Committee membership has been amended to reflect the appointment of a new Chair, as well as the resumption of the Vice Chair role. Mr McConnell has resumed his role as Chair of the Audit committee as well as Non-Executive member of the Clinical Governance Committee.

Appointment to the vacancy for a Non-Executive (Whistleblowing) Champion may afford the Board a further opportunity to review committee memberships - this role will require membership of the Staff Governance Committee. Likewise, review of committee membership may be considered following Mr Hair's retirement, and Mr Connor's appointment as of 1 September 2021.

Board and Committee membership is noted in Appendix A.

4 RECOMMENDATION

The Board is asked to:

- Note the approved changes to governance committee membership to reflect the recent appointment of Board Chair.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support board business and scrutiny through its standing committee structure. To ensure each committee has appropriate membership.
Workforce Implications	Not applicable
Financial Implications	Not applicable
Route To Board Which groups were involved in contributing to the paper and recommendations.	Board Secretary
Risk Assessment (Outline any significant risks and associated mitigation)	No specific risk assessment required as this ensures appropriate membership and chair appointments to the committee structure
Assessment of Impact on Stakeholder Experience	No specific assessment of this required
Equality Impact Assessment	Not required
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not relevant
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.

BOARD AND STANDING COMMITTEE MEMBERSHIP

MEETING	MEMBERSHIP
BOARD	**Chair – Brian Moore** **Non-Executive Directors:** **Stuart Currie** **Cathy Fallon** **Tom Hair** **David McConnell (Vice Chair)** **Pam Radage** **Vacancy (Whistleblowing Champion)** **Executive Directors:** **Gary Jenkins** **Robin McNaught** **Mark Richards** **Lindsay Thomson**
AUDIT COMMITTEE	**Chair – David McConnell** **Stuart Currie** **Tom Hair** **Pam Radage**
CLINICAL GOVERNANCE COMMITTEE	**Chair – Cathy Fallon** **Stuart Currie** **David McConnell**
STAFF GOVERNANCE COMMITTEE	**Chair – Pam Radage** **Stuart Currie** **Cathy Fallon** **Tom Hair**
REMUNERATION COMMITTEE	**Chair – Brian Moore** **Stuart Currie** **Cathy Fallon** **Tom Hair** **David McConnell** **Pam Radage** **Vacancy (Whistleblowing Champion)**