THE STATE HOSPITALS BOARD FOR SCOTLAND

BOARD MEETING

THURSDAY 25 AUGUST 2022
at 10 am, 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 23 June 2022	For Approval	TSH(M)22/05
4.	**Matters Arising:**		
	Actions List: Updates	For Noting	Paper No. 22/64
5.	**Chair's Report**	For Noting	Verbal
6.	**Chief Executive Officer's Report**	For Noting	Verbal
10.15pm	**RISK AND RESILIENCE**		
7.	**Corporate Risk Register** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 22/65
8.	**Resilience Update – Governance Structure** Report by the Board Secretary	For Noting	Paper No. 22/66
9.	**Infection Prevention and Control Report (incorporating Covid-19 update)** Report by the Director of Nursing and Operations	For Noting	Paper No. 22/67
10.	**Bed Capacity in The State Hospital and Forensic Network** Report by the Medical Director	For Noting	Paper No. 22/68
10.45pm	**CLINICAL GOVERNANCE**		
11.	**Patient Story: "Get On and Get out"** Introduced by the Medical Director	For Noting	Presentation
12.	**Supporting Healthy Choices** Report by the Medical Director	For Noting	Paper No. 22/69

13.	**Implementation of Specified Persons – Annual Report 2021/22** Report by the Director of Security, Resilience and Estates	For Decision	Paper No. 22/70
14.	**Quality Assurance and Quality Improvement** Report by the Head of Planning and Performance	For Noting	Paper No. 22/71
15.	**Clinical Governance Committee** Approved minutes – meeting held 12 May 2022 Chair's Update – meeting held August 2022	For Noting	CGC(M) 22/02
16.	**Clinical Forum** Chair's Update – meeting held 17 May 2022	For Noting	Verbal
11.30am	**** BREAK ****		
11.50am	**STAFF GOVERNANCE**		
17	**Workforce Report** Report by the Director of Workforce	For Noting	Paper No. 22/72
18.	**Whistleblowing Quarter 1 Report 2022/23** Report by the Director of Workforce	For Noting	Paper No. 22/73
19.	**Staff Governance Committee** Approved minutes – meeting held 19 May 2022 Chair's Update – meeting held 18 August 2022	For Noting	SGC(M) 22/02
12.10pm	**CORPORATE GOVERNANCE**		
20.	**Corporate Governance Improvement Plan** Report by the Board Secretary	For Decision	Paper No. 22/74
21.	**Finance Report to 30 June 2022** Report by the Director of Finance & eHealth	For Noting	Paper No. 22/75
22.	**Perimeter Security and Enhanced Internal Security Systems Project** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/76
23.	**Complaints Annual Report 2021/22** Report by the Board Secretary	For Noting	Paper No. 22/77
24.	**Performance Quarter 1 Report 2022/23** Report by the Head of Planning and Performance	For Noting	Paper No. 22/78
25.	**Visiting Experience - Update** Report by the Director of Security, Resilience and Estates	For Noting	Paper No. 22/79
26.	**Any Other Business**		Verbal
27.	**Date of next meeting** 27 October 2022		Verbal
28.	**Proposal to move into Private Session, to be agreed**	For Approval	Verbal

in accordance with Standing Orders.
Chair

29.	**Close of Session and Reflection on Meeting**	Verbal

Estimated end at 1pm

THE STATE HOSPITALS BOARD FOR SCOTLAND TSH (M) 22/05

Minutes of the meeting of The State Hospitals Board for Scotland held on Thursday 23 June 2022.

This meeting was conducted virtually by way of MS Teams, and commenced at 1300 hours

Chair:	Brian Moore
Present:	
Employee Director	Allan Connor
Non-Executive Director	Cathy Fallon
Chief Executive	Gary Jenkins
Director of Nursing and Operations	Karen McCaffrey
Vice Chair	David McConnell
Director of Finance and eHealth	Robin McNaught
Non-Executive Director	Pam Radage
Medical Director	Lindsay Thomson
In attendance:	
Director of Workforce	Linda Davidson [from Item 5]
Head of Risk and Resilience	Allan Hardy [Item 26]
Head of Planning and Performance	Monica Merson
Head of Communications	Caroline McCarron
Board Secretary	Margaret Smith [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 Stuart Currie (Non-Executive Director) as well as Dr Sheila Howitt (Chair of the Clinical Forum).

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 28 April 2022 were noted to be an accurate record of the meeting.

The Board:

1. Approved the minute of the meeting held on 28 April 2022: TSH(M)22/03.

4 ACTION POINTS AND MATTERS ARISING FROM PREVIOUS MEETING

The Board received the action list (Paper No. 22/41) and Ms Smith led the Board through the paper in detail, noting the range of items which were being presented to the Board as part of today's meeting. She then noted that the majority of other items listed were being actively progressed as detailed in the report, and that updates would be presented to the Board at its next meeting in August. She noted that one item would remain on the action list until the Board's meeting in December – this related to the roll out of Carer Clinics being taken forward through the Realistic Medicine workstream. This was to allow this roll out to take place followed by a review and analysis of it which was scheduled for November 2022.

Mr Moore noted the progress as outlined and that the Board were content to accept this as a satisfactory update on progress.

The Board:

1. Noted the updated action list.

5 CHAIR'S REPORT

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

He had attended a joint session for NHS Board Chairs and Whistleblowing Champions with the Independent National Whistleblowing Officer. This had covered progressing the related standards across NHS Scotland, including the possibility of incorporating awareness of whistleblowing in the iMatter survey in the future to help capture the views of staff.

Mr Moore noted that the Board had taken part in a Development Session on 3 May on Active Governance led by NHS Education for Scotland. This had been a very interesting and beneficial session and the learning taken from it would help inform how the Board approached assurance reporting. He had met the newly appointed Staff Care Specialist in the Wellbeing Centre, and she had been keen to outline what would be on her agenda to help progress this important workstream. There was particular focus on how to reach all staff throughout the organisation, and recognising that front-line staff may experience difficulty in taking up all the opportunities within the Wellbeing Centre itself, and may require targeted support.

The Chair had taken part on a Quality and Safety Walkround in Lewis Hub. This had been constructive and informative and offered the opportunity to meet with both patients and staff and hear their views directly. Reporting of this workstream would be through the Clinical Governance Committee so that any issues arising could be interrogated.

He noted that the Scottish Government Resource Spending Review had been published in May, including the budget for health and social care. Mr Moore outlined the key requirement to deliver financial break-even across the whole system. He had attended a further briefing session for NHS Chairs in respect of the new National Care Service, and drew members' attention to the information published on the Scottish Government website in this regard. The proposed date for establishing this new service was 2026, and it would represent a major change to local and national relationships in the delivery of care services. This was an area of great complexity and could represent the greatest reform of the public sector since the establishment of the NHS itself. It was essential for the Board to remain alert to any implications that may emerge for The State Hospital, affecting future governance arrangements.

Mr Moore had also participated in meetings of NHS Board Chairs, as well as meeting with Chairs of National Boards. He had also attended the system pressures and recovery meeting with the Cabinet Secretary for Health and Social Care, which were now taking place on a monthly basis.

The Board:

1. Noted this update from the Chair.

6 CHIEF EXECUTIVE'S REPORT

Mr Jenkins provided an update to the Board on key national issues as well as local updates and the wide range of his activities since the date of the last Board meeting.

Mr Jenkins advised that he had taken part in National Boards Collaboration by Chief Executive Officers. This focused on seeking areas of potential collaboration especially a property management strategy and a refresh on sponsorship. This is linked to development of Annual Operation Plans and how to distil opportunities into specific workstreams.

He had participated in Board Chief Executive meetings, and highlighted the particular focus on the challenges faced following the Resource Spending Review - ten specific areas had been identified including data, workforce, communications and winter pressures. This was aimed at utilising resources more efficiently if possible through "Once for Scotland" collective approaches. Mr Jenkins had also liaised with the Centre for Sustainable Development as part of the Chief Executives cycle to maintain collaboration.

Mr Jenkins noted the work being progressed by NHS Chief Executives in setting up the SARCS network (sexual assault response co-ordination service) for the population of Scotland. This work followed the launch of the Forensic Medical Services (Victims of Sexual Offences) (Scotland) Bill placing a duty on NHS Boards to provide forensic medical services for victims of sexual offences.

Mr Jenkins provided assurance that he had, with the Director of Finance and e-Health, followed with NHS National Services for Scotland on commissioning arrangements for Northern Irish patients being cared for by The State Hospital (TSH) and a link had been made with the Northern Irish Government.

He advised that the Corporate Management Team (CMT) had held a further development session on 23 May, with particular focus on planning throughout this year for the organisation.

As Chair of the MSN Neurology, Mr Jenkins had attended its Annual Review process, alongside the Chief Medical Officer Professor Sir Gregor Smith. He also chaired the Scottish Healthcare in Custody Oversight Board meeting on 16 June and a development workshop would take place at TSH on 27 June, focused on issues around health and prisoner care priorities.

He advised that the work was progressing in relation to a women's pathway for high secure forensic care in Scotland, and the clinical infrastructure required to take this forward. He would be in a position to provide a further detailed update to the Board at its next meeting in August. He had also continued to participate in the short life working group for the review of forensic mental health services, alongside Professor Thomson, which would undertake an options appraisal of the short-listed options on 24 June. On behalf of NHS Chief Executives, he had been involved with in ViSOR (the Violent and Sex Offender Register) meetings with multi agency partners which provided interface in this respect across Scotland.

He underlined that the Board would receive fully detailed reporting on the progress made to take forward planning for the implementation of the new clinical model for the hospital during today's meeting. In addition, work was being progressed on the Annual Operational Plan, and Workforce Plan both of which were on target. Finally, work was continuing through the CMT on planning for the hospital within the context of living with Covid-19 for the future.

The Board:

1. Noted the update from the Chief Executive.

RISK AND RESILIENCE

7a COVID 19 RESPONSE AND REMOBILISATION - RESILIENCE REPORTING UPDATE

A paper was received from the Chief Executive (Paper No. 22/42) to provide the Board with an overview of the continuing response to Covid-19 and to provide key updates to the Board on actions taken since the date of its last meeting. The report also outlined proposed changes to reporting to the Board in this area going forward.

Mr Jenkins acknowledged the current position on community transmission and incremental rises in levels of Covid-19, and the ways in which this was impacting internally for TSH, particularly in pressures on staffing. This was being managed closely to ensure the continued delivery of services. He then led the Board through the detail of the report, beginning with the continued development of the management structure including organisational groups. This was being led through the CMT, recognising the need to connect the Hubs and the Skye Centre more directly. This would enable a more dynamic structure providing the means through which to better support key workstreams and challenges, especially patient activity. A new Activity Oversight Group was being developed which would replace the Operational Model Monitoring Group, taking the lessons and benefits from this group as the new clinical model was introduced.

He drew members' attention to the renewed Health Improvement Scotland Infection Control standards effective from the 8 August, and which would be underpinned by a programme of inspections through the HEI.

Mr Jenkins provided a summary of testing reported on both patients and staff to the end of May, and advised the Board that since the time that this report was prepared there had been further outbreaks of Covid-19 with five wards currently affected. Ms McCaffrey was leading the response with an Incident Management Team in place. It was felt by the team that the rise in infection within TSH was linked to the rise overall in community infection. He summarised continued efforts to ensure vaccination of patients, as well as LFD testing of contractors and visitors coming onto the TSH site. There was continued assurance on the availability of acute care from NHS Lanarkshire, should this be required.

Mr Jenkins advised that focused efforts were being made to help support patients on their journey once able to leave TSH, including linking with medium secure services.

Work was progressing for planning the required structural changes to the Family Centre, and Mr Jenkins was able to provide an update that it now appeared likely that costs may not reach the previous estimate of £80k. Detailed reporting on this would be brought back to the Board.

Moving on to workforce reporting, Mr Jenkins noted that more detailed reporting in this respect would be provided later as part of today's agenda. However, he could confirm that the supplementary staffing model was being progressed, and that the new recruitment strategy would be brought to the next meeting of the CMT. As previously noted, the Workforce Plan was being developed and was on target. The Board had approved the Staff and Volunteers Wellbeing Strategy in April and reporting would flow through both the Staff Governance Committee as well as the Board itself throughout the year. He echoed the Chair's previous comments in noting the local work being developed to ensure that all staff had access to wellbeing services.

In terms of training, he asked the Board to note the improvement made on the delivery of Prevention and Management of Violence and Aggression (PMVA) Level 2 and Soft Restraint Kit (SRK) training to front-line staff, acknowledging that this did have an impact on Personal Development Personal Reviews, although progress in this area was now being made.

Mr Jenkins summarised the proposed changes to reporting, should the Board in agreement, that a single source report of this nature was no longer required. Dedicated reporting from each directorate area would provide comprehensive assurance reporting within their remit. It was therefore proposed

that the Risk and Resilience section of the Board agenda be retained, and should encompass reporting around Covid-19 responses including outbreaks, as well as overarching reporting on Hospital Acquired Infection, as would have been the case prior to the pandemic. There should also be dedicated reporting on patient flow and movement within the forensic estate – again this was previously required by the Board. The Board would also continue to receive reporting on the Corporate Risk Register within this section.

As well as dedicated reporting on the Staff and Volunteer Wellbeing strategy, the Board would also receive reporting from the workforce directorate encompassing the elements on workforce contained within this report to date.

There would be dedicated reporting on the developments to the Family Centre to support in-patient visiting at every second Board meeting, as well as updates on virtual visiting as part of existing digital transformation reporting received by the Board. Finally, he advised that the Board would receive an update report on developing the communications function at today's meeting and this would then be brought back to every second meeting of the Board alternating with updates on the Corporate Governance Improvement Plan.

Mr Moore thanked Mr Jenkins for providing such a comprehensive report which was a very useful overview of the situation and response, since the last Board meeting.

Mr McConnell asked about the current outbreaks of Covid-19 being experienced within the hospital, especially in terms of whether there were any significant concerns for how seriously patients were being affected, and the use of antiviral drugs. Professor Thomson provided assurance that the patient population were coping well in terms of their physical health, and confirmed that antiviral medication would be used if required – to date this had been the case for one patient only. There had been no need to transfer any patients into acute care in the last two months. Professor Thomson also asked the Board to note potential concern for impacts on patients' mental wellbeing should they have to be isolated from the rest of their ward due to infection. More generally, Covid-19 infection led to a decrease in patient activity. Ms McCaffrey provided further advice on the efforts being made to bring resources for activity into ward and hub areas, to try to maximise what was possible for those patients. Mr Jenkins echoed this, noting the balance between what could be tolerated by patients who had fallen ill with Covid-19, and encouraging activity if possible.

Ms Fallon asked about in-person visiting, noting that ward visits were offered for patients who may be too unwell to tolerate a visit within the Family Centre. She wished to know whether there was an element of choice for patients and carers, of they simply preferred a ward visit. Mr Jenkins confirmed that this was arranged on an individual tailored basis for patients and their visitors. It was recognised that there was personal preference, especially for newly admitted patients, whose families and carers may benefit from being able to visit the ward and see the quality of accommodation available.

Mr Moore summarised for the Board, confirming that the Board welcomed this reporting and endorsed the ongoing operational management of the response to Covid-19. Further, he confirmed agreement around the table that the changes to reporting as outlined in detail, should be taken forward at this stage.

<u>The Board:</u>

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

2. Agreed that the current comprehensive Covid-19 Resilience Report format and reporting requirements to the Board would continue in this area to provide consistent concise assurance.

7b COVID-19 RESPONSE AND REMOBILISATION - FINANCIAL GOVERNANCE

Finance and eHealth Director provided the Board with a verbal update on financial governance to in relation to specific Covid-19 related costs.

Mr McNaught confirmed that the specific funding for Covid for 2022/23 had ceased, and that the focus was on maintaining directorate budgets to accommodate this. This was recognised as a pressure, and it was confirmed that any significant risks would be highlighted to the Board throughout the year.

The Board:

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

8 CORPORATE RISK REGISTER

The Board received a paper (Paper No. 22/43) from the Director of Security, Resilience and Estates, which provided an overview of the medium, high and very high risks featuring on the Corporate Risk Register, and provided assurance that these were being addressed appropriately.

Mr Walker presented this report and highlighted that review of each risk was up to date. He provided an update on any risks being considered for inclusion on the register. In particular, that SD54 Climate change impact on The State Hospital was under review by the Sustainability Group and an update would be brought to the next Board meeting. He noted that HRD112 – Compliance with mandatory PMVA Level 2 refresher training and ND73 – Lack of SRK Trained Staff had been formally reviewed and reduced to medium in view of the progress made in delivering training. He asked the Board to note the updates on the four risks rated as high on the register, as well as the risk distribution profile. Work was underway to focus on risks not at their target level.

Ms Fallon provided an update on the Sustainability Champions Network for Non-Executive Directors, which had held its first meeting. This had included agreement of tis terms of reference. There had been discussion on the need to establish an executive lead network, as well as how to underpin the strategic focus of the network with an operational role. The network would meet again on 15 July.

In respect of the high risk of patient obesity, Ms Fallon asked about progress on the recruitment for a Project Manager for Supporting Healthy Choices. Mr Jenkins confirmed that this would be advertised by 8 July, and it was hoped that the position would be filled quickly.

Mr Moore provided a summary for the Board, and noted that the Annual Report for Risk and Resilience was also on today's agenda. He commented on the more dynamic nature of reporting with evidence of review and adjustments being made. He thanked Mr Walker and his team for the progress made.

The Board:

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

CLINICAL GOVERNANCE

9 CLINICAL MODEL IMPLEMENTATION

The Board received a paper (Paper No. 22/44) from the Chief Executive and the Medical Director which provided updates to the Board in relation to the development of a detailed plan by way of a

Project Initiation Document (PID) as a mechanism through which to manage the project. Secondly, to provide an update on the outcome of the assessment and review into the nursing workforce requirements underpinning the Clinical Model.

Mr Jenkins introduced this paper by emphasising the need to gain traction with implementation at this stage though planned phasing, and to bring it into focus as a process. Ms Merson then led the Board through a detailed summary of the paper beginning by describing the overall current context in which the model would be implemented, recognising the delay in this due to the Covid-19 pandemic. A number of factors had arisen in the intervening period and these could present challenges that could impact on the plan. These were set out in the paper and included the continuing impact of Covid-19, and therefore plan specifically considered infection prevention and control mechanisms to limit risk from Covid-19. In addition, it was expected that patient flow would improve across the forensic network. The current number of patients within TSH should not be a barrier to its implementation, with the possibility that should patients exceed planned model number then some Major Mental Illness (MMI) patients would need to be housed in Intellectual Disability (ID) wards.

Further, clinical teams were progressing work to phase moves including recognising patient profiles as well as the need to minimise the number of moves made. It was also expected that an update would be available on the pathway for female patients by August 2022. Finally, workforce pressures may impact on delivery, and focused work, particularly on nurse recruitment, continued to be taken forward.

Ms Merson paused at this point, and Mr Moore opened discussion around the table. Mr McConnell asked for more clarification on how MMI patients would be accommodated in ID wards, and whether there was experience of this being managed previously. Professor Thomson advised that mixing MMI and ID patients already took place, with some ID patients being accommodated in MMI wards. She recognised that although this was not the optimum arrangement, it may be necessary dependent on patient numbers. The potential for this had been agreed with the ID service, and it would be considered only for the most settled MMI patients, who would continue to be nursed by an MMI nursing team.

Ms Radage asked about how to measure the success of the implementation especially around collaborative work. Ms Merson confirmed that the plan would be linked to the KPIs attached to the Staff and Volunteer Wellbeing Strategy, and that pulse checks would be taken throughout. Further that the communications plan would help support this and provide transparency during delivery. Mr Jenkins added that targeted metrics would be produced organisation wide on key indicators (such as patient incidents) to produce a matrix that would overlay the staff wellbeing metrics.

Professor Thomson also advised that the plan would be for staff to remain working on existing hub areas as much as possible to support recognised working units. Over time, staff would then have the opportunity to move into different working areas to help increase their range of experience.

Ms Merson then provided a summary outline of the project definition, including the project aims and the approach being taken alongside the structure underpinning it. She described the essential planning elements as well as the key components for governance. Finally, she summarised the staffing model underlining that the model would not produce savings as had originally been anticipated. It would be cost neutral based on current costs, and fit within the current funded baseline establishment.

Mr Moore thanked Ms Merson for this very detailed presentation, which was helpful, as the hospital moved into this new phase of implantation for the model, with complex change management and implications for both patients and staff. He added that this would be an area in which the Board would benefit from updates outwith formal Board meetings and it as agreed to add this to the workplan for Board Development sessions. He asked a question around the recruitment of a dedicated Project Manager, as well as further feedback on the role of Patient Advocacy Service (PAS) and for Allied Health Professionals (AHPs) within the model. He also made the suggestion for external oversight through adding a critical friend role as part of governance.

Ms Radage asked whether there would be any additional risks in relation to the workforce, as phased moves were made, that didn't currently exist. Mr McConnell also asked how significant the challenge would be to fit existing clinical services to the new model, and whether this would represent a resultant resource challenge.

Ms McCaffrey commented on the opportunity for staff to increase their expertise and transfer existing skills into a new area. She also confirmed that opportunities to do so would encompass AHPs alongside nursing staff, and medics.

Mr Jenkins advised that with a re-organisation of the allocation of care, then decision would be required around how to distribute and align staff resources. It was not anticipated that this would be a resource challenge as staff would be continuing in the same care roles. He also advised that the PAS service would be valuable in helping to support patients, and to explain the changes as they occurred. For the Project Manager role, he confirmed that this would be a dedicated resource for the model implementation.

Ms Merson made the suggestion that the Mental Welfare Commission had played a helpful role previously, as external oversight and this could be explored again. She also would be linking the model implementation into the Annual Operation Plan and related Delivery Plan for 2022/23 which would be submitted to Scottish Government.

Mr Moore summarised the position for the Board in agreeing to the recommendations as set out, and also for progress to be reported through a Board Development Session as well as the agreed formal reporting routes.

The Board:

1. Noted the content of the Paper No. 22/44 for due diligence prior to any further work being progressed on the Clinical Model.

2. Endorsed the final draft of the Project Initiations Plan.

3. Acknowledged and supported the review of the nursing workforce requirement.

4. Requested that progress reporting be brought to a Board Development Session this year.

10 CLINICAL GOVERNANCE COMMITTEE ANNUAL REPORT 2021/22

A paper was received from the Chair of the Clinical Governance Committee (Paper No. 22/45) to provide the Board with an update on the wide range of activity overseen by the Committee during 2021/22. The stock take also includes the Committee's terms of reference, reporting structures and work programme. Ms Fallon presented the report to the Board to confirm the committee had met its remit.

The Board:

1. Approved the Clinical Governance Committee Annual Report 2021/22.

11 QUALITY ASSURANCE AND QUALITY IMPROVEMENT

A paper was received from the Head of Planning and Performance (Paper No. 22/46) providing an update on progress made towards quality assurance and improvement activities since the last Board meeting in April 2022.

Ms Merson provided an overview, highlighting activities in relation to quality assurance and quality improvement and how these relate to strategic planning and organisational learning and development. This included progress on clinical audits and variance analysis tools, the Quality Forum and Capacity Building for Quality Improvement. She also highlighted work progressed in Realistic Medicine, and Evidence for Quality including analysis of the national and local guidance and standards recently released and pertinent to The State Hospital

The Board noted the beneficial nature of recent clinical audit work, and that the programme for work around this at 25- 28 audits per year was significant. It was also noted that the variance analysis tool indicated inconsistencies in attendances at care reviews. In relation to this last point, Ms Merson advised that this had been recognised and that Lead Nurses were targeting work in this area for improvement.

The Board:

1. Noted the content the report.

12 CLINICAL GOVERNANCE COMMITTEE

The Board received the agreed minutes of the meeting (CGG(M) 22/01) of the Clinical Governance Committee which took place on 10 February 2022.

Ms Fallon provided a verbal update from meeting on 12 May 2022 and advised that this had included oversight of the implementation of electronic prescribing (HEPMA) as well as reporting on patient feedback and on complaints activity. The new Service Level Agreement for GP services had been noted as positive. The Committee had been pleased to note the success of two members of staff who had received awards for research studies. The Committee would also transfer its Areas of Good Practice to the Staff Bulletin so that these could be communicated site wide.

The Board:

1. Noted the approved minutes of the Clinical Governance Committee (CGG(M) 22/01) from the meeting which took place on 10 February 2022.
2. Noted the verbal update from the Committee Chair on the meeting which took place on 12 May 2022.

13 CLINICAL FORUM

The Board received the agreed minutes of the meeting (CF(M)22/01) of the Clinical Forum which took place on 22 March 2022.

The Board:

1. Noted the approved minutes of the Clinical Forum (CF(M)22/01).

STAFF GOVERNANCE

14 STAFF GOVERNANCE COMMITTEE ANNUAL REPORT 2021/22

A paper was received from the Chair of the Staff Governance Committee (Paper No. 22/47) which outlined the key achievements and key developments overseen by the Committee during 2021/22. The report included the Committee's terms of reference. Ms Radage presented an overview to confirm that the Committee had met its remit.

The Board:

1. Approved the Staff Governance Committee Annual Report 2021/22

15 REMUNERATION COMMITTEE ANNUAL REPORT 2021/22

The Board received a paper from the Chair of the Remuneration Committee (Paper No. 22/48) which outlined the work overseen by the Committee during 2021/22 in the oversight of Executive and Senior Manager pay as well as consultant's discretionary points. Mr McConnell presented an overview to confirm that the Committee had met its remit.

The Board:

1. Approved the Remuneration Committee Annual Report 2021/22.

16 WHISTLEBLOWING ANNUAL REPORT

The Board received a report from the Director of Workforce (Paper No. 22/49) to present a draft Annual Report detailing the work undertaken in the implementation of the whistleblowing standards. Ms Davidson presented an overview of the report, which included information on the cases investigated any lessons learnt, as well as reporting to the Staff Governance Committee and to the Board.

Ms Fallon noted the helpful nature of the report, and the possible benefit in the sharing of confidential Contacts as a resource between NHS Boards.

Mr Moore added that it would be helpful to present the data on staff training in percentage rather than whole number terms for more clarity on progression. He noted the latest INWO bulletin which emphasised the need for confidentiality of whistleblowers and witnesses, which was adhered to when reporting of cases came to the Board. He also emphasised the importance of culture as a positive culture would ensure that concerns were dealt with, and that it was worth underlining the focus on this within TSH.

He added that the standard also applied to independent contractors, so procurement of services should take this into account in terms of whether contractors did have a whistleblowing policy.

The Board:

1. Approved the report, subject to the minor amendments as discussed and outlined.

17 ATTENDANCE PERFORMANCE REPORT

The Board received a report from the Director of Workforce (Paper No. 22/50) detailing the quarterly update on overall attendance performance to 31st May 2022 and placing this in the context of wider workforce reporting.

Ms Davidson summarised the report, advising that the new format was the product of work taken forward by Human Resources (HR) and the eHealth team through use of business tableau. She asked the Board to note in particular that the slight increase in sickness absence during May, and the support in place to help support staff back to work. Further, she detailed the work being progressed for improvement in the recruitment process, by use of national comparators. Given the pressures experienced nationally in recruitment of staff, she also underlined that the HR team would use feedback from staff leaving the organisation, to establish if any learning could be taken from the reasons given through this mechanism.

Mr Moore thanked Ms Davidson for her report, and for the helpful nature of the report in bringing the relevant workforce data together into one report. He noted that it would be important to balance what data was being presented to the Staff Governance Committee and to the Board and to avoid duplication. Ms Radage agreed with this, and added that this was a good baseline from which to refine reporting and get value from it. Mr Jenkins commented that this was a good way forward, and thanked the Human Resources team for their work. Ms Davidson provided assurance that the team would now work on how to use this type of reporting to add the learning that could be taken from the data trends, especially around any emerging areas of concern.

Mr Moore summarised for the Board, noting the way in which reporting enhanced governance oversight and thanking the HR team for their work in this area.

The Board:

1. Noted the content of the report (Paper No. 22/50).

18 STAFF GOVERNANCE COMMITTEE

The Board received the agreed minutes of the meeting (SGG(M)22/01) of the Staff Governance Group which had taken place on 17 February 2022.

In addition, the Committee Chair, Ms Radage, provided a verbal update from the meeting which had taken place on 9 May 2022. The meeting had considered in particular how to continue improving reporting to give meaningful information and oversight. The meeting had been pleased to note the lowest rate of sickness absence experienced by the hospital for six years, during April 2022. The Committee had also agreed to consider a form of self-assessment on its own effectiveness.

The Board:

1. Noted the approved minutes SGG(M) 22/01 from the Staff Governance Committee from the meeting that took place on 17 February 2022.
2. Noted the verbal update from the Committee Chair on the meeting which took place on 19 May 2022.

CORPORATE GOVERNANCE

19 REPORT ON THE ANNUAL ACCOUNTS 2021/22

The Board received a paper from the Chair of the Audit Committee (Paper No. 22/51) which detailed the Annual Accounts for the year end as of 31 March 2022. This paper outlined the requirement to have the Annual Accounts formally adopted by the Board, certified by external audit and submitted to the Scottish Government Health and Social Care Directorate by 30 June 2022 (although there was an extension available this year to 30 September due to impacts of Covid-19).

Mr McConnell advised the Board that the Audit Committee had considered the Annual Accounts and the associated recommendations in detail at its meeting earlier this morning. He advised the Board that external auditors had concluded their audit and issued a report certifying them as unqualified in respect of a fair and true opinion. Their opinion on the account's regularity was unqualified, and their report on the Board's Governance Statement was also unqualified. Further, that internal auditors were satisfied with the systems of internal controls in place as evidenced, and the Governance Statement as submitted. Mr McConnell highlighted the Annual Reports from each of the governance committees, and statement of Board Members responsibilities.

As Chair of the Audit Committee, he confirmed the Committee's Statement of Assurance to allow the Board to approve the Statutory Annual Accounts. The Audit Committee had considered the

control environment and systems of internal control to be adequate, and could be relied upon by the Board. Mr McNaught led the Board through the detail of reporting, noting that some very minor amendment to the paper as presented had been indicated by the Audit Committee, and these had been made. Mr McConnell added that these amendments were not material points of change and that auditors had been content in this respect.

On this basis, Mr Moore summarised that the Board was content to adopt the Annual Accounts for the year ended 31 March 2022, and approved the submission to the Scottish Government Health and Social Care Directorate.

The Board:

1. Adopted the Annual Accounts for the year ended 31 March 2022 and approved submission to the Scottish Government Health and Social Care Directorate.

2. Authorised:

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

20 PATIENT FUNDS

The Board received a paper from the Director of Finance and eHealth on the Patients' Funds Annual Accounts (Paper No. 22/52). Mr McNaught asked the Board to note that patients' funds were the balances of money held by TSH on behalf of patients. These were presented in a format directed by the Scottish Government Health & Social Care Directorate and had been audited by external auditors. Due to site access restrictions, the 2020 and 2021 audit had not been possible at the usual times, but were completed for approval in early 2022. He advised that there was no statutory deadline for these reviews. These were approved by the Audit Committee at their meeting on 17 March 2022. The 2022 audit was then completed in May 2022 and approved by the Audit Committee at their meeting this morning.

The Board:

1. Approved the abstract of receipts and payments of Patients' Private Funds for the years ended 31 March 2020, 2021 and 2022 for signature by the Chief Executive and Director of Finance and eHealth.

21 AUDIT COMMITTEE ANNUAL REPORT 2021/22

The Board received the Audit Committee Annual Report (Paper No. 22/53) from the Chair of the Audit Committee. Mr McConnell provided an overview of the report, which confirmed that the Committee had fulfilled its remit for the year, and thanked members for their work throughout the year.

The Board:

1. Approved the Audit Committee Annual Report (Paper No. 22/53).

22 FINANCE REPORT TO 31 MAY 2022

A paper was submitted to the Board (Paper No. 22/54) by the Finance and eHealth Director, which presented the financial position to 31 May 2022. Mr McNaught provided a summary of the report,

including that draft base budgets had been established and that the forecast was for a breakeven year end position, set on achieving £0.811m efficiency savings. This position was pending notification of the Agenda for Change pay for 2022/23 - to manage this prudently an element of contingent reserve was being maintained until the final pay award levels were confirmed by Scottish Government. Following notification that no Covid funding would be available ongoing into 2022/23, a number of processes were being put in place with individual budget-holders so that the pressures of Covid-related costs which would continue to be incurred would to be met within the specific Directorates in 2022/23.

He noted the year to date position of £0.021m underspend, and that it was anticipated that capital allocation would be fully utilised in-year.

The Board was content to note this update report.

The Board:

1. Noted the content of the Finance Report, to 31 May 2022 (Paper No. 22/54).

23 PERIMETER SECURITY AND ENHANCED INTERNAL SECURITY SYSTEMS PROJECT

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 22/55) detailing the update of the Perimeter Security and Enhanced Internal Security Systems re-fresh project and planning for the remainder of this year.

Mr Walker asked the Board to note the position, and in particular that Programme Revision 39 had been accepted with caveats. This projected completion on 12 September 2022, exceeding the contract completion date by approximately 20 weeks. Further, that the caveats included issues that had the potential to create further slippage. Given the sensitivities around security issues and commercial negotiations, further reporting would be made to the Board in private session.

The Board:

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

24 PROPERTY AND ASSET MANAGEMENT – UPDATE

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 22/56) which provided an update for the Property and Asset Management Strategy (PAMS), and national guidance in this respect.

Mr Walker noted that the TSH 2017 – 2022 PAMS was approved by the Board in June 2017 prior to submission to Scottish Government Health and Social Care Directorate. For this year, the deadline set for the return of the State of NHSScotland's Infrastructure (SAFR) programme pro forma templates would be Friday 24 June 2022. In terms of PAMS the Scottish Government had advised that they were not seeking submission of PAMS documents this year.

Mr Moore noted the importance of PAMS in the whole framework of the delivery of health and social care, and asked if there was risk in a backlog building especially around maintenance of the estate. He noted that the Quality and Safety walkrounds may help identify areas of concern. Mr Walker advised that within TSH, the estates maintenance programme was continuing and also that Control Book Holders were supported to report any areas requiring attention. The Risk and Resilience team was rolling out training to this cohort in the coming year.

Mr Moore summarised for the Board, in noting the content of this update and assurances provided on maintenance of the estate.

The Board:

1. Noted the content of the Property and Asset Management update report (Paper No. 22/56).

25 PERFORMANCE ANNUAL REPORT 2021/22

The Board received a report from the Head of Corporate Planning and Business Support (Paper No. 22/57) to give a high-level summary of organisational performance for the year from 1 April 2021 until 31t March 2022.

Ms Merson provided the Board with a detailed overview of the paper, noting that trend data was provided to enable comparison with previous performance. The paper set out performance against the national standards directly relevant to TSH: Psychological Therapies, Waiting Times and Sickness Absence. In addition, local Key Performance Indicators (KPIs) were included in this report. Ms Merson highlighted that there was one KPI which has increased this year and moved into a more positive zone and this was that patients would be engaged in off-hub activity centers during COVID-19.

There were four KPI's which had missed their target this year: patients would have their care and treatment plans reviewed at six monthly intervals, patients would be offered an annual physical health review, patients would have a healthier BMI and sickness absence. Ms Merson outlined the work being progressed in each of these areas to support improvement in performance. A new GP service was in place from 1 April 2022, and the Supporting Health Choices programme would have additional resourcing through the recruitment of a dedicated Project Manager.

She also asked the Board to note that it was proposed to make a change to the KPI for patients having 90 minutes of physical activity each week. In reviewing this, the Physical Health Steering Group had advised that if this target was simply increased to 150 minutes, those patients who are already physically active would make this revised target, but it may not encourage other patients into physical activity. Professor Thomson commented that the national guidance for all adults was 120 minutes of physical activity each week. Further, that during Covid-19 there had been increased activity on the part of patients but that now some patients were evidencing lower rates of activity so this needed to be interrogated to ascertain what types of support would be most helpful
Mr Moore commented that the focus should be on supporting patients into activity, and this should be ambitious given the potential health benefits. Mr Jenkins added that the introduction of the new clinical model should help to support oversight of activity, and the optimal ways in which to support patients to be more active. Following this discussion, Mr Moore noted that the Board would be comfortable with a change to the KPI to better reflect the aspiration of improving levels of physical activity at a local level.

The Board:

1. Noted the content of the Performance Annual Report 2021/22, Paper No. 22/57.

26 RISK AND RESILIENCE ANNUAL REPORT 2021/22

The Board received a report from the Director of Security, Resilience and Estates (Paper No. 22/58) which detailed the activity undertaken within the Risk and Resilience Department over period 1 April 2021 until 31 March 2022. Mr Walker introduced the paper noting the significant progress that had been made in this areas in the past year, and highlighting the commitment of the team in progressing this. Mr Hardy joined the meeting to presented an overview of the paper.

He led the Board through the key areas of the report, including the work progressed on the Corporate and Local Risk registers where the focus was on making this into a dynamic process, ensuring

adjustments were made if and when required. He noted that a focused session with the internal auditors was planned in respect to the risk appetite of the organisation.

Resilience planning was under development, and all resilience plans had been reviewed taking into account internal audit reporting in this respect. Plans had been tested in practice, to ensure the appropriate learning could be taken from this live experience. This work would continue to be developed in the current year, supported by the Risk and Resilience Team. The team had also managed serious adverse events reviews, improving the timeline for reporting on these so that potential areas of learning were understood at an early opportunity.

Further, there had been key focus on developing training in a number of important areas including for Fire Safety, Negotiator Skills and Control Book Holders, and this work was continuing into the current year. Mr Hardy also outlined the successful work in supporting positive relationships with partner agencies, particularly Police Scotland and the Scottish Fire and Rescue Service as well as the Lanarkshire Local Resilience Partnership. The reporting of incident through the Datix system was also under scrutiny to ensure the quality of reporting and how this could be refined to help inform the assessment of risk. He also provided an update on the governance arrangements for the reporting of risk and resilience within the new organisational structure.

Mr Moore thanked Mr Hardy for this overview, and for the quality of reporting. Ms Fallon echoed this and commented that the outline of governance arrangement gave assurance. She offered thanks to Mr Hardy and his team for the work progressed, and asked what gains in particular were hope for through the risk appetite session with internal auditors. Mr Hardy advised that this could be helpful in helping to establish how to measure perceived movements in risk, and understand what lay behind that.

Mr Moore noted that the Board were content to note this report, and offered the Board's thanks to the Risk and Resilience team for their work in enhancing performance ion this key area.

The Board:

1. Noted the content of the Risk and Resilience Annual Report 2021/22 (Paper No. 22/58).

27 COMMUNICATIONS UPDATE

The Board received a report from the Chief Executive (Paper No. 22/59) which provided an overview of the proposed development of the communications function.

Mr Jenkins provided the Board with a summary of the proposed way forward, following the Board's decision to support service transformation especially around the developing arenas of media and digital communications. The paper set out the need for further recruitment into the service, and the financial pressure this would entail. As discussed earlier in today's agenda, reporting would come to every second meeting of the Board going forward.

The Board noted this update as an important and necessary development, and that further updates would return to the Board for assurance.

The Board:

1. Noted the update in this paper (Paper No. 22/59) and that dedicated communications reporting would be received at every second meeting.

28 MODEL CODE OF CONDUCT

The Board received a report from the Board Secretary (Paper No. 22/60) which detailed the update on the Model Code of Conduct for NHS Boards. Ms Smith confirmed that this paper was submitted

to confirm the Board's previous agreement to the code, and that this had been published on the TSH website.

The Board:

1. Noted the content of the paper on the action taken in respect of the Model Code of Conduct, (Paper No. 22/60).

29 AUDIT COMMITTEE

The Board received the agreed minutes of the meeting (AC(M)22/01) of the Audit Committee which took place on 17 March 2022.

In addition, the Committee Chair Mr McConnell noted the meeting which took place earlier today, and the main business of which had been discussed during this meeting in the consideration of the Annual Accounts, and Patient Funds Accounts.

The Board:

1. Noted the agreed minutes (AC(M)22/01) from the Audit Committee which took place on 17 March 2022.
2. Noted the update from the Committee Chair in respect of the meeting which took place on 23 June 2022.

30 ANY OTHER BUSINESS

There were no other items of competent business to be considered by the Board at today's meeting.

31 DATE AND TIME OF NEXT MEETING

The next public meeting would take place on 25 August 2022.

32 PROPOSAL TO MOVE TO PRIVATE SESSION

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

The meeting ended at 3.55pm hours.

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 2021/April 2021	Resilience Report – Covid-19 (Item 7a)	Provide benchmarking comparison to other organisations on use of virtual visiting	R McNaught	Adjusted to June 22	Update August 21: Update included in Covid response report at Item 7a. Full report to be brought to October meeting Update February 22: trial of new system used in other high secure hospitals pending start date = delayed due to need for full DPIA to be completed. Update to Board in December. Update April 22 – Work progressing to pilot following completion of DPIA- update on agenda as part of digital strategy Update June 2022: Update as part of Covid report on today's agenda including comparator visit to high secure unit. **Update August 2022: Reporting will be presented as part of digital/eHealth reporting at next meeting in October.**

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

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

			CMT agreement then update to Board.			number of suggested scenarios drafted by patients for use in recruitment - focus on issues important to patients and their care and treatment. To be taken forward through CMT**.** **<u>Update August 2022:</u> Patients provided a samples set of questions and this is incorporated into interview planning CLOSE**
9	April 2022	Nurse Registration Report (Item 10)	Add revalidation into reporting for next report in 2023	K McCaffrey	Immediate	Confirmed added to reporting for future – CLOSE
10	April 2022	QA and QI (Item 11)	Update on Carer's clinic workstream	K McCaffrey	December 2022	<u>Update June 2022:</u> Progress with clinic in 2 Hubs during Feb – May 2022. Given positive feedback, further clinics will be held on 3-monthly basis. Feedback Reporting to be prepared end of November, and then update back to the Board for December meeting.
11	April 2022	Staff and Volunteer Wellbeing Strategy (Item 13)	Highlight wellbeing workstream and also develop digital means e.g. podcasts to demonstrate TSH as positive place to work. Add Trauma Informed approach	L Davidson L Davidson	August 2022 Immediate	<u>Update June 2022:</u> Progressing as part of the roll out of the Action Plan and also for the Recruitment Strategy. Information was added in the

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

Last updated – 15.08.22 – M Smith

Author:
Margaret Smith
Board Secretary
01555 842012

Paper No. 22/65

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 7
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Risk Management Facilitator
Title of Report:	Corporate Risk Register Update
Purpose of Report:	For Decision

1 SITUATION

A corporate risk is a potential or actual event that:

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

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

2 BACKGROUND

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

3 ASSESSMENT

3.1 Current Corporate Risk Register - See appendix A.

3.2 Review Dates

4 CRR currently require review within the Finance Directorate.

3.3 Update on Proposed Risks for inclusion on Corporate Risk Register

- Following a review of the Security Directorate Corporate Risks – **SD54 Climate change impact on The State Hospital** - is to be reviewed by the Sustainability Group to better align with DL38 - The Climate Emergency and Sustainable Development Policy. The risk assessment will look to focus on our compliance with the policy as well as the potential impact to the wider hospital should this not be implemented. Group was scheduled to meet in mid-June however this was cancelled due to Staffing Resource Issues across the hospital. The group is meeting next on 08 September and update will be finalised.

3.4 Corporate Risk Register Updates

IT Risk Updates

Work has been ongoing to finalise the risks below since the last board meeting. A full update of the risks below with be shared with the Board once final sign off is complete.

Risk	Action
FD91 - IT System Failure	Updates made to Risk Assessment, awaiting sign off from Director.
FD98 - Failure to Comply with Data Protection Arrangements	Updates made to Risk Assessment, awaiting sign off from Director.

3.5 High and Very High Risk – Monthly Update

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

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

Monthly Update: Risk was reviewed in August 22, agreed to leave at High for now as the Hospital continues to be affected by ward closures relating to covid. An in depth review will take place at the next Infection Control Committee.

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

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

Monthly Update: Level 3 PPE training has been completed. Policy has been shared with the Patient Safety Group and will be out for consultation once initial feedback is received. Once implemented the Risk and Resilience Team will monitor use and effects on Violence and Aggression through Datix incident reporting.

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

Monthly Update: Obesity figures have increased– 86.6% up from 81.1%. This change could be attributed to an increase in the number of patients without a monthly record (3% to 14%), this

equated to 16 patients with no BMI data, 2 were recent admissions but no reason was given to other 14 not having data other than potentially being affected by the staffing resource incidents across the hospital.

5 patients gained enough weight to move up a category (3 patients moved from Normal to Overweight, 1 patient moved from Overweight to Obese 1cand 1 patient moved from Obese 1 to Obese 2) – 4 of these patients had dropped to a lower weight category in June 2022 however gained again and returned to their previous category. There were 7 patients who reduced in weight enough to move down a category (4 patients moved from Obese 1 to Overweight and 3 patients moved from Obese 3 to Obese 2) - 4 of these patients had increased to a higher weight category in June 2022 however reduced in weight and returned to their previous category.

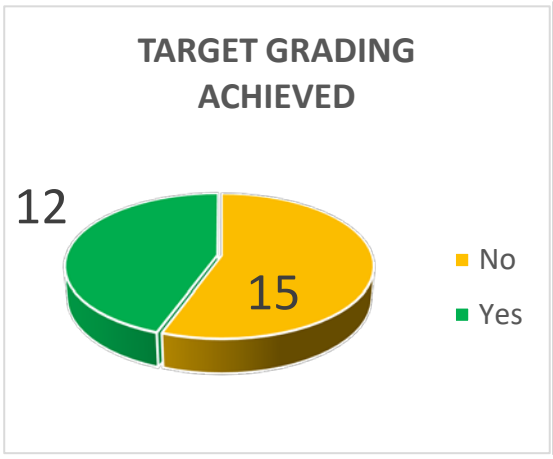
- **Nursing Director: ND70: Failure to utilise our resources to optimise excellent patient care and experience.**

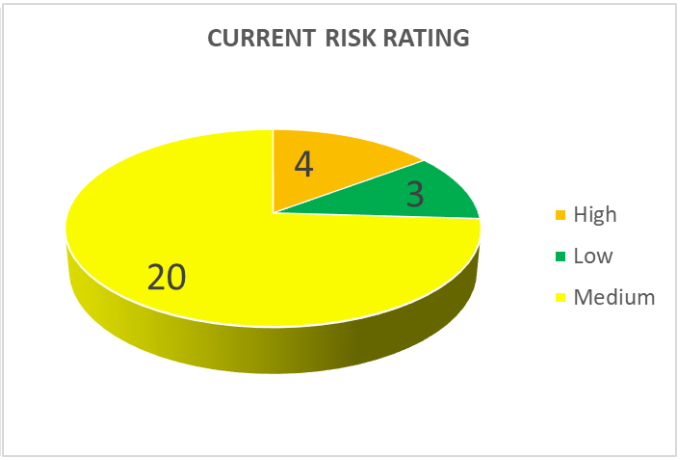
Monthly Update: Staffing issues continue to affect TSH. Daily meeting takes place to monitor staff resources in real time managed through the 'Safe to Start' Process. Hospital recently stood down non-essential operations to help with staffing. This has since stopped and normal business has resumed.

Staffing Resource incident numbers continue to rise through Datix although we are now able to identify which wards have been closed, partially closed and modified working. Closures are also being checked with the weekly indicator report to ensure accuracy.

Staffing is being monitored daily and continues to be a priority for the Hospital, recruitment is ongoing and modified working/closures being utilised where required.

3.6 Risk Distribution





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

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

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

	Negligible	Minor	Moderate	Major	Extreme
Almost Certain					
Likely			ND70,	MD30	
Possible			CE12, SD54, SD57, FD91, ND73	ND71, CE14	
Unlikely			MD33, SD55, FD90, HRD110, HRD112	MD34, HR111, SD51, SD50	
Rare			FD97, CE13, FD94, SD52,	MD32, FD96, SD56,	CE10, CE11, SD53

Review Periods:

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

4 RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The report provides The Board with an update of the Corporate Risk Register.
Workforce Implications	There are no workforce implications related to the publication of this report.
Financial Implications	There are no financial implications related to the publication of this report.
Route To Board Which groups were involved in contributing to the paper and recommendations	Board Workplan / CMT
Risk Assessment (Outline any significant risks and associated mitigation)	There are no significant risks related to the publication of the report.
Assessment of Impact on Stakeholder Experience	There is no impact on stakeholder experience with the publication of this report.
Equality Impact Assessment	The EQIA is not applicable to the publication of this report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	The Fair Scotland Duty is not applicable to the publication of this report.
Data Protection Impact Assessment (DPIA) See IG 16	Tick One ✓ There are no privacy implications. ☐ There are privacy implications, but full DPIA not needed ☐ There are privacy implications, full DPIA included

- Blue denotes risk that will be leaving the CRR

Appendix A

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

Corporate SD 50	Service/Business Disruption	Serious Security Incident	Moderate x Possible	Major x Rare	Major x Rare	Security Director	Security Director	01/11/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 51	Service/Business Disruption	Physical or electronic security failure	Extreme x Unlikely	Major x Unlikely	Major x Rare	Security Director	Security Director	01/11/22	Audit Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 52	Service/Business Disruption	Resilience arrangements that are not fit for purpose	Major x Unlikely	Moderate x Unlikely	Moderate x Rare	Security Director	Security Director	01/11/22	CMT	Y/Y	N/A	Quarterly	-
Corporate SD 53	Service/Business Disruption	Serious security breaches (eg escape, intruder, serious contraband)	Extreme x Unlikely	Extreme x Rare	Extreme x Rare	Security Director	Security Director	01/11/22	CMT/Risk and Resilience Committee	Y/Y	Y/Y	Quarterly	-
Corporate SD 54	Service/Business Disruption	Climate change impact on the State Hospital	Minor x Possible	Moderate x Possible	Minor x Possible	Security Director	Head of Estates and Facilities	01/11/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate SD 56	Service/Business Disruption	Water Management	Moderate x Unlikely	Moderate x Rare	Moderate x Rare	Security Director	Head of Estates and Facilities	01/11/22	Infection Control Committee	Y/Y	N/A	Quarterly	-
Corporate SD57	Health & Safety	Failure to complete actions from Cat 1/2 reviews within appropriate timescale	Moderate x Possible	Moderate x Possible	Moderate x Unlikely	Finance & Performance Director	Head of Corporate Planning and Business Support	01/11/22	CMT	Y/Y	N/A	Quarterly	-
Corporate ND 70	Service/Business Disruption	Failure to utilise our resources to optimise excellent patient care and experience	Moderate x Possible	Moderate x Likely	Minor x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/11/22	CMT	Y/Y	Y/Y	Quarterly	-
Corporate ND 71	Health & Safety	Failure to assess and manage the risk of aggression and violence effectively	Major x Possible	Major x Possible	Major x Possible	Director of Nursing & AHP	Director of Nursing & AHP	01/09/22	CMT	Y/Y	Y/Y	Monthly	-
Corporate ND 73	Service/Business Disruption	Lack of SRK trained staff	Moderate x Likely	Moderate x Possible	Moderate x Unlikely	Director of Nursing & AHP	Director of Nursing & AHP	01/11/22	PMVA Group and CMT	Y/Y	N/A	Monthly	Likelihood ↑
Corporate FD 90	Financial	Failure to implement a sustainable long term model	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance & Performance Director	Finance & Performance Director	31/07/22	Audit Committee, RF&P Group & CMT	Y/Y	N/A	Quarterly	-

Corporate FD 91	Service/Business Disruption	IT system failure				Finance & Performance Director	Head of eHealth		Information Governance Group & CMT	Y/Y	N/A		-
Corporate FD 96	Service/Business Disruption	Cyber Security/Data Protection Breach due to computer infection	Moderate x Unlikely	Moderate x Unlikely	Moderate x Rare	Finance and Performance Director	Head of eHealth	31/07/22	CMT/Risk and Resilience Committee	Y/Y	N/A	Quarterly	-
Corporate FD 97	Reputation	Unmanaged smart telephones' access to The State Hospital information and systems.	Major x Likely	Moderate x Rare	Moderate x Rare	Finance and Performance Director	Head of eHealth	01/09/22	Information Governance Group & CMT	Y/Y	Y/Y	6 Monthly	-
Corporate FD 98	Reputation	Failure to comply with Data Protection Arrangements				Finance and Performance Director	Head of eHealth/ Info Gov Officer		Information Governance Group & CMT	Y/Y	Y/Y		-
Corporate HRD 110	Resource	Failure to implement and continue to develop the workforce plan	Moderate x Possible	Moderate x Unlikely	Minor x Rare	Interim HR Director	Interim HR Director	01/11/22	CMT	Y/Y	N/A	Quarterly	-
Corporate HRD 111	Reputation	Deliberate leaks of information	Major x Possible	Major x Unlikely	Moderate x Unlikely	Interim HR Director	Interim HR Director	01/11/22	CMT	Y/Y	Y/N	Quarterly	-
Corporate HRD 112	Health & Safety	Compliance with Mandatory PMVA Level 2 Training	Major x Unlikely	Moderate x Unlikely	Major x Rare	Interim HR Director	Training & Professional Development Manager	01/11/22	H&S Committee	Y/Y	N/A	Monthly	Likelihood ↑

Paper No. 22/66

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 8
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Resilience Update - Governance Structure
Purpose of Report:	For Noting

1 SITUATION

Throughout the Covid pandemic The State Hospitals Board for Scotland has been able to maintain all aspects of board governance, including its regular schedule of Board and Committee meetings, except for a short postponement of the Audit Committee originally scheduled in January 2022.

The Board has also received an update report at each of its meetings on any changes within organisational governance to support service delivery. Focus is now on what is required to enable TSH to safely deliver its services whilst living with Covid-19.

2 BACKGROUND

Since the date of the last Board meeting, the organisation has varied its governance arrangements in response to what can be expected to be a regular cycle of Covid-19 infections within the community, which will then impact on The State Hospital (TSH) especially in relation to staffing availability.

At the beginning of July, the Corporate Management Team (CMT) took the view that variance would be required in order for the organisation to be in a position to respond quickly and proactively to the challenges being faced. At the same time, it was recognised that this did not require a full standing up of incident command arrangements in line with the Business Continuity and Emergency Planning Policy. This reflected the recognition that whilst some variation was needed, it should be a response that specifically underpinned operational leadership.

Therefore, the decision was taken that as of 5 July, the CMT would move to short weekly meetings for any urgent business and decision-making required only. The framework of groups, reporting into the CMT were stood down (including the Operational Management

Team - OMT) and were replaced with an Operational Planning Group (OPG). The following exceptions were made to this to enable an appropriate level of clinical governance as well as recognising the need to support the continued oversight of the security project works and of capital spending. Therefore, these groups continued to function:

- Clinical Governance Group
- Infection Control Committee
- Security Project – Project Oversight Board/Groups
- Capital Group

Clinical Team Meetings and Patient Pathways Meeting also continued as appropriate.

The OPG met twice a week and linked to the resilience and on-call arrangements in place over the weekend periods as well as the daily "huddle" which takes place each morning on Monday to Friday.

This group was chaired by the Director of Security, Estates and Resilience and linked Heads of Departments on key service including all of the clinical professions and security, estates and related support services. The focus was on the Safe to Start methodology for the hospital each day, and promoted varying ways of working within the hospital dynamically to support the most optimal care possible within the difficult landscape faced. This resilience work was supported through the Risk and Resilience Team, with governance and administrative support though the Corporate Services Team.

This organisational structure was in place until 2 August, at which point the stabilising picture meant that it was felt appropriate to stand down the group, and move back to business as usual.

It can be expected that levels of community infection with Covid-19 will move in cycles, and that TSH will be impacted in a similar way over the course of the coming year, especially during the winter months when there may be additional impact from the seasonal flu virus. The OPG model is now embedded and understood well within the hospital. It has demonstrated an effective model for quick, responsive and collaborative decision-making for the senior leadership team during a period of challenge. It can be utilised in the future during similar periods of organisational stress.

Prior to these developments, the CMT had held development sessions during May 2022, in which the senior leadership team took a pause to consider organisational strategy and operational priorities underpinning planning; as well as the existing management and governance structure through which to deliver these priorities.

This work focused in particular on how to build a bridge between clinical leadership through Hub Leadership Teams, linked directly to the operational structure through the Organisational Management Team (OMT). The key issues included the recognised need to review the remit of the existing Hospital Management team (HMT) and Hub Leadership Teams (HLTs).

This has led to the decision to formalise the operational responsibility of the HLTs, providing a standardised approach across all four Hubs, and to include the Skye Centre as the fifth HLT. Given this new structure, the HMT will now be stood down. Work has also progressed to stand down the Operational Model Monitoring Group (OMMG) and for a new Oversight Activity Group to be stood up, and this group will meet for the first time in September. The AOG will

provide a long term structure to monitor and seek improvements in the delivery of patient activity in a cohesive way throughout the hospital.

The CMT endorsed this positon at its meeting on 6 July, but a pause followed for implementation due to the need to vary operational management through the OPG during July. With a return to business as normal, this structure is now being implemented. The CMT will review progress, and monitor the functionality and the impacts of this change on a regular basis

4 RECOMMENDATION

The Board is invited to:

Note this update on the variance to the governance structure to enable TSH to be in a position to respond quickly and proactively to the challenges being faced. Further that this structure did prove effective, and is embedded within the hospital and can be stood up in the future if required.

Note the review of governance with the HMT being replaced by a strengthened HLTs structure giving cohesion across the Hubs and the Skye Centre; as well as the formation of the AOG to provide a long term structure to continue the work to closely monitor and seek improvement for the delivery of patient activity across the hospital.

Author:
Margaret Smith
Board Secretary
01555 842012

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To support operational management and governance structure during Covid 1-19 cycles
Workforce Implications	No direct implications due to reporting
Financial Implications	No financial implications in this update
Route to Board Which groups were involved in contributing to the paper and recommendations.	Presented as update as part of Board requested section on risk and resilience.
Risk Assessment (Outline any significant risks and associated mitigation)	Governance varied in response to risk of Covid-19 cycles, and means of monitoring this outlined as per through CMT.
Assessment of Impact on Stakeholder Experience	No specific impacts for reporting
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:	25 August 2022
Agenda Reference:	Item: 9
Sponsoring Director:	Director of Nursing and Operations
Author(s):	Senior Nurse for Infection Control
Title of Report:	Infection Prevention & Control Report (Including Covid19 activity)
Purpose of Report:	For Noting

1. BACKGROUND

This report is presented to the Board to provide an update in relation to HAI activity (including Covid19). Dates for reported will be indicated in each section.

2. INFECTION PREVENTION & CONTROL ACTIVITY

Hand Hygiene

In July 2021, the Clinical Quality Improvement Facilitator (CQIF) for HAI was appointed. This was a 12month secondment with an extension granted to 31st March 2023. During this time the CQIF has made significant improvement of ensuring that HAI data is acted upon and not just reported on. The priority for activity is based on the areas identified previously i.e. Hand Hygiene and Clinical Waste.

Hand Hygiene audits are completed by a member of staff within that area and are based on that individual's perception of compliance. 16 clinical areas were monitored and completed audits are sent to the Clinical QI Facilitator by the 20th of each month. Chart 1 shows the percentage of overall completion rate. The overall in May 2022 with an overall average of 76% and in June of 83% although there has been an increase from May to June 2022, this is the lowest average in compliance over the last year therefore has move from Amber to Red. The CQIF is working in collaboration with the Lead Nurses and Senior Charge Nurses to address this area of concern.

Chart 1: Overall compliance with Hand Hygiene

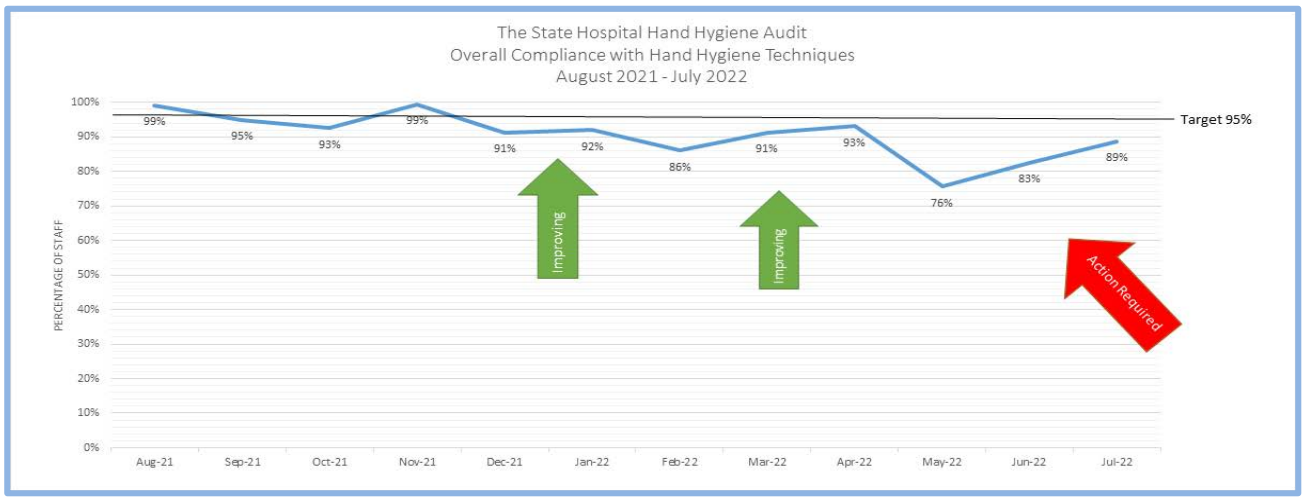
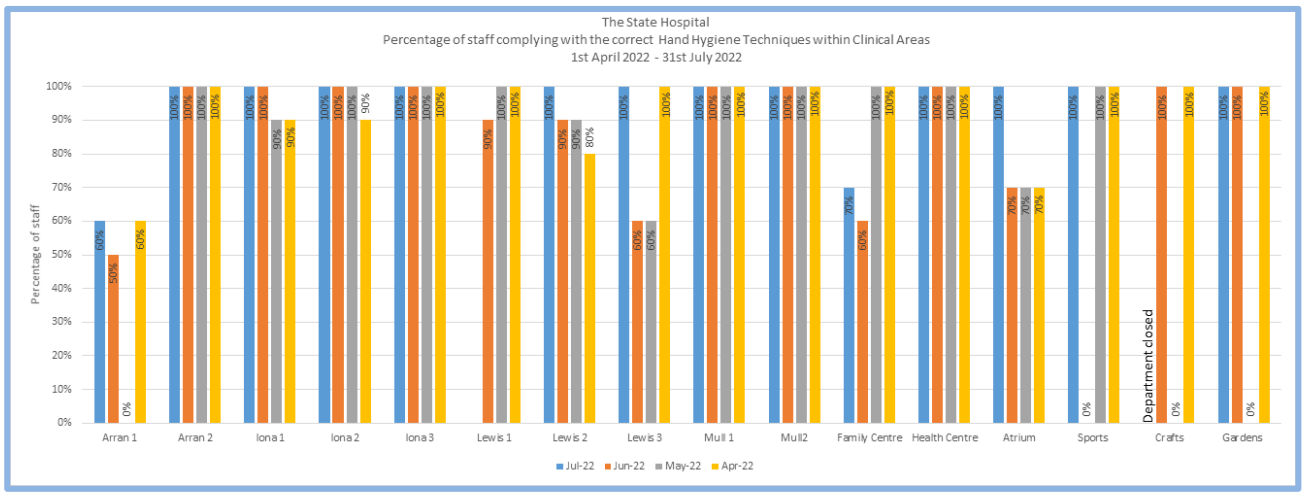


Chart 2: Percentage of staff complying with correct hand hygiene techniques within clinical areas



It can be seen from Chart 2 that there are areas of concern within Arran 1 and Lewis 3. The CQIF is working with the Lead Nurses and Senior Charge nurses from these areas to improve compliance. The SNIC continues to monitor trends between poor hand hygiene compliance and Covid19 outbreaks.

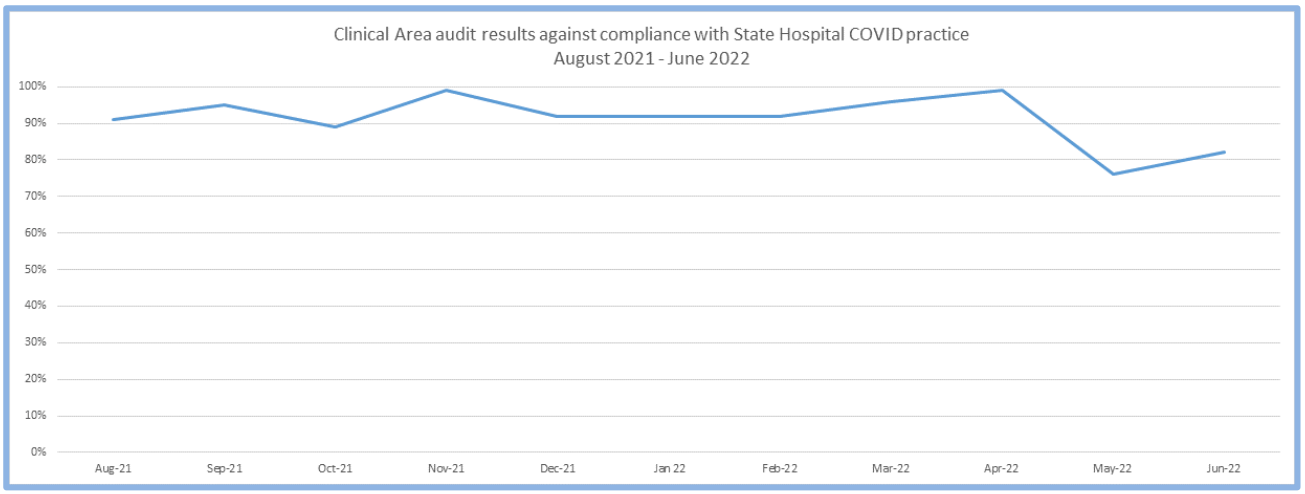
In addition to the work with the Lead Nurses/Senior Charge Nurses posters are placed in each hub area, security search area. The use of Onelan within the wards will also help to prompt Infection Control messages.

State Hospital Safe Covid Practice

The data presented is from August 2021 – June 2022.

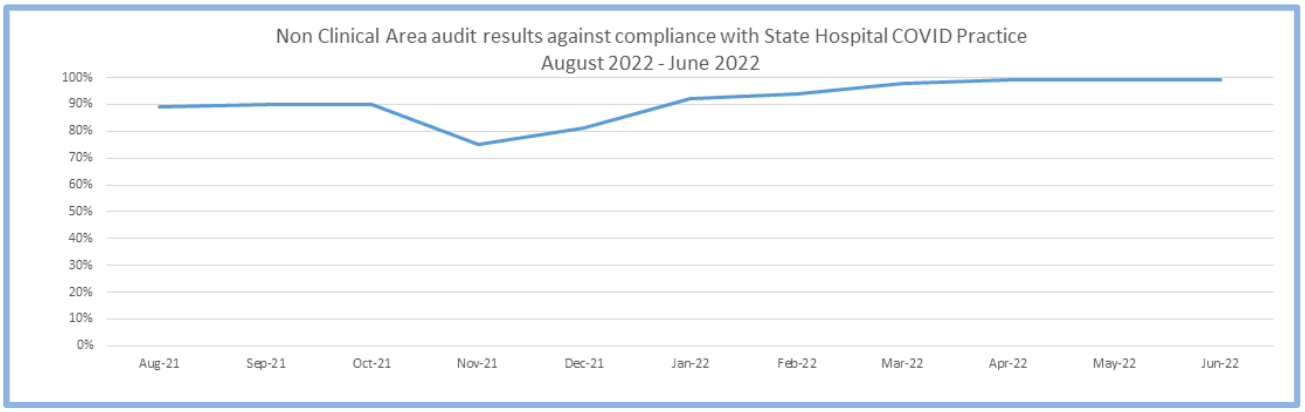
In November 2020, it was agreed to audit against the control measures put in place to minimise the risk of cross infection. The audits were tailored to meet the needs of Clinical and Non-clinical areas. With changes in national guidance/relaxation of restrictions the audit tools were amended in June 2022, hence the data reporting points.

Chart 3: Clinical Area audit compliance with Covid practice



It can be seen from Chart 3 that there was a dip in compliance, on investigation there were 3 areas that did not submit an audit (Arran 1, Gardens, Craft & Design). Going forward if departments are closed for 1month (which was the case for Craft & Design) they must inform the CQIF and this will be reflected in reports.

Chart 4: Non Clinical audit compliance with Covid practice



It can be noted from chart 4 that there is a consistent adherence to Safe Covid Practice within non-clinical areas. It was agreed at the ICC in July that these audits would be incorporated into the quarterly workplace inspections. This will not happen until the ICC can be assured that there is an identified person who will undertake these audits. The Risk Management Facilitator will inform the CQIF when a person has been identified.

DATIX INCIDENTS FOR INFECTION CONTROL (March 2022 – June 2022)
During this period there were 29 infection control related incidents

- 11 of these pertained to Safe Management of Linen e.g. bags not being tagged and bags not being managed via the correct route.
- 16 related to Covid.
- 2 related to Diarrhea and Vomiting

Following a report to the Infection Control Committee in April 2022 based on the data detailed above, a small team (Housekeeping, Infection Control, Risk Management, Linen Staff and the Lead Nurses) commenced work in May 2022 as to why pink alginate bags were not being disposed of correctly. Some of these reasons that could be a contributing factor were; clearer signage, information to

Senior Nurse Teams within the area, separate area for disposing pink alginate bags and refreshing the Management of Safe Linen Policy.

A small test of change was implemented (June 2022) within Lewis Hub (using the data reported submitted in April 2022) this included improving, quarterly reports to each Senior Nursing Team around Laundry incidents, clearer signage on the process for disposal of laundry, Clearer signage and additional disposal area within the DRS Room within the hub area for pink alginate bags and clearer communication with the Senior Nursing Teams within this area to ensure that all nursing staff refresher the Management of Safe Linen Policy.

Reviewing at the data retrieved from June 2022 and taking into account that Lewis was in an outbreak within June, as indicated above there was only one incident in relation Laundry for the month of June 2022 and we are unable to determine where this happened as it was not clearly tagged. Feedback from Linen staff there has definitely be an improvement in relation to the number of incidents.

Following the success of the small test of change, the intention is to roll this out to the wider hospital. This will be dependent on the Autumn/Winter Vaccination program and any subsequent Covid outbreaks.

It is the intention of the ICC to revert back to quarterly meetings. An Infection Prevention & Control Group will be established and will meet monthly. This will be an operational group with the Committee acting as a Governance Committee. Terms of reference and membership are to be developed.

3. Policies and Guidance

All infection control policies and procedures are reviewed as per policy schedule and there are no outstanding policies.

4. Autumn/Winter Vaccination Program

The SNIC in conjunction with the Pharmacy department are planning the Autumn/Winter Vaccination Program. The Joint Committee for Vaccination and Immunisations (JCVI) have identified priority groups. A final position is to be agree with Ministers on frontline Health and Social Care Staff is expected imminently. The vaccination program will commence in September 2022. Communication has been issued to staff (x2 staff bulletins and direct emails to line manager) in order to seek a note of interest. To date this response has been poor with only 82 staff responding (24 clinical staff).

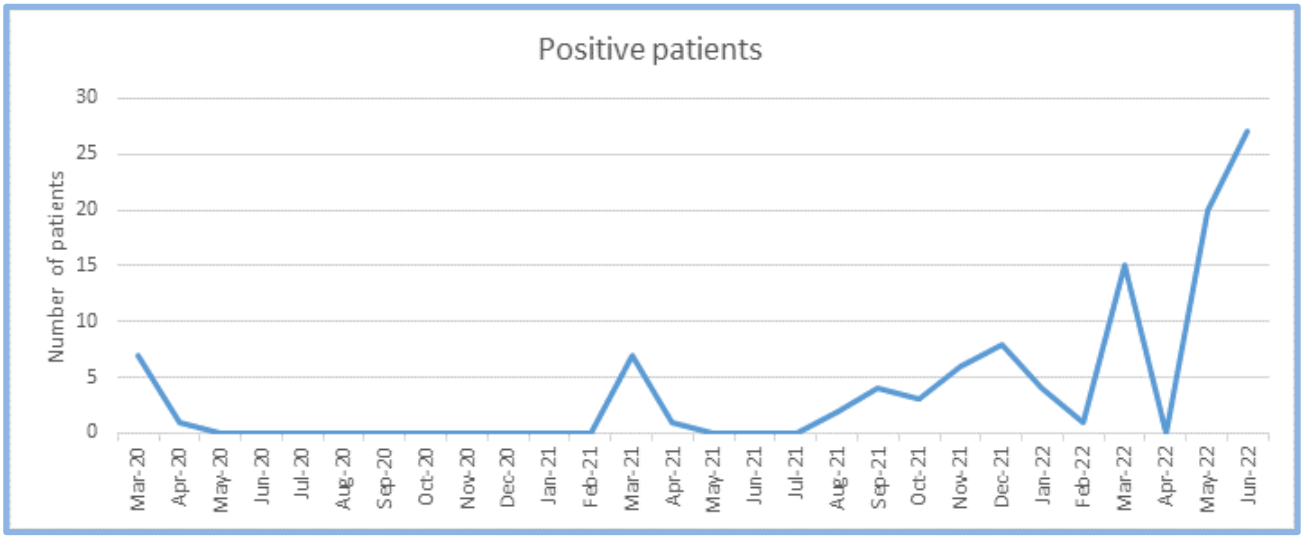
5. COVID19 Activity

Omicron is a variant of the SARS-CoV-2 virus first identified in South Africa and designated a Variant of Concern by the WHO on 26th November. Omicron is more infectious but evidence suggests less virulent than the Delta variant. There a sub-lineages of the Omicron variant which are move transmissible yet less severe. It is difficult to accurately record the number of cases within the community as testing facilities and the requirement to test has ceased. Testing via the ONS survey and hospital admissions are determining the Covid cases in Scotland. Staff working in Healthcare settings are still required to undertake twice weekly LFD testing.

Covid Cases

To date there have been 113 patients who have tested positive. There has been a steady rate of Covid activity from August 2021, as demonstrated in the chart 5 (overleaf).

Covid Chart 5: Trends in Covid Cases



From 1st May the Covid19 activity has been significant with approximately 50% of our total cases being identified during this timeframe. This increase in cases corresponds with the increase in community cases.

Table 1: Location and duration of Outbreaks

Ward closed	Dates of ward closure	Confirmed patient cases
Mull 1	09.05.2022 -29.05.2022	9
Mull 2	11.05.2022 - 28.05.2022	5
Arran 2	29.05.2022 - 12.06.2022	5
Lewis 2	30.05.2022 - 09.06.2022	1
Lewis 2	15.06.2022 – 08.07.2022 (change to SOP)	8
Lewis 3	16.06.2022 – 03.07.2022	8
Arran 2	19.06.2022 – 08.07.2022 (change to SOP)	7
Mull 2	19.06.2022 - 06.07.2022	2
Arran 1	19.06.2022 - 03.07.2022	6
Lewis 1	21.07.2022 – 4.08.2022 (change to SOP)	2
Arran 3/Iona 2	30.07.2022 – 15.08.2022 (change to SOP)	3

The Covid19 vaccination uptake rate (up to 12.07.2022) is:

- 87% of patients are fully vaccinated,
- 3% partially vaccinated and
- 10% have not received any vaccination.

Since March 2020 there have been a total of 19 patients (still resident) that have had Covid twice; 3 of the 19 had not been fully vaccinated.

On 16 June 2022, one patient required treatment for Covid this was managed onsite and he recovered well.

On 14th July 2022 the existing SOP for the Management of Suspected/Confirmed Cases was revised. This new SOP moves towards a least restrictive practice and is mirroring the practice in other establishments. The State Hospital will manage individual cases and therefore there should not be routine closures of wards. The Senior Nurse for Infection Control will continue to review each positive case and make amendments to the SOP if required.

6. RECOMMENDATION

The Board is invited to

1. Note the content of this report.
2. Advise on information to be reported

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	To provide the Board with specific updates infection control as well as any other areas specified to be of interest to the Board.
Workforce Implications	As detailed within sections 2 and 3 of report.
Financial Implications	No financial implications identified.
Route To Board Which groups were involved in contributing to the paper and recommendations.	Nursing and AHP Directorate Board requested information.
Risk Assessment (Outline any significant risks and associated mitigation)	Not identified for this report.
Assessment of Impact on Stakeholder Experience	Not identified.
Equality Impact Assessment	Not formally assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	Not identified as relevant.
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:	25 August 2022
Agenda Reference:	Item No: 10
Sponsoring Director:	Medical Director
Author(s):	Forensic Network Manager
Title of Report:	Bed Capacity within The State Hospital and Forensic Network
Purpose of Report	For Noting

1 SITUATION

Capacity within the State Hospital and across the Forensic Network has been problematic and requires monitoring.

2 BACKGROUND

1) TSH

There were 112 current patients in TSH as of the 31st of July.

	MMI	LD	Total
Bed Complement	128	12	140
Staffed Beds	108	12	120
Admissions	4	0	4
Discharges / Transfers	8	1	9
Average Bed Occupancy: Available beds/All beds			94.1% / 81.0%

2) TSH Contingency Plan

A contingency plan is being finalised through CMT. This is summarised below:

I Ongoing Actions

a) Formal transfer review meeting established on a monthly basis (AMD)

b) Monitoring of imminent transfers (next 2-3 weeks) at weekly Patient Pathway Meeting and likely bed state reported to directors weekly (AMD)
c) Regular meeting in place to discuss with NHS Greater Glasgow and Clyde fully accepted patients for transfer to Rowanbank Clinic (CEO).

II Further Actions agreed by CMT in the event of further bed pressure:

1. Use Mull 3 for patients to sleep in but to be located in another ward during day. 2 staff required to open ward at night. Facility time would not be possible. Establish operational group to plan this (ND).
2. Any agreement to use last bed must be with AMD / MD consent or out of hours with duty director consent. Communicate to RMOs (MD).

3) Forensic Network Capacity Initiatives

At the request of the Scottish Government, the Forensic Network developed plans to improve capacity across the forensic estate. These plans and their outcomes to date are set out in Appendix 1.

3 ASSESSMENT

Work is ongoing within TSH and across the Forensic Network on issues of capacity. The current situation within TSH has eased but it is recognised that there is a natural variation in the number of referrals and admissions and further pressure is likely in the future unless the medium and long term plans outline in Appendix 1 are progressed.

4 RECOMMENDATION

The Board is asked to note the report.

MONITORING FORM

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

Appendix 1

Forensic Network Capacity Paper & Plan

Forensic Network

The State Hospital

Carstairs

Lanark

ML11 8RP

Gavin Gray

Deputy Director, Improving Mental Health Services

Scottish Government

7th June 2022

Dear Gavin

Forensic Network Capacity Paper & Plan

In September 2021, the Forensic Network were asked to identify immediate actions to free up beds across the forensic mental health estate so as to provide capacity to deliver care and treatment to those who require it. Actions were to be outlined within a short-term delivery plan, with clear lines of responsibility for each action and how implementation would be monitored. The commissioning letter provided a list of suggested options that should be considered as part of the work.

After engaging with a broad range of stakeholders and professionals across the forensic mental health estate, we provided a report on 30th September 2021 containing an overview of the various options that we were asked to consider, alongside a 16-point short-term plan, a 4-point medium term plan and a 3-point long term plan.

Since the submission of the paper in September 2021, as a Network we continued to engage with the Advisory Group of stakeholders who contributed to this work. In total, three meetings of the group were held (September 2021, November 2021 and March 2022) and an update paper was circulated to all members in January 2022 in lieu of a meeting. The group primarily focused on progressing the items within the short-term plan and monitoring delivery of same.

We are delighted to update that each of the items within the short-term plan have now been progressed and/or completed. Highlights include:

- Five Transfer for Treatment Direction (TTD) patients were returned from High and Medium secure services to prison settings. This created some capacity within The State Hospital which supported their ability to consider admissions under the exceptional circumstances clause once more.

- Rohallion Clinic undertook work to identify patients across the estate who could transfer in order to utilise some of their available beds.
- The Orchard Clinic agreed to utilise two available rooms for a period of 12 months, one of which was being used as a storage space. Risk assessments were undertaken and furniture ordered to support these rooms being used for patient care. These rooms are due to become operational in the coming weeks (June 2022).
- Monthly bed management meetings have now been established involving representatives from across all levels of security (from March 2022). These aim to provide a national forum for services to share information with regard to admissions, patient flow and capacity within forensic mental health services.

For a full overview of each item within the short-term plan please see appendix A.

The delivery of items within the short-term plan was made possible due to the engagement of Chief Executives, clinical leads and senior managers working within high, medium and low secure forensic mental health services.

With regard to progressing longer-term solutions (Appendix B), it is recognised that in order to address the challenges posed by the current level of capacity within the forensic mental health estate, Health Boards, Chief Executive and Scottish Government support is crucial. It is anticipated that items within the medium and long term plans submitted as part of this work will be considered once the Scottish Government: Planning and Collaboration short-life working group is concluded and clear proposals have been made with regard to the future governance of forensic mental health services.

Yours sincerely,

Professor Lindsay Thomson

Director, Forensic Network & SoFMH

APPENDIX A: 16-point short-term delivery plan

Short-Term Delivery Plan (1– 9 months)

	Action to be taken	Responsible for actions	Timescales	Updates
1.	Establish weekly bed management meetings for 3 MSUs and High Security to prioritise need	Forensic Network Inter Regional Group	1 month	First meeting held on 07.01.22. Agreement that future meetings should include reps from services at all levels of security – scheduled for 25.03.22.
2.	Identify Orchard Clinic and Rowanbank patients likely to be suitable to move to Rohallion low security	Clinical Leads, Rowanbank Clinic / Orchard Clinic	1 month	Complete.
3.	Ensure use of IPCUs for MDOs is based on clinical need and has national consistency (no quotas)	Principal Medical Officer (PMO)	1 month	Complete.
4.	Establish weekly regional low secure bed management meetings to prioritise need	Forensic Network Inter Regional Group	3 months	Initially agreed to be reviewed after initial bed management meetings were piloted. Now one bed management meeting for all levels (see item 1). Established March 2022 onwards.
5.	Utilise extra available bed in Orchard Clinic admission ward	Clinical Director, Orchard Clinic	3 months	Risk assessments completed and furniture ordered in December 2021. Furniture delayed until April 2022. Due to open in June 2022 once Clinic recovers from Covid closures and clinical activity levels reduce.
6.	Adapt storage area in Orchard Clinic admission ward back to bedroom	Clinical Director, Orchard Clinic	3 months	As above.
7.	Utilise 3 Rohallion Clinic rehabilitation beds to create medium secure capacity	Regional Service Manager	3 months	Complete.

elsewhere in the forensic estate	(North) & Clinical Lead Rohallion Clinic		
8. Explore staffing of Rohallion low secure ward as temporary measure to allow Stobhill and REH low secure capacity to be developed	Regional Service Manager (North)	3 months	Agreed item for removal at meeting on 17/11/21.
9. Explore 11 TTD patients identified for discussion by PMO with RMOs re suitability to return to prison using criteria outlined.	Principal Medical Officer (PMO)	3 months	Complete.
10. Review and shorten Scottish Government processes to return an individual to prison estate	Principal Medical Officer (PMO)	3 months	Noted that the SG Team attempt to process referrals for transfers as quickly as possible.
11. Discussions with COSLA re plans for provision of supported accommodation	Scottish Government	3 months	Ongoing within Scottish Government. No further actions to be taken by capacity group.
12. Review guidance on maternity leave and COVID-19	Scottish Government	3 months	Scottish Government have confirmed they will not be taking this issue forward so marked as no further action (Jan 2022).
13. Complete review of staffing across Forensic Estate	Forensic Network / Scottish Government	3 months	Feedback received from high / medium & several low secure services. Data shows that the majority of services have nursing vacancies and active recruitment campaigns to fill these.
14. Explore use of independent sector beds in Scotland or the north of England whilst additional secure provision is developed in Scotland	Scottish Government	3 months	Noted current arrangements (e.g. Northgate Hospital) and the desire to keep patients in Scotland where possible. To be kept on SG/HB agendas.
15. Review existing Rowanbank Clinic extension proposals	NHS GG&C CEO /	6 months	Further discussion will take place after

	General Manager (West) / Clinical Lead Rowanbank Clinic		the work of the Scottish Government: Planning and Collaboration SLWG has concluded in Summer 2022.
16. Utilise Stobhill 20 bed ward without adaptations, or bring forward adaptation timescale (NB medium-term)	NHS GG&C CEO / General Manager (West) / Clinical Lead Rowanbank Clinic	6-9 months	15 beds at Stobhill are now being put forward for adaptation and the plan to be presented to the Clinical Management Team. This was due to be considered in December 2021, however was deferred. Final approval of funding still awaited; likely to be discussed further once Planning & Collaboration SLWG reports in Summer 2022.

Additional Ideas - Noted at Advisory Group meeting on 17th November 2021

Action to be taken	Responsible for actions	Timescales	Updates
Consideration to be given to delays experienced by patients due to lengthy decision making processes of the Parole Board.	Principal Medical Officer (PMO)	2 months	Discussions have taken place regarding one specific case to date. Broader discussions taking place with SG/Parole Board within FMH Unit.
Exploration of expedited timescales for Mental Health Tribunals or earlier tribunals for Conditional Discharge patients, to avoid them being in low secure services longer than they need to be	Principal Medical Officer (PMO)	2 months	Restricted Patient team working with MHTS around improving processes around expediting mental health tribunals.
MAPPA Guidance to be checked to ascertain	Service Manager,	2 months	Complete: MAPPA Guidance states

timescales for meetings and for this to be communicated	NHS Lanarkshire		"For those offenders in the community an initial Level 2 meeting must be held within **twenty working days** of receipt of referral by the MAPPA Coordinator or their administrator. An initial Level 3 meeting must be held within **five working days** of receipt of referral." Some areas (e.g. Lanarkshire) work towards ten working days for level 2 referrals.
Identify solutions for the five damaged male forensic beds in NHS Forth Valley	Forensic Network	2 months	Five beds require new doors to become operational. However, a proposal is currently with NHS FV at the moment to reduce capacity within the service to 12 beds – likely to be agreed in near future. IRG agreed to write to NHS FV to highlight need to progress this or make efforts to utilise the available beds as an interim measure (May 2022).

APPENDIX B: Medium and Long-Term Plans

Medium-Term Delivery Plan (12 – 24 months)

Action to be taken	Key Decision Makers	Timescales
Develop seclusion facilities in Rowanbank Clinic	General Manager (West) / Clinical Lead Rowanbank Clinic	12 months
Make functional seclusion facilities in Rohallion Clinic	Regional Service Manager (North) & Clinical Lead Rohallion Clinic	12 months
Develop 15-bed low secure unit on Stobhill site (NHS GG&C) (NB short-term option)	NHS GG&C CEO / General Manager (West) / Clinical Lead Rowanbank Clinic	18 months
Regional low secure service for females in North of Scotland	NHS Tayside CEO / Regional Service Manager (North) & Clinical Lead Rohallion Clinic	18 months

Longer-Term Delivery Plan (24 months +)

Action to be taken	Key Decision Makers	Timescales
Modify and enact Rowanbank Clinic extension proposals in light of review in short-term actions	NHS GG&C CEO / General Manager (West) / Clinical Lead Rowanbank Clinic	24-36 months
Develop 6-bed male pre-discharge unit on REH site	NHS Lothian CEO Services Director (Psychiatry) Royal Edinburgh Hospital / Clinical Director Orchard Clinic	24-36 months
Potential development of low secure service within NHS Lothian – currently being explored	NHS Lothian CEO Services Director (Psychiatry) Royal Edinburgh Hospital / Clinical Director OC	4-5 years

Paper No. 22/69

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 Aug 2022
Agenda Reference:	Item No: 12
Sponsoring Director:	Medical Director
Author(s):	Chair and the PHSG/SHC Group and Lead Dietitian
Title of Report:	Supporting Healthy Choices Progress
Purpose of Report:	For Noting

1 SITUATION

The Supporting Healthy Choices Group is focused to support TSH in managing obesity as rates continue to prevail at between 83 to 93% of patients being overweight or obese with the risk of associated comorbidities and known increased risk of morbidity and mortality from the current COVID -19 pandemic.

2 BACKGROUND

The second SHC action plan was agreed by the board in the August 2021 and subsequent plan of progress commenced.

3 ASSESSMENT

Of the actions agreed to maintain/commence;

Action	Progress
Monthly weight/BMI monitoring of patients continues	Ongoing, reported into Rio and reports from such and used for Tableau data
Review provision of hospital shop bags	Skye centre action (JG)
Patient related information on aspects related to health via use of physical health education boards on all wards.	Actioned currently monthly by dietetics team
Review of weight management pathway to include information on national weight management tiers and dissemination to wards and health centre for staff education,	Actioned Oct ’21.
Audit of patient menu choices to identify if colour coding in line with FSA national coded increases uptake of healthier/healthy choices,	Completed by clinical effectiveness, results to PHSG March ’22. Findings: There are many factors which can influence a patient’s meal choice. The most noticeable change in the choices that patients

	made during the coloured meal order form cycle was in the red meal options; 50% of patients made a healthier choice and ordered fewer red options when these choices were identified as 'red' (eat less of). There were 27% of patients that increased their red meal options and the remaining 23% of patients did not change their levels of ordering in relation to red options. With amber (moderate intake) and the green (healthy) options, 47% of patients increased their options whereas 45% and 46% respectively decreased their options. For both amber and green options 9% and 8% of patients respectively did not make any changes to their ordering habits during the coloured meal order form cycle. The changes patients made when ordering meals using the coloured meal order form broken down further into Body Mass Index (BMI) groupings. Within the Obese 2 category 63% (10) of patients chose to reduce their selection of red options for their meals with 50% (8) choosing additional amber (moderate intake) and 56% (9) choosing additional green healthier options. In comparison, within the normal BMI range 70% (7) patients chose less healthy green options and limited intake red option (50%) instead choosing amber (moderate intake) options (50%). As can be seen within the Obese 3 category with the fewest number of patients, there were patients who chose less healthy green options and limited intake red options (60% decrease for both) and chose more moderate intake amber options (60% increase). Given the introduction of restrictions due to the Covid-19 pandemic, the ordering of takeaway meals was cancelled for a period of time and therefore were not applicable during the black and white meal order form cycle. Of the 7 dates when takeaways were ordered during the second meal order form cycle, there were orders also placed for hospital meals on 3 (43%) of these occasions. These were for Arran 2, Iona 2 and Lewis 3. During both cycles, there were times where wards did not submit the patient's meal order form to the Catering department and therefore these could not be included within the audit. As

	can be seen below, Iona 2 and Lewis 2 submitted all meal order forms on all occasions. Arran 1 did not submit meal order forms on the highest number of occasions (28% of occasions for the black and white meal order form cycle and 32% of occasions for the coloured meal order form cycle). In the instances where no meal order form was submitted, Catering Department practice is to provide a meal serving to these wards based on each individual patient's past choices. Recommendations: • Although a new national system is operational and should replace the current system during 2022/3, some thought should be given to reviewing the meal ordering process with the aim of standardising and streamlining it e.g. use of centralised electronic process via use of tablets to minimise steps in the ordering process and to minimise risk of human error • Staff should have a greater awareness and understanding of the FSA coding so that they can assist patients with their meal options • All staff should continue to encourage patients to maintain a healthy diet to aid both physical and mental health • PHSG has agreed to undertake an individual case study to identify a patient's access to food items
Funding for health psychologist post (versus trainee post),	Post recruited to
Scoping of weight history screening tools to assess all patients within 6 months' admission,	Currently ongoing by dietetic team
Annual takeaway audit (TBC date of last)	Annual audit ceased when practice improved and guidelines for patients orders in place
Full length mirrors have been agreed for communal areas and spend agreed to purchase.	Now in place
Counterweight plus (meal replacement plan) has been maintained in practice for designated patients	Ongoing. Bid for 2022/3 funding and end of year report completed April/May '22.
Work to progress the move from Health and Wellbeing plans (HWP) to Nutrition and Physical Health Care plans (NHCP) is ongoing.	Currently ongoing with Nursing practice development and prof Nursing Officer. NPCP will combine NST and Physical Health checklist with separate (nutritional)

	care plan using current nursing plans. Pilot on Lewis due August.

4 RECOMMENDATION

The Board to note the current progress and situation.

Recruitment of a project manager to progress with the outstanding SHC actions during 2022/3 is anticipated. Interviews will be held 9th September 2022.

MONITORING FORM

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

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 13
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Director of Security, Resilience and Estates
Title of Report:	Annual Report to Scottish Government on the Implementation of Specified Persons Legislation
Purpose of Report:	For Decision

1 SITUATION

The Mental Health (Care & Treatment) (Scotland) Act 2003, Section 286, makes provision for regulations (the regulations) relating to safety & security, use of telephones and correspondence. The Safety & Security Regulations place a duty on The State Hospital to furnish Scottish Government with an annual report on the implementation of the regulations. In the interests of openness and transparency, the annual report to the Scottish Government also includes information on the implementation of the regulations relating to correspondence and telephones.

The draft report for 2021 – 2022 is attached at Appendix 1.

2 BACKGROUND

The regulations are:

- The Mental Health (Safety & Security) (Scotland) Regulations 2005
- The Mental Health (Use of Telephone) (Scotland) Regulations 2005
- The Mental Health (Definition of Specified Persons) (Scotland) Regulations 2005

The regulations allow restrictions to be made relating to “Specified Persons”. The purpose of the specified person designation and related restrictions are to ensure the safety and welfare of the patient and others by allowing the Clinical Team to introduce managed and proportionate controls in defined areas. A system of reviews, reporting and appeals is also in place to safeguard the patient from excessive or disproportionate use of the specified person designation.

The specified person designation relates to:

- Correspondence
- Telephone calls
- Property and visitors
- Searching of patients and their property
- Searching of visitors and their property
- The taking of samples
- Surveillance of patients and visitors

Outside of the State Hospital the specified person designation is applied by the Responsible Medical Officer. The Act states that all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

3 ASSESSMENT

The report attached at Appendix 1 is in the same format as previous years. It meets our obligation for an annual report. The data included in the report is regularly reported in more detail to the Clinical Governance Committee.

4 RECOMMENDATION

The Board is invited to **approve** the report for submission to the Scottish Government.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	Meets obligation for annual report to Scottish Government
Workforce Implications	None
Financial Implications	None
Route to the Board Which groups were involved in contributing to the paper and recommendations?	Requested as part of Board Workplan
Risk Assessment (Outline any significant risks and associated mitigation)	None
Assessment of Impact on Stakeholder Experience	None
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).	Not applicable
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.

Appendix 1

Annual Report to the Scottish Government Health Department on the Implementation of:

- **The Mental Health (Safety and Security) (Scotland) Regulations**
- **The Mental Health (Use of Telephones) (Scotland) Regulations 2005**
- **The Mental Health (Definition of Specified Person: Correspondence) (Scotland) Regulations 2005**

by The State Hospitals Board for Scotland for the period 1 August 2021 to 31 July 2022

1 THE HOSPITAL'S CURRENT POLICY ON SAFETY AND SECURITY

The State Hospital has 140 beds and is currently operating with 120. According to the Mental Health (Care and Treatment) (Scotland) Act 2003 (the Act) all patients at The State Hospital are automatically deemed to be Specified Persons due to their detention in The State Hospital.

The State Hospital does not have a single "Safety and Security" Policy. Due to the intrinsic nature of security within a high security hospital, safety and security are a part of all policies and procedures. Areas in which policy exists that implement or are affected by the above regulations include:

- Patient mail and telephones
- Searching Patients
- Restricted and excluded items
- Restrictions on visitors
- Taking of samples
- Surveillance

Detail on these areas is provided below.

2 PATIENTS' MAIL AND TELEPHONES

Mail

The State Hospital Policy allows mail to or from the patient to be inspected and read by staff if individually prescribed by the Clinical Team. Mail can then be withheld from the patient or from being sent if it satisfies criteria related to safety or distress. During 2022 the mail policy was reviewed and the categories were changed to High, Medium and Low. As at July 2022 the patient numbers in the differing categories and instances of withheld mail were as below:

Incoming Mail Scrutiny	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**	**19-20**	**20-21**
Opened in the presence of staff	39	48	35	31	28	23	22	15
Opened then inspected by staff	27	25	22	22	22	21	20	22
Opened, then inspected and read by staff	61	50	61	60	57	60	71	77

Incoming Mail Scrutiny	**21-22**
High	2
Medium	79
Low	31

Outgoing Mail Scrutiny	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21
Sealed by patient and handed to staff	25	34	24	22	19	17	16	11
Inspected by staff	33	35	27	24	24	22	19	19
Inspected and read by staff	69	54	67	67	64	65	78	82

Outgoing Mail Scrutiny	21-22
High	1
Medium	84
Low	27

Withheld Mail	13-14	14-15	15-16	16-17	17-18	18-19	19-20	20-21	21-22
Being sent by patient	1	2	0	0	0	2	2	2	0
Being sent to patient	1	0	0	3	7	0	0	3	7

Telephones

The State Hospital Policy allows outgoing calls from patients to persons approved by the Clinical Team. Under normal circumstances patients cannot take incoming calls.

Patients are either directly supervised by a member of staff who listens to the patient during the call, or indirectly supervised by a member of staff in the vicinity of the telephone. Technology and a new policy has been introduced which allows staff to hear both sides of the call and will allow recording of calls if deemed appropriate when the required technology has been introduced.

As at July 2022 the patient numbers in the differing categories were as below:

Telephone Call Supervision	13-14	14-15	15-16	16-17	17-18	18-19	19-20
All Supervised	53	45	59	57	49	52	65
All Unsupervised	53	56	34	30	22	20	18
Some Supervised	21	22	25	26	36	30	30

Telephone Call Supervision	20-21	21-22
High	0	0
Medium	69	62
Low	45	50

Calls to Advocacy, The Mental Welfare Commission, Legal Representatives and other persons listed in the Act are not to be supervised and do not require Clinical Team approval.

3 SEARCHING AND RESTRICTED OR EXCLUDED ITEMS

The State Hospital Policy allows the regular searching of:

- Patients
- Patients' rooms
- Patients' Lockers
- Patients' Visitors

Planned search frequencies are as follows:

Patient	Weekly
Locker	Weekly
Room	Monthly

Patients are also randomly searched when moving between areas, or if leaving an area where risk items are present that have not all been accounted for. An example of this would be when a patient needs to leave the dining room before cutlery has been counted.

In addition to these measures, to which every patient is subject, searches can be individually directed at a patient, his room or his locker based on information or presentation.

Policy also details those items that a patient is allowed in his room or is able to access. Items are excluded or restricted for a number of reasons, particularly the potential to cause harm or communicate with other devices and the internet. There are also overall restrictions on the quantity and volume of items to ensure rooms can be quickly and safely searched.

4 RESTRICTIONS ON VISITORS

The State Hospital Policy restricts patient visitors to those authorised by the patient's Clinical Team and restricts the items that can be brought into the Hospital by visitors. Policy also allows for Restricted Visits, in which 1:1 close supervision of the patient takes place.

The policy relating to Child Protection makes special arrangements to protect children who may visit patients or be present during Leave of Absence. Child contact requires special approval arrangements.

All visitors may be requested to submit to a search following entry through airport style security; all bags and other carried items are X-rayed and then searched if necessary.

5 TAKING OF SAMPLES

The State Hospital Policy allows the taking of oral fluid or urine samples to test for drugs of abuse. The majority of patients opt for an oral fluid test. The frequency of testing has changed during 2020 the patient provides between one sample during the year to twelve samples during the year as determined by the Clinical Team. The numbers of patients' subject to each frequency as July 2022 is as follows:

Sampling Frequency	**13-14**	**14-15**	**15-16**	**16-17**	**17-18**	**18-19**	**19-20**	**20-21**	**21-22**
2 Weekly	21	24	23	29	15	15	N/A	N/A	N/A
1 Monthly	14	12	13	5	14	7	31	35	35
3 Monthly	20	13	18	17	17	16	18	19	17
6 Monthly	29	25	22	19	19	23	N/A	N/A	N/A
Annually	43	49	42	43	42	43	63	60	60

6 SURVEILLANCE

The Hospital operates a CCTV system around the perimeter, grounds and reception building of the Hospital, including areas of reception used by patient visitors.

CCTV is not currently used in clinical areas or to observe patients meeting visitors, however this position will change on completion of the Perimeter Security and Enhanced Internal Security Systems Project.

7 POLICY REVIEW

The Hospital's policies and procedures are reviewed on a regular basis and as required.

Paper No. 22/71

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 14
Sponsoring Director:	Medical Director
Author(s):	Head of Corporate Planning and Business Support Head of Clinical Quality
Title of Report:	Quality Assurance and Quality Improvement
Purpose of Report:	For Noting

1 SITUATION

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

2 BACKGROUND

Quality Assurance and Improvement in TSH links to the Clinical Quality Strategy 2017 – 2020. TSH will work towards updating and revising the Clinical Quality Strategy in 2023. 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:

1) Setting and delivering ambitious quality goals to support the provision of high quality care and services to our patients and carers

2) Engaging staff, patients, carers, volunteers and other stakeholders in improving our quality of care

3) Ensuring that everyone in the organisation understands their accountability for quality and are clear about the standards expected of them

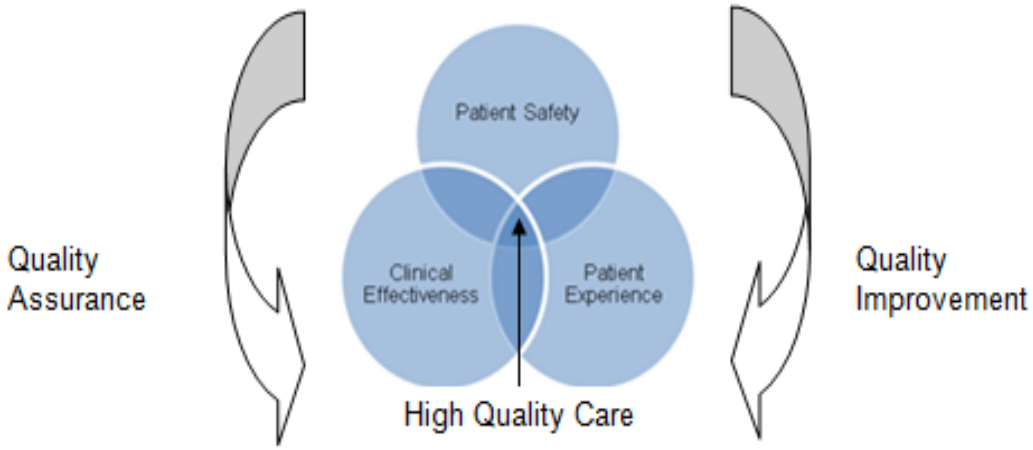
4) Gaining insight and assurance on the quality of our care

5) Ensuring access to and understanding of improvement data to build a positive momentum in relation to quality improvement

6) Evaluating and disseminating our results

7) Building improvement knowledge, skills and capacity

TSH 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 TSH

4 RECOMMENDATION

The Board is asked to note the content of this paper.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives?	The Quality Improvement and Assurance report supports the Quality Strategy and Corporate Objectives by outlining the actions taken across the hospital to support QA and QI.
Workforce Implications	Workforce implications in relation to further training that may be required for staff where policies are not being adhered to.
Financial Implications	Covid monies have been approved to continue with the Daily Indicator Report due to CQ staff workload/ weekend working.
Route to Board	Route to the Board is via the CMT.
Risk Assessment (Outline any significant risks and associated mitigation)	The main risk to the organisation is where audits show clinicians are not following evidence based practice.
Assessment of Impact on Stakeholder Experience	It is hoped that the positive outcomes with the weekly indicator report will have a positive impact on stakeholder experience as they will be getting more fresh air, physical activity and timetable sessions.
Equality Impact Assessment	All the policies that are audited and included within the quality assurance section have been equality impact assessed. All larger QI projects are also equality impact assessed.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	This will be part of the project team work for any of the QI projects within the report.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

QUALITY ASSURANCE AND IMPROVEMENT IN TSH AUGUST 2022

ASSURANCE OF QUALITY

Clinical Audit
The Clinical Quality Department carries 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.

Due to the pausing of meetings during July 2022 there are a number of audit reports that have not been approved as yet but are ready to be presented at the relevant meetings. These include:

- PMVA Observation Level
- Advance Statement
- Admission to the Hospital

PMVA Observation Level Audit
This audit is commissioned through the Patient Safety Group to give the hospital assurance that the PMVA Observation Levels Policy is being adhered to.

Areas showing improvement:

Level 2 Observations
- Observation Plans were available for all 74 (100.0%) occasions where observation level changes took place.
- There were 71 (95.9%) occasions where Observation Plans were accompanied by a corresponding Nursing progress note.

Level 3 Observations
- Observation Plans were available for all 17 (100.0%) occasions where observation level changes took place.
- There were 15 (88.2%) occasions where Observation Plans were accompanied by corresponding Nursing progress note entries.

Areas for improvement:

Level 2 Observations
- From a possible 48 occasions, there was no evidence (0%) available to support that any discussion had taken place with the patient to seek their permission to update their relative/named person of the increase in observation levels.
- There were 2 (4.2%) occasions from a possible 48 when the relative/named person had been contacted and advised of the increase in observation levels.
- Evidence was found of review discussions around observation levels within the note types in RiO on 24 (40.7%) occasions.
- The RMO interviewed the patient prior to observation levels being reduced on 6 (9.2%) occasions.

Level 3 Observations
- From a possible 12 occasions, there was no evidence (0%) available to support that any discussion had taken place with the patient to seek their permission to update their relative/named person of the increase in observation levels.
- There was 1 (1%) occasion from a possible 12 when the relative/named person had been contacted and advised of the increase in observation levels.
- Evidence was found of review discussions around observation levels taking place every day for the first 7 days within the note types in RiO on 1 (9.1%) occasion.
- The RMO had conducted at least 2 in person reviews with the patient on 5 (45.5%) occasions.
- Observations were discussed twice weekly on 6 (75.0%) occasions.
- The RMO interviewed the patient prior to observation levels being reduced on 12 (70.6%) occasions.

These findings will be presented to the Patient Safety Group when meetings are re-started with a view to agreeing an improvement plan.

Advance Statements
The Mental Welfare Commission published guidance indicating that it is best practice to store a copy of the patient's Advance Statement in the treatment room to ensure availability of the statement in an emergency. An example of this is to check the patient's Advance Statement before prescribing a particular PRN medication.

With the introduction of HEPMA and the change in practice with regards to medicine kardexes and administration sheets, it was agreed to carry out an audit to ensure:

- the Advance Statement was properly stored on RiO.
- Where a patient had an Advance Statement, a copy was filed in the treatment room.
- The correct version of the Advance Statement was stored in the treatment room.

The findings included:

- 100% were properly stored on RiO.
- 54.3% were available in the treatment room.
- On 3 occasions an out of date copy of the Advance Statement was in the treatment room.

Due to the importance of these standards, immediate action was taken with Medical Secretaries to ensure that all advance statements are now available in the treatment rooms. A further spot check will be completed in 6 months.

Admissions to TSH
This is an audit that is undertaken to give the hospital assurance that the Referrals Policy is being adhered to.

Finding included:

- Only 47% of patients were assessed within the standard 2 weeks of referral. Moreover, the length of time between referral to assessment was within 1 week for 16.7% (5) compared to 20% (5) of patients in 2018. This is a further decrease from 50% (21) in 2017 and 67% (29) in 2013. Also, 23.3% (7) had no date recorded which is an increase of non-recorded assessments from 12% in 2018.
- 70% (21) patients were admitted in under 3 weeks from assessment but 16.7% (5) did not have a recorded date of assessment. This is an increase from 4% (1) patient recorded as unknown timescale in 2018.
- 60% (18) of patients were admitted within 4 weeks from referral which is a decrease from 2018 where 70% of patients were admitted in this timescale. 10% (3), however, were recorded as unknown timescale due to not having an assessment date on record.

These findings will be taken to the Medical Advisory Committee for agreement of an improvement plan or amendments to the Policy.

Paper No. 22/71

Variance Analysis Tool – Quarterly Report

Areas of good practice

- Nursing VAT completion was excellent at 98%. Key Worker/Associate Worker attendance improved from 50% in the previous quarter to 65%. This is due to wards ensuring that relevant staff are on shift for their patients' Case Reviews.
- All Skye Activity Centre reports were provided for the patients' Annual Review.
- All Pharmacy reports were provided for the patients' Case Review.
- Security attendance increased from 24% to 37%.
- All Social Work reports were provided for the patients' Case Review.
- Provision of the Dietetics report increased from 85% to 95% and attendance increased from 58% to 90%.
- Advocacy attendance increased from 76% to 96% - patient declined on 2 occasions.

Chart 1: KW/AW attends Case Review

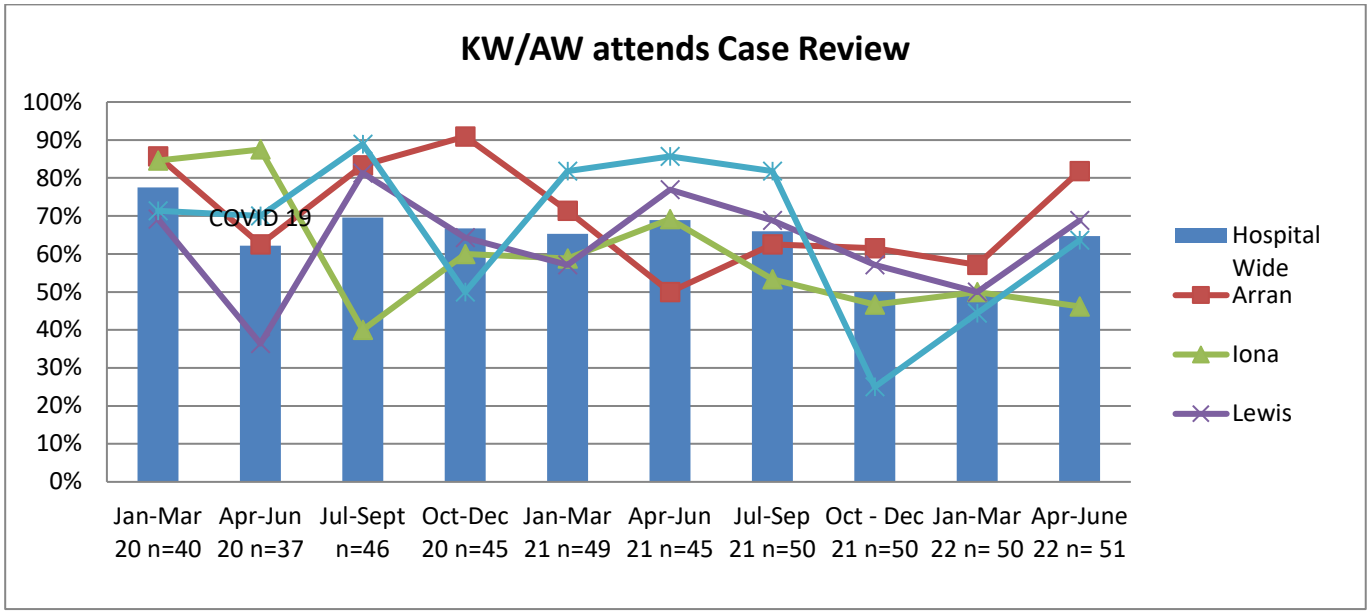
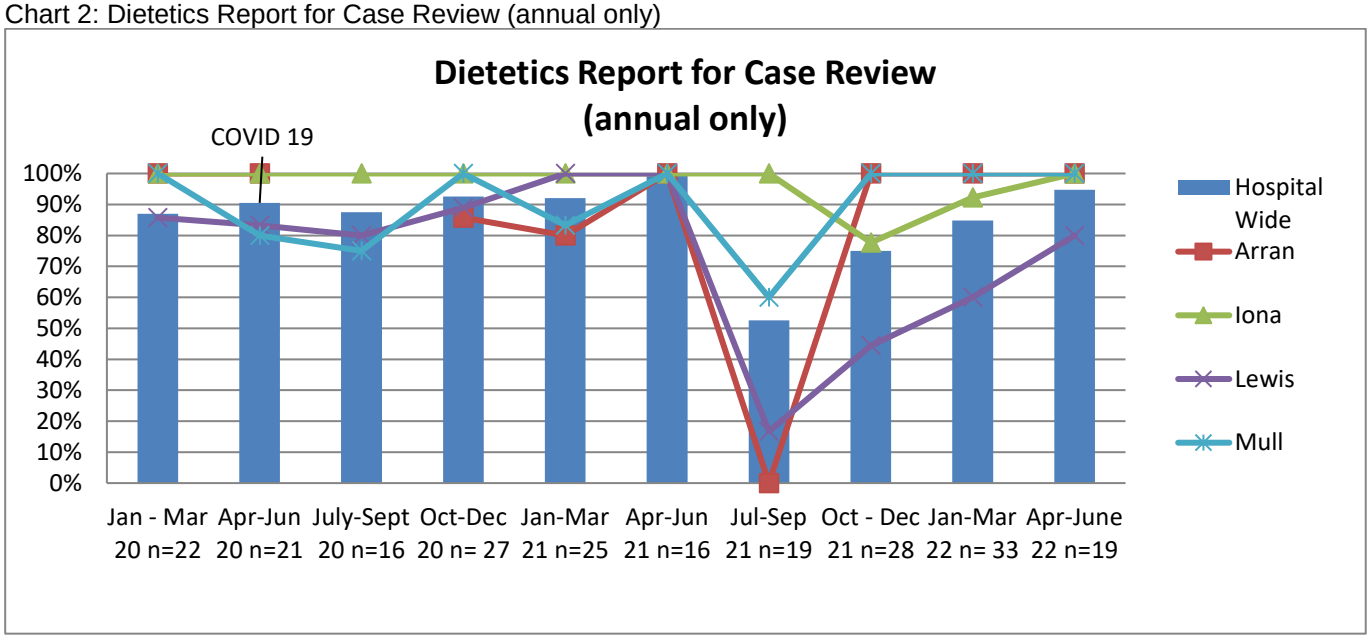


Chart 2: Dietetics Report for Case Review (annual only)



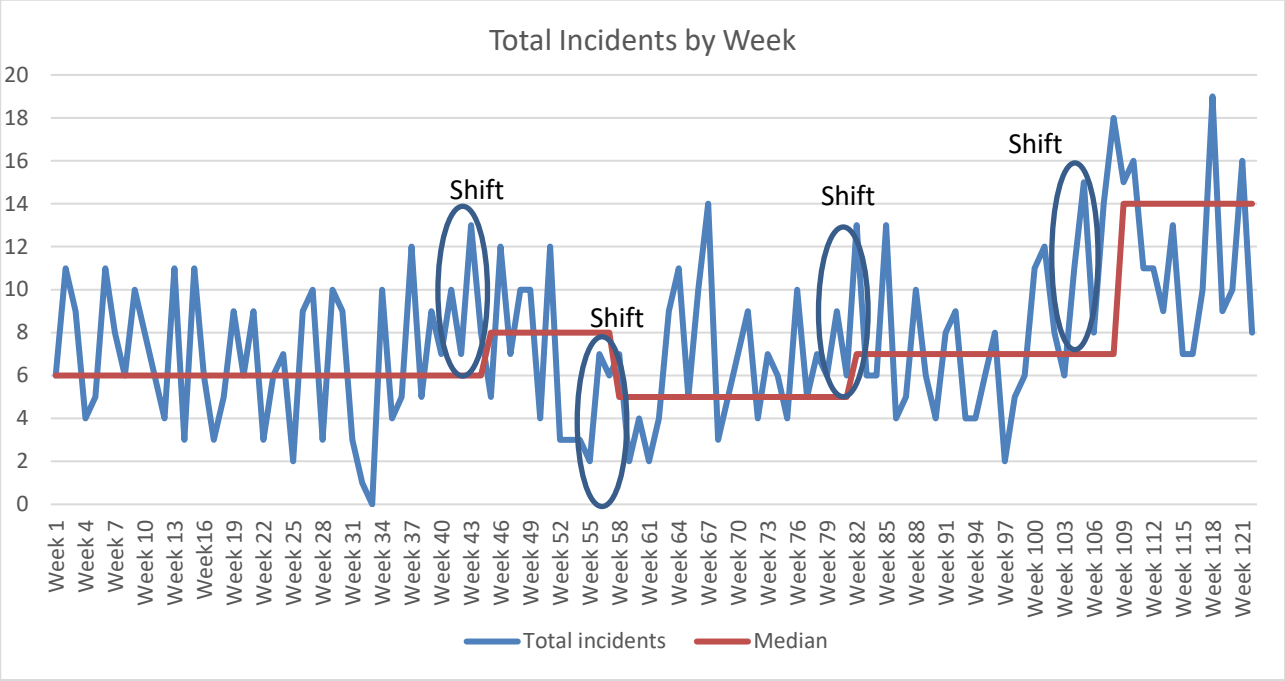
Clinical Governance Committee
At the meeting in August 2022, the following papers were presented with a number of quality assurance and improvement activities contained within them:

- Mental Health Practice Steering Group 12 monthly report
- Patient Safety 12 monthly report
- Duty of Candour 12 monthly report
- Corporate Risk Register
- Staffing and Care report
- Learning from Feedback report
- Learning from Complaints report
- Incident Reporting and Patient Restrictions report
- Covid 19 Update
- Discussion Item – Activity Project

Daily and Weekly Indicator Reports
Clinical Quality continue to collate and present the data that gives the Corporate Management Team the assurance that it is safe to continue with the Interim Operational Policy. A sample of the most recent data is below, with week 122 representing data from 29 July to 4 August 2022. The full report can be provided on request.

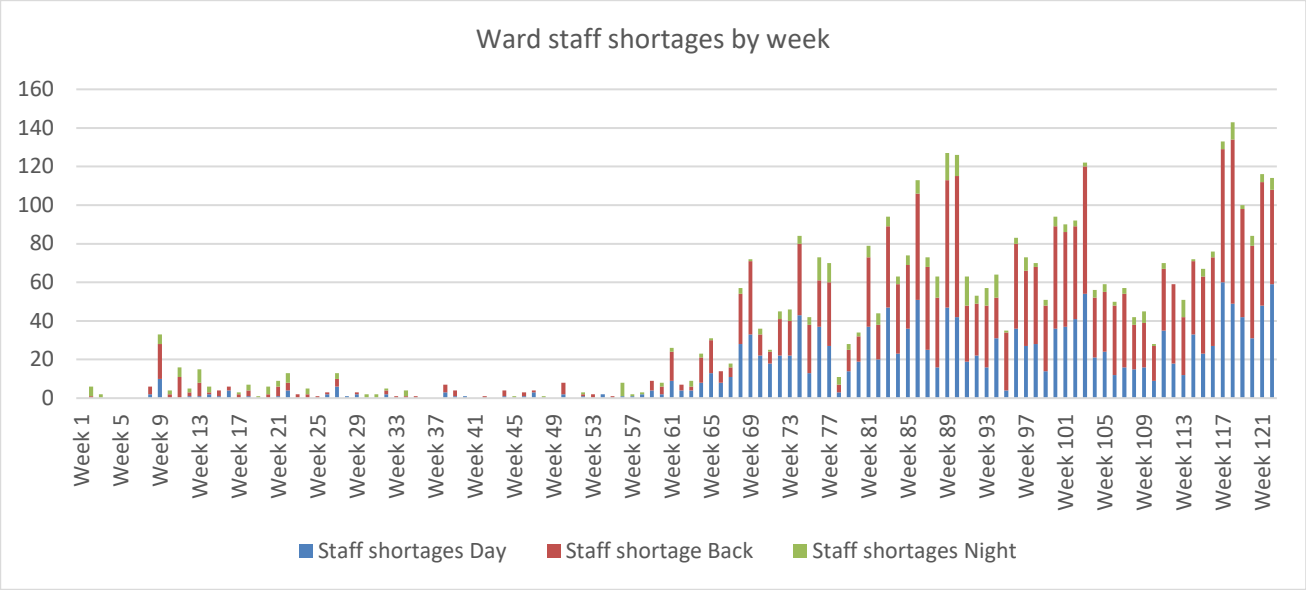
Datix assaults, attempted assaults and behaviour
Since the median was moved in April from 7 to 14 due to a shift in the data there has been random variation seen. The increase has been brought to the attention of the Operating Model Monitoring Group who continue to put things in place to try and reduce the number of incidents. This will be discussed further at the Patient Safety Group when it re-starts.

Chart 3: Total Incidents by Week



Ward Staff Shortages
Since the last Board Meeting we have again seen increases in the number of ward staff shortages. A number of measures were put in place during July 2022 to try and ensure that these shortages had minimal impact on ward closures and the patient's day.

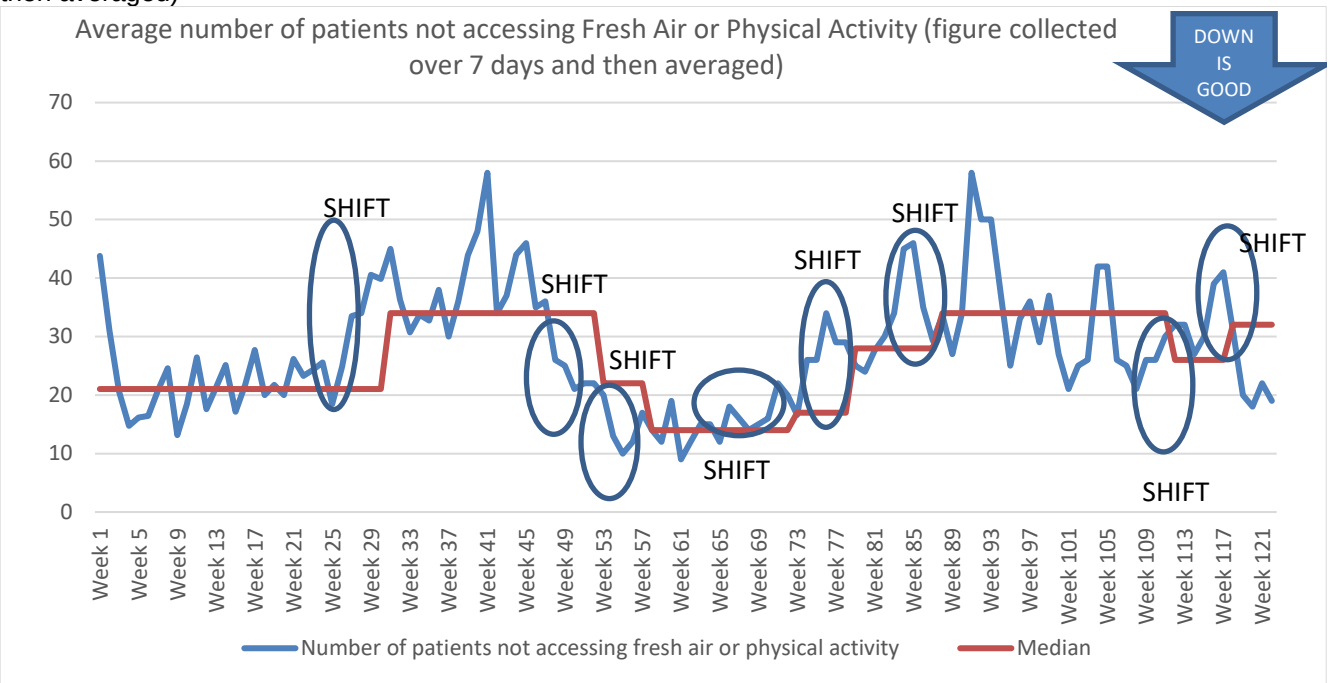
Chart 4: Ward Staff Shortages by week



Patients not accessing Fresh air or Physical Activity (this is an average daily figure)
This indicator looks at both the fresh air data from PMTS and timetables and the physical activity data from RiO and highlights the patients that have had no fresh air or physical activity.

As can be seen in the data, although the wards have had a very challenging time, patients have still continued to get access to fresh air and physical activity. In the most recent report (5 August 2022) all patients had physical activity at some point in the week.

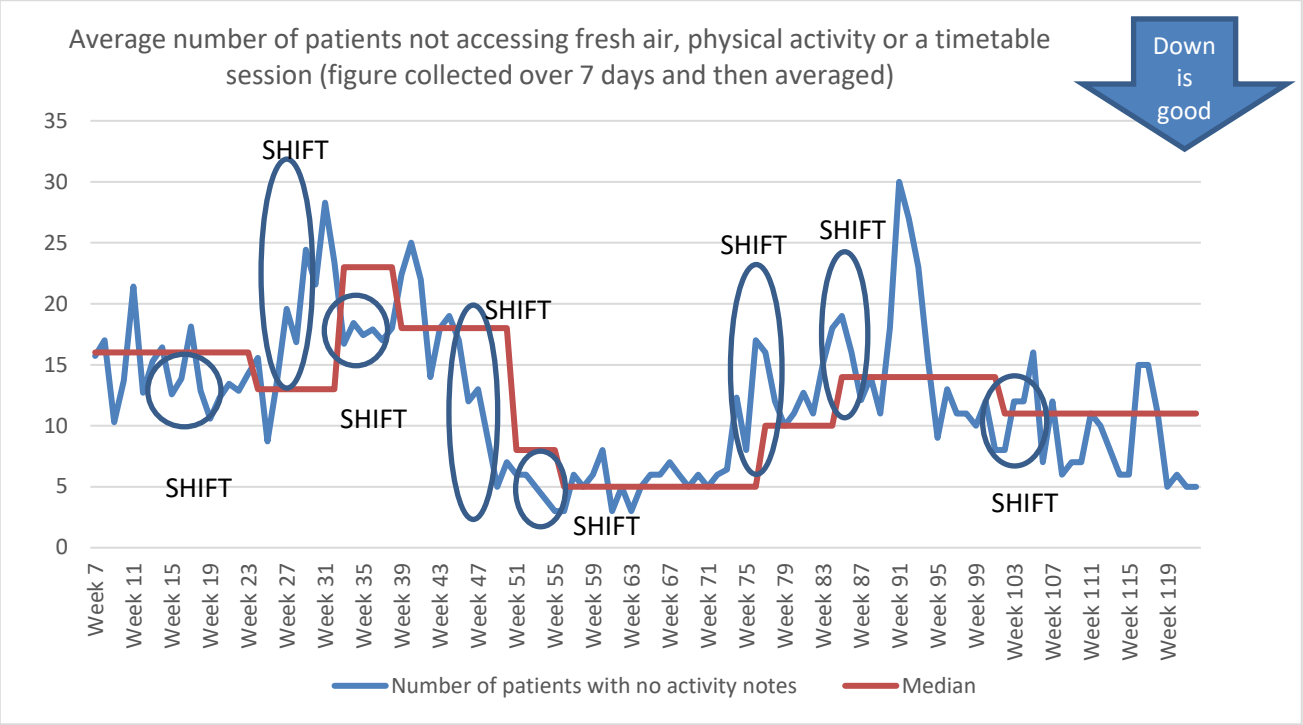
Chart 5: Average Number of Patients Not Accessing Fresh Air or Physical Activity (figure collected over 7 days then averaged)



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

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

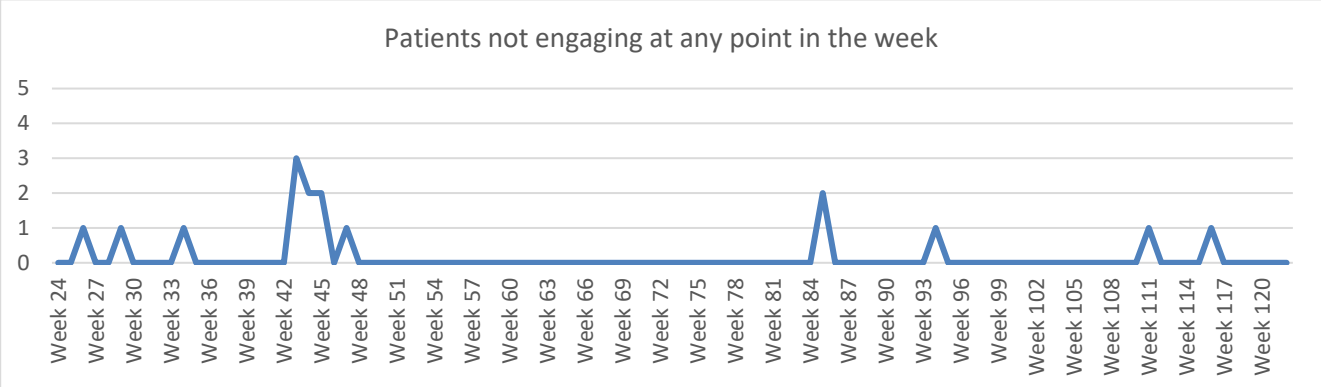
Chart 6: Average number of patients not accessing fresh air, physical activity or a timetable session (figure collected over 7 days then averaged)



Patient not engaging with fresh air, physical activity or a timetable session at any point in the week

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

Chart 7: Patients not engaging at any point in the week



Planned Timetable Activity
In February 2022, the much anticipated planned timetable went live on RiO. This allows staff to programme in planned activities for our patients, linked to their recovery objectives. A report is issued weekly to show the number of these planned activities that have gone ahead and the reasons when they haven't. An excerpt from the most recent report (5 August 2022) is below:

Table 1: Planned sessions v actual sessions provided

	Week 115	**Week 116**	**Week 117**	**Week 118**	**Week 119**	**Week 120**	**Week 121**	**Week 122**
Planned sessions that went ahead	477	293	204	266	340	413	450	461
Planned sessions that did not go ahead	250	443	483	438	369	265	277	226
% planned that went ahead	65.6%	39.8%	29.7%	37.8%	48.0%	60.9%	61.9%	67.1%
Planned activities that have not been completed so we do not know if the activity went ahead or not	90	76	94	66	67	102	80	112

Week 122 (29 July to 4 August 2022) saw an improvement in the number of planned activities that went ahead from 450 to 461. This resulted in 67% of planned activities going ahead. There was an increase however (80 to 112) in the number of planned activities that have not been completed so we do not know if the activity went ahead or not. The Skye Centre Administrator continues to monitor the timetables and provide further training to ensure the planned timetable is as accurate as possible.

QUALITY IMPROVEMENT

QI Forum
The QI Forum's purpose is to champion, support and lead quality improvement initiatives across the hospital and raise awareness and understanding of QI approaches. The QI Forum met recently and has a focus to raise awareness of outcomes for Mental health and build capacity to support and embed QI.

QI Capacity Building
Planning is underway for QI essential training starting in September / October 2022. This will help to build foundation level understanding of QI methods and approaches and will be used as a method of enabling teams to take forward QI projects. TSH also link with NHS Education for Scotland to take advantage of national QI training opportunities. TSH have been allocated one place on the next cohort for ScLIP, with a colleague now ready to take up this training place. TSH has also been allocated 3 places in the future cohort 43 of ScIL commencing in early 2023. This will be open to applicants beginning of September and the QI Forum will encourage staff to engage with this national training. Early planning is underway to offer another round of TSH3030. Aim of this would be to support new teams in QI activity following the implementation of the Clinical Model.

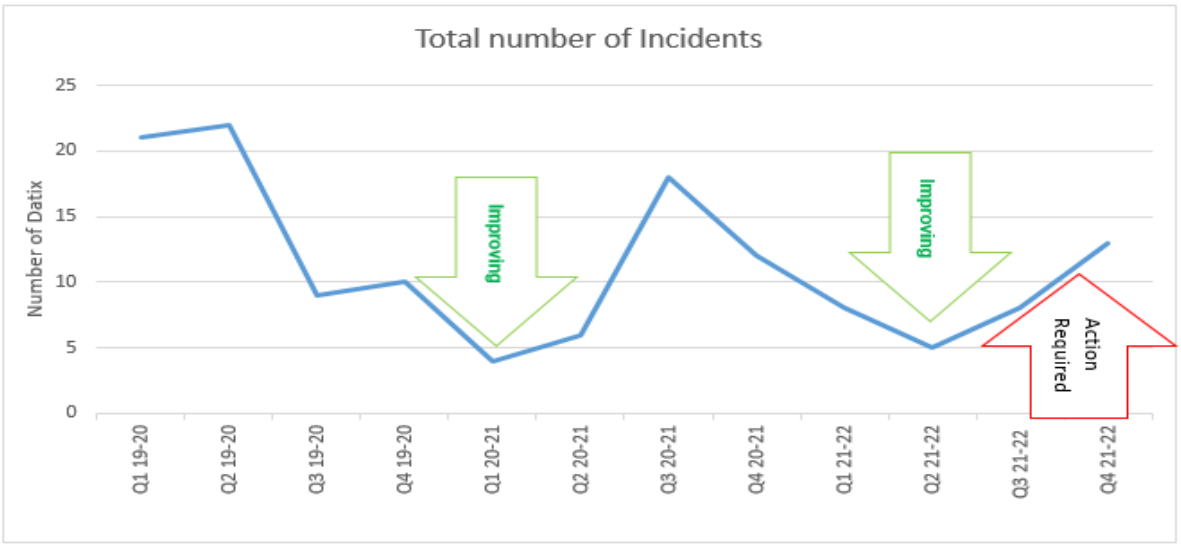
QI Projects
QI projects have continued to be progressed. Two examples of local QI projects are presented below.

The Pre-Admission Specific Needs Assessment Form QI Project
In March 2021 a QI project was started to improve the completion of the Pre-Admission Specific Needs Form. This form collects data on any specific requirements regarding subjects such has hearing, mobility, physical health, nutrition and hydration, spiritual and pastoral care, communication and smoking prior to admission to ensure the provision of high quality patient care at TSH. After initial improvement when the QI project commenced there is still no consistent improvement in this process. After discussion at the Medical Group and Mental Health Practice Steering Group a change has been made to the process in a bid to ensure sustained improvement. The new process should be used from 1 August 2022 and data will be feedback to the MHPSG in September. Since implementation there has been one successful PDSA cycle with further discussion on upscale and spread to be held.

Clinical Waste Laundry QI project

It was noted at the Infection Control Committee in April 2022 through monthly audit reporting that there was a continual rise in the number of incidents recorded on Datix relating to clinical waste laundry (chart 8). This has been an ongoing issue and raised has an area for concern by the Board previously.

Chart 8

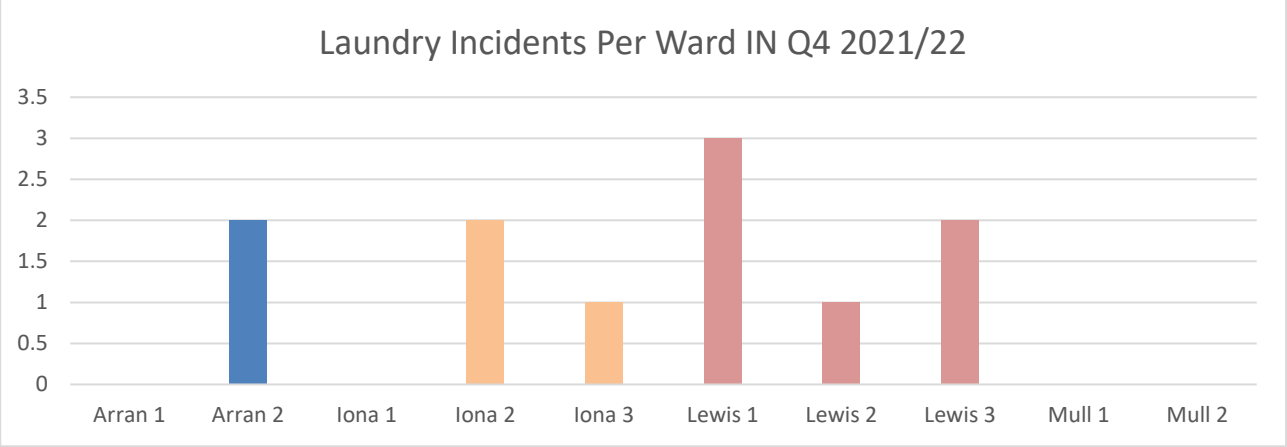


The Infection Control Committee requested the Infection Control QI Facilitator, Housekeeping and Linen Services Manager, and Risk Management Facilitator to meet and review the incidents. This resulted in the development of an action plan to decrease the rising numbers of Datix reports using QI approaches. The aim was to reduce the number of Datix incidents being recorded each month in relation to Clinical Waste – Laundry by 50% by July 2022

The team reviewed data to determine the reasons of why pink alginate bags were not being disposed of correctly and in line with the State Hospital Safe Management of Linen Policy. Using the 5 why's techniques some of the reasons identified that could be a contributing factor were; signage, Information/Communication, disposing area, Tools available and Policy.

An action plan was developed and a small test of change was implemented (June 2022) within Lewis Hub (Table 2) areas identified as having a high incident rate

Chart 9



Some of the changes implemented were: quarterly reports to each Senior Nursing Team around Laundry incidents, clearer signage on the process for disposal of laundry, separate disposal area within the DRS Room within the hub area for pink alginate bags and clearer communication with the Senior Nursing Teams within this area to ensure that all nursing staff refresher the Safe Management of Linen Policy.

Data presented at the June 2022 Infection Control Committee noted a significant improvement where only 2 Datix was received in May and 1 Datix in June 2022. The Infection Control Committee agreed to Implement this model across the remaining 3 hubs. They also requested there was continued data monitoring and reporting on a monthly basis to the Infection Control Committee, Lead Nurses and Senior Charge Nurses

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:
1) Building a personalised approach to care
2) Changing our style to shared decision making
3) Reducing harm and waste
4) Becoming improvers and innovators
5) Reducing unwarranted variation in practice and outcomes
6) Managing risk better

Quality and Safety
One Quality and Safety (Q&S) Visits was held within Arran 2 over this period. Three Q&S Visits were cancelled due to staffing pressures; all three are intended to be rescheduled. Patients and staff have engaged well in these visits and themes have emerged around time for staff to access staff support resources. Areas for improvement were noted and these will be discussed at our local Patient Safety Group for further comments and action if required.

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

Over a 12-month period, an average of 200 evidenced based guidance documents issued from a variety of recognised bodies can be reviewed for relevancy by the Clinical Quality Facilitator. During the period 1 June to 29 July 2022, 38 guidance documents have been reviewed. There were 32 documents which were considered to be either not relevant to TSH or were overridden by Scottish guidance. Of the remaining documents, 2 were recorded for information and awareness purposes, 2 required completion of an evaluation matrix (from NICE regarding Gout and Depression in adults) whilst the decision regarding relevancy for another 2 documents are still pending; these are in relation to Pneumonia and Multiple Sclerosis.

Table 2: Evidence of Reviews

Body	Total No of documents reviewed	Documents for information	Evaluation Matrix required
Healthcare Improvement Scotland (HIS)	2	0	0
Mental Welfare Commission (MWC)	2	2	0
National Institute for Health & Care Excellence (NICE)	34	0	2 (2 pending)

As at the date of this report, there are currently an additional 4 Evaluation matrices nearing the end of the review process. It should be highlighted that the completion of the review process was paused due to the

implementation of operational restrictions as a result of staffing issues. Please see the table below for further information.

Table 3: Evaluation Matrix Current Situation

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	Sexual Health Standards	PHSG	Evaluation matrix completed with 100% compliance achieved. Tabled at PHSG on 10/08/2022 for agreement and final sign off.	January 2022
HIS	Infection prevention and control standards for health and adult social care settings	ICC	Evaluation matrix currently being completed by the Senior Nurse Infection Control.	May 2022
MWC	Social Circumstances Reports (SCR) – Good practice guidance on the preparation of SCRs for MHOs and managers	CGG	Following discussion at CGG on 25/05/2022, it was agreed that the Evaluation Matrix would be reviewed by Social Work. The review is ongoing.	April 2022
NICE	Stroke & transient ischaemic attack in over 16s: diagnosis & initial management	PHSG	Draft gap analysis has been created and is pending completion.	April 2022

There are currently 6 additional evaluation matrices which have been outstanding for a prolonged period of time and await review by their allocated Steering Group. The progress of the first 2 evaluations from HIS and the MWC was temporarily paused due to TSH adapting to the COVID-19 pandemic however as per Gold Command, action on matrix completion began again at the start of July 2020. The responsibility to review these matrices changed ownership from the PMVA Review Group to the Patient Safety Group which recommenced meetings in September 2020. Work is progressing with both. The review of the Public Health England guideline was unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. At the date of this report, a date for the next SHC meeting to review the document is still awaited. Although the Clinical Quality Department were approached to in order to complete an evaluation matrix for the Kings Fund document entitled Courage of Compassion, this has now been placed on hold due to the retirement of the lead for this. This will be revisited now that the post has been filled and pending removal of current operational restrictions. There are 2 remaining documents from NICE which are currently undergoing the review process regarding Chronic Kidney Disease and Rehabilitation after Traumatic Injury – it should be noted that these are fairly comprehensive documents and as such, a reviewed review process is being followed in order to reduce the time required by all involved MDT members.

Table 4: Evaluation Matrix Summary

Body	Title	Allocated Steering Group	Current Situation	Publication Date
HIS	From Observation to Intervention: A proactive, responsive and personalised care and treatment framework for acutely unwell people in mental health care	MHPSG (via Patient Safety)	Evaluation matrix completed with 28 outstanding recommendations Patient Safety meeting took place mid-September. Evaluation matrix to be revisited upon creation of updated draft Clinical Engagement Policy.	January 2019
MWC	The use of seclusion	MHPSG (via Patient Safety)	Work ongoing. Release of updated Seclusion Policy currently on hold due to ongoing work with Clinical Engagement Policy currently being drafted with seclusion tier 1 and 2 being incorporated. Both to be launched together.	October 2019

Body	Title	Allocated Steering Group	Current Situation	Publication Date
The Kings Fund	Courage of compassion – Supporting nurses and midwives to deliver high quality care	HR and Wellbeing Group	CQ were asked to assist in review of document in October 2021. Placed on hold due to change in lead role (Dec 2021). Although post has been filled, remains on hold pending removal of current operational restrictions. Review as to the requirement of an Evaluation Matrix will be taken thereafter.	September 2020
PH England	Managing a healthy weight in adult secure services - Practice guidance	SHC	Unable to be completed within the tight deadline set by the Supporting Healthy Choices group due to poor attendance at the review meeting and delay in members submitting feedback responses. Awaiting next SHC meeting in order to take document forward.	February 2021
NICE	Chronic Kidney Disease: Assessment & management UPDATED	PHSG	Initial review delayed due to Practice Nurse vacancy and extended leave by the GP. Review decision made and Evaluation Matrix to be completed. Resulting delays on prioritising of Practice Nurse duties. Due to large number of recommendations, review process will be split into 2 parts: Part 1 will be reviewed by GP/Practice Nurse and Part 2 will be wider multi-disciplinary review. Part 1 Evaluation Matrix completion commenced 28/07/2022.	August 2021
NICE	Rehabilitation from Traumatic Injury	PHSG	After initially being thought of as not relevant to TSH setting, decision was changed and gap analysis is to be completed. Due to large number of recommendations, review process will be split into 2 parts: Part 1 will be reviewed by AHP/Manual Handling Advisor and Part 2 will be wider multi-disciplinary review. Part 1 Evaluation Matrix completion commenced June 2022.	January 2022

THE STATE HOSPITALS BOARD FOR SCOTLAND

Minutes of the Clinical Governance Committee Meeting held on Thursday 12 May 2022 at 9.45am via MS Teams **CGC(M) 22/02**

CHAIR:
Non-Executive Director — Cathy Fallon

PRESENT:
Board Vice-Chair — David McConnell

IN ATTENDANCE:

Head of HR	Audrey Bevan (Item 11)
Senior Nurse for Infection Control	Karen Burnett (Item 8)
Complaints Officer	Anne Donnelly (Item 14)
Chief Executive	Gary Jenkins
Consultant Forensic Psychiatrist	Khuram Khan
Head of Psychology	John Marshall
PA to Medical & Associate Medical Directors	Jacqueline McDade
Patient Learning Manager	Julie McDonald (Item 12)
Director of Finance and e-Health	Robin McNaught
Director of Nursing and Operations	Karen McCaffrey
Board Chair	Brian Moore
Board Secretary	Margaret Smith
Head of Clinical Quality	Sheila Smith
Medical Director	Lindsay Thomson
Lead Pharmacist	Morag Wright (Item 6)

1 APOLOGIES AND INTRODUCTORY REMARKS

Apologies were noted from Stuart Currie and Monica Merson.

Cathy Fallon welcomed those present to the meeting.

2 CONFLICTS OF INTEREST

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

3 TO APPROVE THE MINUTES / ACTON NOTE OF PREVIOUS MEETING HELD ON 10 FEBRUARY 2022

The Minutes of the previous meeting held on 10 February 2022 were approved as an accurate record.

4 PROGRESS ON ACTION NOTES

Workplan

Cathy Fallon advised the Committee that she and Lindsay Thomson had met to discuss the workplan and that they had concluded that there was nothing that could be dropped.

Lindsay Thomson advised that the Mental Health Practice Steering Group report had already been moved and the Committee can respond to any request to move agenda items if required.

Areas of Good Practice / Matters of Concern
An updated copy of the areas of good practice / matters of concern was issued prior to the meeting with a revised format.

Learning From Feedback
Sheila Smith informed the Committee that she and Sandie Dickson will link up before any reports are due in relation to trend data related to covid and staffing.

5 MATTERS ARISING

There were no matters arising at this time.

6 MEDICINES COMMITTEE / PHARMACY 12 MONTHLY REPORT

The Committee **received** and **noted** the Medicines Committee / Pharmacy 12 Monthly Report which was presented by Morag Wright, Lead Pharmacist.

Key activities over the last 12 months around medicines include:

- Maintaining supply processes to the wards during Covid-19 challenges
- Continuing with vaccination programme for staff and patients in line with national guidance
- Ensuring all patients have a regular review of their mental health and physical health medicines. Pharmacy provide reports for all CPA meetings (100%)
- Policy and prescribing guidance updates
- Significant range of clinical audit projects including Consent to Treatment Adherence, Use of Psychotropic PRN (as required) Medicines and Lithium monitoring
- Proactive work around medication incidents

Electronic prescribing has been implemented over the last few weeks; this has been a significant piece of work and it is hoped that the benefits will be seen during the coming months.

David McConnell asked Morag for further detail on what this brings to us operationally and what the prospects are going forward.

Morag Wright advised that this was a national piece of work to implement electronic prescribing across Scotland for safer use of medicines with regards to being able to get clarity around prescriptions and will also help with regards to being able to check prescribing remotely. Information has been taken from current prescriptions sheets to help with clinical audit and it is hoped that they will be able to use information more for pulling reports around prescription use which will save on resources; the main thing is around clarity of prescribing for nursing staff to administer. Going forward operationally, we will be able to have a report highlighting warnings for individual patients with regard to what they can and cannot have in regards to allergies and side effects.

Sheila Smith stated that the medication audit was significantly hard to read as they were unable to tell who had administered the medication but HEPMA will make this easier and will also show historical data and all information will be at their fingertips at the time of audit.

Brian Moore asked if new arrangements had been made for pharmaceutical waste and if a decision has been made about reducing DVT risk.

Morag Wright's response was that we have minimal waste; historically this was boxed up appropriately and sent back to St John's Hospital for destruction but the national change has extended to include ampules and blister packs and each ward has its own waste unit which is picked up by Estates and everything is working fine. With regards to reduced DVT risk, work is

ongoing around policies and guidance for soft restraint kits and thought should be given to prophylactic use to prevent any thrombosis due to limited mobility.

Cathy Fallon stated that this report does not include any KPIs and asked if there was any move in including these going forward.

Morag Wright advised that the Pharmacy Service Level Agreement has standards around service delivery, what expectations are with regard to visits and reports and also the service received from St John's; there is a clear standard for KPIs around service delivery but it is more complex when it comes to patients and prescribing due to the small patient population with specific needs which are reviewed regularly; it is hard to set KPIs for treatment.

Sheila Smith stated that performance KPIs has attendance and variance analysis tool for reports to CPA.

Lindsay Thomson advised the Committee that the recently signed SLA with NHS Lothian has a section on KPIs and there are six of them; if we add a KPI section to subsequent report and provide information against each of these will address the KPI issue.

Gary Jenkins suggested he and Lindsay Thomson go over the SLA and try and bring from other reports a summary of measures that they have and what that may look like. Cathy Fallon asked that this be brought to the next meeting.

Action: Gary Jenkins / Lindsay Thomson

Morag Wright advised that this report is a Medicines Committee report and that there is a separate 3 monthly Pharmacy performance report connected to the SLA that goes to the Associate Medical Director and her line manager in NHS Lothian.

Cathy Fallon stated that this was a really comprehensive report and commended Morag Wright for being able to work within the budget and also that the clinical audit stood out.

Lindsay Thomson wished to thank Morag Wright, who was retiring from the State Hospital after more than 20 years. She stated that the highest compliment you can give is "you are a safe pair of hands". She informed the Committee that Morag had been involved in The Prescribing Observatory for Mental Health national audits, which gives confidence that prescribing is in line with elsewhere and similar services. Morag goes out with a bang as HEPMA was an enormous task to bring in. She thanked Morag for all her hard work and wished her well for her retirement.

Gary Jenkins also thanked Morag for all she has done in the State Hospital and wished her well for the future.

The Committee **noted** the report.

7 RESEARCH COMMITTEE 12 MONTHLY REPORT

The Committee **received** and **noted** the Research Committee 12 monthly report presented by Lindsay Thomson, Medical Director.

Lindsay Thomson stated that research remains extremely important and is a means of innovation, moving forward and is also a means of improving recruitment and retention.

During the last year, research has moved under the medical directorate. Three quarters of the budget was spent and next year's budget has already been committed.

The Research conference was extremely good with an excellent key note speaker on preventing child sexual abuse.

The Research portfolio workshop identified key themes and we looked at how we can implement research study findings such as staff wellbeing during Covid, randomised control trial on the road to recovery and relational aspects of care scale.

KPIs are included within the report.

The Research Committee meets monthly and looks at new reports, progress reports, studies approved, details of which are included in the report.

Two studies have received awards;

> Laura McCafferty was a winner of the award for Innovation and Excellence, at the Mental Health Nursing Forum Scotland, Practice Excellence Awards. The award was for her study Triple Jeopardy: a learning partnership to enhance care for people who are ageing, with mental disorders and dementia, in high secure settings
>
> Lindsey McIntosh was joint winner of the Royal College of Psychiatry Forensic Faculty Conference Research prize for her presentation on Reporting of unwanted events in evaluations of psychological and psychosocial interventions with forensic patients: a systematic review of current practice.

A great deal of research using the recovery model for patients has been undertaken; this is a piece of work that takes the patients perspective and is the patients journey through the State Hospital which has been illustrated by patients. Lindsay hopes to bring this to a Board meeting.

Jamie Pitcairn has been working on updating the research strategy, which will reflect both the priority areas for research as identified by the State Hospital research portfolio review and the implications of the outcomes of the Scottish Government review of the Barron report recommendations, will be a key quality improvement activity for the work of the research committee and the School.

Governance arrangements are listed within the report, along with research activity, completed studies, journal articles and ongoing research studies, with links through the University of the West of Scotland for nursing and University of Edinburgh for Psychiatry and Psychology; this works for us in terms of carrying out research and ensuring it happens and is disseminated and implemented across the hospital and Forensic Network.

Lindsay Thomson stated that the list of studies is not as extensive as she would like it to be and she would like to second nursing staff for 2 or 4 sessions to give them research experience and this would give them skills that are transferrable to other areas; due to staffing issues we have been unable to do this over recent years. She also stated that she would like to see a wider cohort of people involved in research across the hospital.

David McConnell stated that he was interested in the stakeholder experience and patient feedback and would welcome further detail on that going forward. With regards to research budget, he noted that there was £25k remaining to be allocated and asked if money was carried forward into the next financial year.

Lindsay Thomson responded that finance are very good at allowing money to be accrued and carried forward and there is more this year than would have been expected. The general rule was that the budget could sway up or down by 10% each year and we have been trying over the last year to get more proactive with the research strategy so that we are spending money.

Brian Moore asked what the objectives or aims were of the “on the road to recovery” study and the future of psychological therapies within the Forensic Network.

Lindsay Thomson responded that over 10 years ago work was undertaken on forensic or psychological matrix, led by NHS Education for Scotland. This looked at psychological therapies

and putting them out to Health Boards and they established the forensic matrix; our field is more complex dealing with mental health and criminogenic factors and there is a raft of programmes delivered. 10 years on and a review was done on the way forward for psychological therapy with the network having a group which is chaired by Lindsay Burley. A draft report has been prepared which has many recommendations for work to be done through the Forensic Network board. There is great data within the State Hospital, with 446 members of staff trained in low intensity psychological therapies; data we lack is around how many get help to implement the programme.

John Marshall sits on the group and advised that one main issue is the variability of delivery of therapies in different boards and services and we need a better agreement on parity across services on interventions. One opportunity that came out of the report is digital delivery and thinking about how we deliver high intensity interventions digitally across different sites. The report is being presented to the Forensic Network Inter Regional Group tomorrow.

Lindsay Thomson advised that this piece of work covers the whole of Scotland and the Inter Regional Group needs to work out the way forward; the report needs to be finalised and the normal route would be that it then goes to the Forensic Network Board. It can also be shared with this group or the Board and all reports are published on the Forensic Network website.

Cathy Fallon noted that there is no research from Social Work and asked if that was just for this year or a common occurrence.

Lindsay Thomson replied that this is the usual state of play and research is not an area of particular interest with Social Work but we continue to encourage it. She went on to say that on occasion we have security or colleagues from other areas of the hospital, for example, admin support, involved in research and our Librarian is also involved.

Cathy Fallon stated that this was a very thorough report and it was good to see the number of research projects undertaken; she looks forward to seeing the patient perspective.

The Committee **noted** the report.

8 INFECTION CONTROL 12 MONTHLY REPORT

The Committee **received** and **noted** the Infection Control 12 monthly report presented by Karen Burnett, Senior Nurse for Infection Control.

Karen Burnett advised that the first key area was to improve compliance with hand hygiene and a significant amount of work has been undertaken since August 2021 when the Quality Improvement Facilitator took up post, looking at audit tools and how we make it more relevant to the ward environment and liaised with Lead Nurses and Senior Charge Nurses on this piece of work. Results are quite positive and are above 90%.

With regards to seasonal flu vaccinations, Karen Burnett advised that vaccinations for staff have reduced and it is believed to be as a result of people taking covid and flu vaccinations together in the wider community and there is no requirement for staff to inform us if this is the case.

There has been a significant improvement in audit submission rates over the last 12 months for PPE compliance, with a target being set at 95%. Spot checks have been introduced and completed by the Infection Control Team on a bi-monthly basis and reported to the Infection Control Committee.

The Quality Improvement Facilitator took up post in August 2020 and is looking to refresh all audit tools to make them more meaningful; she is also looking at other auditing and what can be done with the audit results.

Datix is an area of concern, specifically around laundry and work is being done with Risk Management and the Laundry and Housekeeping Manager to look at a different format of managing laundry, linking with Lead Nurses and Senior Charge Nurses to make them more accountable at ward level. This will hopefully see an improvement in this area. Safe management of linen has also been added to the induction for student nurses. They have also tried to create innovative ways for infection control training using online tools.

Cathy Fallon asked for an update on the audit database and defects within the Skye Centre. Karen Burnett advised that they are looking at building data for every audit and this is done through several excel spreadsheets that can be used to pull data from. This is being looked at as they review each audit tool. With regards to remedial work within the Skye Centre, Skanska were on site 2 weeks ago and following a survey have identified a larger piece of work which requires scaffolding and taking parts of walls down, etc; they will be on site in August. Hopefully by next report a further update can be provided.

Brian Moore acknowledged the additional responsiveness of the housekeeping department and asked if the additional capacity of the Quality Improvement Facilitator was permanent or temporary. Karen Burnett replied it is a secondment for one year which is due to finish in August, however, she has had agreement for a 6-month extension to the end of March 2023 but she is looking to make the post permanent.

Cathy Fallon echoed the comment made by Brian Moore and the work done by staff during Covid and praised all staff involved.

The Committee **noted** the report.

9 PATIENT MOVEMENT STATISTICAL REPORT

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

There have been 12 admissions and 16 discharges since between 1 October 2021 and 31 March 2022. Today there are 117 patients.

The report outlines issues around where patients are admitted from and there are no delays between referral and admission, with the exception of two outliers; one of which was as a result of ward closures due to Covid outbreak and the patient contracting the virus and work being done to the allocated bedroom and the second was an issue with surgery prior to him moving to us.

We have no-one under the age of 18.

There are 3 exceptional circumstances and 2 appeals against excessive security listed; all are supported by us.

There are 32 patients on the transfer list, with 18 fully assessed and transfer agreed.

Brian Moore asked if we could see any improvement in movement of patients across the system as this will impact on the new Clinical Model and with us having 117 patients seem to be a big challenge for us in the coming period.

Lindsay Thomson advised that the Network did 3 plans:

> Short term which has been fully implemented and resulted in 10 beds within the system
> Medium term plan, for example, development of low secure ward in Stobhill
> Longer term which includes the development of a rehabilitation unit within NHS Lothian.

We have no power to implement medium and long term plans as these sit with geographical health boards and there is no update at the present time. This fits in with the Barron review and Gary Jenkins is liaising on a monthly basis to go over our patients to try and get some traction. The block is from medium to low and from low to community and there is a genuine capacity and pathway issue.

Gary Jenkins added that there is a template to submit returns on delays and the reasons for these from the mental health directorate and he will keep the debate live and open with colleagues in Glasgow. He also advised that every ward closed with Covid has had an impact on the current position and, if necessary, this can escalate to the Chief Executive Group.

The Committee **noted** the report.

10 STAFFING AND CARE REPORT

The Committee **received** and **noted** the Staffing and Care Report, presented by Karen McCaffrey, Director of Nursing and Operations. The report covers the period January to March 2022.

Karen McCaffrey advised that it was a challenging period in terms of nursing. We have a funded establishment of 293 and currently have 285 wte in post with a vacancy level of just under 20. There were 10 planned retirals in March, 6 registered nurses and 4 unregistered nurses which has had a significant impact to staffing numbers and the expertise we are losing.

Sickness absence is starting to reduce and we are seeing an improved picture of 6%. Predicted absence was outwith tolerance rate due to staff retiring having annual leave to take; this is being monitored on an ongoing basis.

Karen McCaffrey gave the Committee assurance that steps are being taken to look at the increased number of datix incidents during March and there is a daily resource management meeting to ensure measures are being put in place to manage the impact on care and delivery and patient activity.

The report details the number of full and partial ward closures and this is being monitored and work has been undertaken to ensure people are clear what the definitions are for different measures.

Gary Jenkins advised that the number of staff in post adds up to 273 and not 285.

David McConnell asked if the supplementary staffing capacity is due to the internal bank coming into play and if, under business continuity measures, there was an indication of the trend for ward closures moving into April.

Karen McCaffrey advised that they are currently looking at all supplementary staffing in relation to the bank as there are a number of different groups of people fall into this category. The bank implementation group is looking at pulling together to make this one group of staff and there is also ongoing work in relation to other staff who are eligible to join the bank. Karen went on to say that they are actively monitoring that measures are put in place. There were a number of outbreaks in March and she is working with teams to make sure everyone is clear at what point measures were put in place and consistently applied; we are seeing an improving picture and keep pushing for improvement.

Sheila Smith advised that the Covid-19 report coming up later will give the Committee assurance that there has been an improvement in ward closures since April.

The Committee **noted** the report.

11 FITNESS TO PRACTICE 12 MONTHLY REPORT

The Committee **received** and **noted** the Fitness to Practice 12 Monthly Report, presented by Audrey Bevan, Head of HR. The paper outlines the process for monitoring professional registration status at the State Hospital for all staff for whom professional registration is a statutory requirement for employment. It also provides assurance that all members of staff hold current professional registration.

Audrey Bevan informed the group that checks are undertaken within HR mid month and where registration has not been renewed, the member of staff and manager are contacted. Where registration has lapsed, national processes are followed and staff are able to maintain employment as a nursing assistant at Band 3 level until registration is renewed. In 2021 there was one lapse within nursing and one within medical; there were none for AHP staff. The issue with the Doctor was due to NHS NES not issuing a revalidation recommendation when they had completed their training; this has now been addressed. In relation to the nurse, this was due to a breakdown in communication between the staff member and the NMC not having their updated details and this also has been addressed.

The Committee **noted** the report.

12 PATIENT LEARNING 12 MONTHLY REPORT

The Committee **received** and **noted** the Patient Learning 12 Monthly Report, presented by Julie McDonald, Patient Learning Manager. The report details service activity levels and key achievements for the period January to December 2021.

Julie McDonald advised that patient learning was impacted by Covid last year due in part to staffing resource pressures, department closures, reduced capacity and covid restrictions.

A new timetable was introduced within the Skye Centre in mid-June. Restrictions on patients from different wards mixing were gradually eased and group-based and subject-specific learning sessions were reintroduced in July-December. From July, patients were also able to attend the PLC for several sessions each week.

A total of 64 patients engaged in formal or accredited learning programmes; this is 58% of the patient population across all 4 hubs.

33 formal qualifications were attained within 2021.

There were 56 course enrolments and 33 course achievements.

There were 26 core skill qualifications from level 2 to level 4 covering communication, numeracy, IT and problem solving. 28 core skill units are in progress.

Fewer vocational qualifications were completed due to activity centres not able to open or deliver.

Julie McDonald highlighted some of the course that patients had participated in, including use of hand tools, creative arts, sports leadership, ECDL.

Two members of staff from the Patient Learning Centre are undertaking further ESOL tutoring training which will allow enhanced provision.

One patient is engaged in distance learning with the Open University and this is progressing well.

Seven patients are participating in a reading group.

Planned programmes for the coming year include the introduction of a new volunteering award, qualification in soft landscaping and piloting of level 3 creative arts.

Other significant work activities include the successful upgrade on the IT infrastructure which allows online testing for patients doing the ECDL qualifications although support from IT remains adhoc and unpredictable. Work has commenced on the digital inclusion project to progress the 'interactive education resources' project. This will be focussed initially within the Skye Centre but it is hoped it will expand to hubs and wards to support outreach activities and hub and ward based learning.

Appendix 3 contains evaluations and feedback and the overall levels of satisfaction has been very high. This highlights challenges for patients including missing sessions and despite patient learning activities being impacted there were still significant achievements and lots to celebrate and be positive about.

Brian Moore stated that this was an excellent report and achievement, for example, the feedback and comments people made and the many different courses provided; he asked if we do enough to promote this service as an example of good practice and if we have sufficient numbers of volunteers or if this is an area to further develop.

Julie McDonald advised that we have 2 volunteers who were not able to come in last year to provide support. One has already started back in the learning centre and the second will be back in June. They provide a valuable service and enhance what we deliver and the patients enjoy their support. The volunteers and patients get a lot out of the experience. We do not market the service but do provide information across the network to medium secure facilities so that when patients move on they have an update on what they have done within the State Hospital and they can follow this up. Prior to Covid work was done with the Network around the discharge pathway to support patients on the next part of their journey. We can look at digital side across the network to see what support can be provided to other services.

Lindsay Thomson suggested a one-day meeting to present on what we do and work on a collective way forward and digital inclusion would be part of that.

Lindsay Thomson asked if we look for evidence of improvement from level one, two etc and if we should be thinking about progression and if we could do more.

Julie McDonald advised that patients do progress through levels; when they come we do screening to see what level they are currently at, this is then discussed with the patient and we look at what level to set to start their journey and they will then progress up the levels to potentially level 5.

Lindsay Thomson then asked if we would formally assess again 6 or 12 months later or if it is just progression.

Julie McDonald replied that we do not rescreen them and evidence is how they participate in programmes and they are then certificated on accredited learning. Julie will look at linking progression and will discuss with Sandra Dunlop and incorporate this into the next report.

Cathy Fallon stated that she looks forward to seeing how we link progression in future reports.

The Committee **noted** the report.

13 LEARNING FROM FEEDBACK

The Committee **received** and **noted** the Learning from Feedback Report, presented by Karen McCaffrey, Director of Nursing and Operations. The report provides the Clinical Governance Committee with an overview of activity relating to feedback for the fourth quarter of the financial year 2021/22 (1 January to 31 March 2022).

The report shows feedback based on key themes and gives examples of direct feedback from patients in Iona 2 and the Carers Clinical from the Realistic Medicine Action Plan.

Patient Partnership Group was attended by the Chair and Non-Executives and the report highlights how well received their attendance was. The group are proactive in relation to supporting patients in the consultation process around policies and they responded to 3 within the quarter.

Feedback in relation to measures put in place due to Covid restrictions or absences are being reported to groups such as the OMMG and HMT and actions have been taken as a result of the information fed back.

Quality and safety visits, formerly known as leadership walkrounds, have recommenced; these are an opportunity to hear from patients on their experience and actions taken as a result of that.

During the reporting period there were 54 pieces of feedback provided, this is down from the last quarter.

Concerns have been noted in terms of the time patients are in their rooms due to Covid and this is being monitored and can be reported on an ongoing basis.

Feedback was received from an outgoing Carer Representative who has suggested that the format of meetings be reviewed as they are too formal and they are looking for more scope to have informal discussions. The PCIT are working with the new carer representative to adapt meetings to meet their needs.

Brian Moore acknowledged the useful level of detail contained within the report.

Cathy Fallon noted the involvement of the graduate trainee and the difference they are making and looks forward to carer development.

The Committee **noted** the report.

14 LEARNING FROM COMPLAINTS

The Committee **received** and **noted** the Learning from Complaints report, presented by Margaret Smith, Board Secretary and Anne Donnelly, Complaints Officer. The report provides a summary over the last financial year and comparison to the previous year.

During this year, the number of complaints increased to 65 compared to 42 in the previous year. Four of the complaints received related to one particular issue linked to communications relating to the external purchasing of protein bars. The service was able to help immediately, linking with security and clinical colleagues. Another complaint related to the impact of staffing on patient activity.

The service continues to meet timescales and response times at stage one and stage two. One complaint at stage two did not meet the response time as it is subject to an adverse even and requires to be investigated by the Risk team.

Longer term action has been taken in relation to protein bars.

Activity work is continuing through clinical quality, reporting through OMMG and CMT.

Work continues on the complaints experience feedback, with input from the Person Centred Improvement Team who have discussed the feedback form with patients; positive feedback is being received from patients and they feel that their complaints are being listened too. three patients considered that they had concerns about how the complaint was handled. As feedback is

anonymous, and doesn't ask whether the patient agreed with the outcome of their complaint, it is not possible to differentiate whether these views were linked to the outcome in terms of the issue complained about, rather than the complaints process itself. Anne Donnelly is attending patient partnership meetings to look at how to obtain more qualitative feedback from patients and incorporate this into the report.

An Internal audit was conducted by RSM and we are going in the right direction with complaints handling due to the hard work Anne Donnelly puts in as Complaints Officer and also frontline staff responding well to complaints.

One complaint was referred to the SPSO for consideration. They were content with the handling of the complaint and no further actions required to be taken.

David McConnell asked about the figures under staff shortage / availability and staff attitude / behaviour / conduct as there appeared to be an odd pattern and asked if this was due to a re-categorisation or something else.

Anne Donnelly replied that staff attitude and behaviour fell by the wayside as an issue for complaints as staff shortages have taken over and patients are spending more time in their bedrooms; it is expected that this will come back up again as it is the most common complaint throughout the NHS.

Brian Moore stated that one principle is about informal resolution and wondered if some could be dealt with in this way or do we unnecessarily escalate to a formal complaint. He also stated that there is something about how things get routed through the formal process that could be dealt with informally and asked where the principle of informal resolution fits within this arrangement.

Margaret Smith responded that in previous years' complaints were called informal or formal complaints but the SPSO now ask us to categorise them as stage one and stage 2. Anne Donnelly added that the complaints standards authority did not like the terms informal and formal and this was felt to be a long and protracted process. A lot is happening at ward level and through Sandie Dickson's team, to capture concerns rather than complaints.

Lindsay Thomson advised that we previously had the 4C's; Compliments, Comments, Concerns and Complaints. A lot of the feedback is concerns or it is criticism; she thinks we are capturing this in the right way.

We now have a flowchart for protein bars showing that Clinical Teams consult with the Dietician, Pharmacist and Sports department, this is shared as a clinical team and decisions taken.

Cathy Fallon commended Margaret Smith and Anne Donnelly for their detailed report and stated that she did not see a rise in complaints as a negative. It was also good to have the assurance of the internal audit.

The Committee **noted** the report.

15 INCIDENT REPORTING AND PATIENT RESTRICTIONS

The Committee **received** and **noted** the Incident Reporting and Patient Restrictions paper, presented by Lindsay Thomson, Medical Director.

The main points from the patient restrictions report were:

- PAA activations have decreased from 14 to 11 this quarter. 3 activations Arran, Iona, Mull and 1 activation in Lewis. There was one activation in Iona 2 that did not require assistance.
- Handcuffs were used 16 occasions for 11 patients. This has decreased slightly this quarter.
- 2 patients were nursed in SRK's. A new admission in Mull 2 and a patient in Iona.

- During room searches there was 1 find in Lewis ward. 1 patient was found to have a- stockpile of lozenges in an envelope. These were nicotine replacement tablets.

There were 537 incidents reported during this period, with 284 being reported as staff resource issues.

Four issues were reported as very high. All 4 of these incidents involved staffing issues, specifically relating to the closure of wards. Work is ongoing in the Risk and Resilience Team to standardise the process of reporting ward closures and staffing resource incidents to ensure that reporting is as accurate as possible.

There were 278 high incidents, up from the previous quarter, 6 relate to information governance, 4 direct patient care and 268 staff resource issues.

There were 121 Health and Safety incidents. Assaults were down; behaviour was the highest category; staff / patient injury decreased from 12 to 5

Sexual incidents increased from 2 to 8 and there were 7 patients involved in the 8 incidents.

Overall, during 2021-22 there were 459 incidents reported under Health and Safety Category on Datix. This is an increase of 47 on the 412 reported in the previous year. Assaults reduced from 31 to 21, attempted assaults reduced from 62 to 47. There were rises in verbal aggression and abuse and behaviour.

An assault tracker is completed If a patient records 3 or more assaults within 6 months and the incidents will be referred to their RMO and Learning into Practice (LiP) group for further review. In the 6 months preceding 31 March, no patients met the criteria.

There was 3 patients secluded over the quarter resulting in a total of 4 seclusions.

There were 284 staff incidents and details of the various wards affected are shown on the pie chart on page 7 of the report.

39 security incidents were recorded during this period, a slight decrease of 3 on the 42 in the previous quarter, though there was a slight increase in the number of prohibited items coming through security.

There were 16 infection control incidents with 13 being attributed to clinical waste.

There were 43 direct patient care incidents in the last quarter, 16 relating to self-harm involving 3 patients.

There were 16 equipment incidents reported due to malfunctions and some damage.

16 communications incidents were reported; these are small numbers but important when it relates to breaches in communication.

There have been 3 CAT 2 reviews; one has been completed in relation to the use of SRKs resulting in a patient chipping a bone during restraint.

Brian Moore stated that the figures for the patients without grounds access are consistent over the reporting period and asked if special arrangements are put in place for exercise in the absence of grounds access.

Lindsay Thomson advised that 45 are recorded as not having grounds access which means that 72 patients do and, being a high secure hospital, having 72 patients at such a level where we can let them walk out unsupervised and mixing with peers and be confident a serious incident is not going to occur is in the right ballpark. The 45 without grounds access would, ideally, be accessing the

gym, the ward gym and have escorted walks though it is acknowledged that there is an issue with patient activity and staffing issues but we should be able to compensate in terms of planned activity but in reality it does not happen as often as we would like.

Gary Jenkins advised that one patient had observed and commented that Arran was always getting closed but the pie chart shows that this is not the case and the data can be used to give patients assurance.

John Marshall informed the Committee that a Trainee Clinical Psychologist is analysing data for social contagion effects and that it will be interesting to see what comes from this.

The Committee **noted** the report.

16 COVID-19 REPORT

The Committee **received** and **noted** the Covid-19 Report, presented by Lindsay Thomson, Medical Director.

Lindsay Thomson advised that there had been 4 small outbreaks of Covid-19 since the last meeting and that, unfortunately, we were once again in an outbreak situation this week with 5 patients confirmed in Mull1 and 3 patients in Mull 2. For the period 1 February to 31 March we had 7 wards with 16 patients affected by Covid; 2 of these patients were unvaccinated. Patients were isolated and wards closed. During this period of time we had established a normal clinical model with ward opening and mixing across hubs and the hospital, with the exception of those affected throughout.

Referral of patients to TSH continue to be accepted. There have been 7 admissions over the period of 1 February - 31 March 2022. There have been 5 discharges during this period.

The Operational Model Monitoring Group continues to meet every 2 weeks. The report highlights the issue of ward staff shortages, full and partial closures by week and not accessing fresh air. Physical activity or timetabled activity has been problematic during this period.

We continue to follow medical developments in the treatment of Covid and have developed a protocol with NHS Lanarkshire infection control service to ensure high risk PCR positive TSH patients can access intravenous Sotrovimab or oral Molnupiravir if the patient is not suitable for Sotrovimab.

We have a new Service Level Agreement with a new GP Practice which gives us much greater resilience.

It has not been necessary to open the medical ward during this period.

The Infection Control Committee continues to meet and is now chaired by Karen McCaffrey.

We continue to ask visitors to do a LFT prior to coming to the hospital. There is a website called “Hospital Visiting” where visitors can access LFTs free of charge but should they have any difficulty we will provide them with testing equipment.

The enhanced surveillance report is included in the report as Appendix 2.

Brian Moore asked if we are expecting any longer term pattern of how visitors might have an interface with patients and if there were any issues arising from professionals or patients with regard to a new way of working.

Lindsay Thomson replied that she is not aware of any new issues and it will be interesting to see how this works out; colleagues are electing to do update assessments electronically but if it is a new patient who has not been seen they may wish to do this in person. She also advised that we will

facilitate whatever the preference is for legal professionals.

Cathy Fallon stated that it was good to see the GP SLA being signed off and looks forward to hearing about the pilot project on video visiting.

The Committee **noted** the report.

17 CLINICAL GOVERNANCE STOCKTAKE

The Committee **received** and **noted** the Clinical Governance Stocktake Report, presented by Sheila Smith, Head of Clinical Quality. The Annual report is a summarised version of the reports that have been presented to the Committee over the last 12 months.

Lindsay Thomson advised that she was looking for feedback from the Committee on whether there was a gap in the reporting or if the members felt the report was excessive in content.

David McConnell advised that some dates were not up to date and appear to be from last year.

Lindsay Thomson advised that the dates are correct as data is taken from May and is for the previous financial year.

David McConnell made reference to the Terms of Reference and who is ex-officio and who is an attendee and suggested this be looked at. Margaret Smith will link with Sheila Smith and update the document prior to it going to the Board.

Action: Margaret Smith / Sheila Smith

Margaret Smith advised that the management structure, which was marked as draft, is under active review through the Corporate Management Team.

With regards to the programme of work, Sheila Smith informed the Committee that the Mental Health Practice Steering Group report has been moved to the next meeting to spread papers out across meetings.

The Committee **noted** the report.

18 DISCUSSION ITEM

The discussion item will be reintroduced at the August meeting. At the previous meeting there were 3 suggestions for the discussion item: Barron Report, Clinical Model, and Improved Observation Practice (IOP).

Gary Jenkins advised that these are all pretty active at the moment and the Barron review is heating up in terms of options appraisals.

Karen McCaffrey advised that the IOP is difficult to implement and is more complex than it appears and we can demonstrate within the State Hospital that this goes hand in glove with the implementation of the clinical model.

Gary Jenkins suggested that it may be timely for the committee to consider progress in the Scottish Government led Short Life working Group on the Delivery of Forensic Mental Health Services.

Gary Jenkins suggested activity might be more meaningful for August as this has been a problem area and been a victim of Covid and has good clinical relevance.

The Committee agreed with Gary Jenkins' suggestion for Activity and Lindsay Thomson will work out who will bring this to the meeting.

Action: Lindsay Thomson

Lindsay Thomson suggested having an ideas list and if anything immediate came up for a priority for Clinical Governance we could have some leeway to change that. Cathy Fallon agreed with this and asked members to give this some consideration and send any suggestions to Sheila Smith to pull together.

Action: ALL

Lindsay Thomson advised that there is a short life working group on psychological therapies which is through the Forensic Network which could be included on the list.

19 AREAS OF GOOD PRACTICE / AREAS OF CONCERN

The Committee **received** and **noted** the paper on Areas of Good Practice and Areas of Concern.

No areas of good practice where identified for inclusion on the list.

Lindsay Thomson advised that at the previous meeting there was discussion on how the Committee follows up on areas of good practice / areas of concern.

Brian Moore stated that we have seen considerable progress over the past year with hand hygiene and clinical waste but there may be further improvements required.

Cathy Fallon felt that it would be helpful to keep clinical waste on the list.

Gary Jenkins advised that any exceptional matters could be brought to the Committee. Staffing issues can be deferred to the Staff Governance Committee that looks at staffing issues.

Some work is required to be done to update the areas of good practice / areas of concern paper. The transfer / discharge CPA 100% LDP target should stay on the list but dated from last report. TV hire purchase to be noted but no follow up. Response of staff during Christmas period to be noted as a one off and no follow up.

Action: Jacqueline McDade

Gary Jenkins asked whether we should call this a record of good practice and asked what we are using this document for.

Cathy Fallon thought it may be a good idea to publish this in a staff bulletin once a year.

Sheila Smith advised that she finds this useful when putting together the annual report and thought that we could have a bullet list for the year for areas of good practice but areas of concern should be an action plan so that we do not lose sight of it. This should stay on for a year and every 12 months the record of good practice would change.

20 WORKPLAN

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

21 ANY OTHER BUSINESS

No other business was raised at this time.

22 DAY, DATE, TIME AND VENUE FOR NEXT MEETING

The next meeting will be held on Thursday 11 August 2022 at 9.45am. Margaret Smith advised that it is under consideration on whether the meeting will be via MS Teams or in person. This will be looked at over the next few weeks.

The meeting concluded at 11.47am

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No. 72
Sponsoring Director:	Director of Workforce
Author(s):	Head of HR
Title of Report:	Workforce Report
Purpose of Report:	For Noting

1 SITUATION

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

Information and analysis is provided quarterly to the Staff Governance Committee and Bi-monthly to the Board. Monthly reviews also take place at Hospital Management Team, the Operational Management Team and Corporate Management Team. Information is also provided on a monthly basis to the Partnership Forum and HR & Wellbeing Group.

2 BACKGROUND

The State Hospital use a dashboard system called Tableau. This is still being developed to provide more detailed and up to date staffing information than had previously been available. The information relates to absence levels, sickness absence information, additional staffing levels, recruitment activity and turnover. The reports are still within the test phase, however, once agreed, will be available to all Tableau users, who can then review the information relating to their own areas of work.

The Tableau dashboards are updated on a daily basis with attendance information using information from the SSTS system, meaning that the information available is live and as accurate and up to date as the information input by managers. A monthly upload from EESS enables turnover information to be available, and it is intended that there will also be a monthly upload from JobTrain with recruitment information. The final development at this stage will be to provide centrally available establishment and vacancy level figures.

In addition to the information provided, or to be provided, through Tableau, this report contains information on the national statistics information, providing information for 2021/22 through Turas data using SWISS information, as well Employee Relations casework.

All information is provided to the end of July 2022, with the exception of the national statistics information, which are for May 2022.

3 ASSESSMENT

- The information available shows that the absence rate for July 2022 is 6.94%. The rolling year average is 6.34%.

- 40 staff were being managed through the formal stages of the Attendance Policy and 13 staff were off on long term absence.

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

- Covid related absence accounted for 6.66% of all absence and there are 6 Long Covid cases. It should be noted that in line with DL(2022)21, Special Leave for Long Covid will end on 31st August 2022. The DL confirms that staff members who receive a positive LFD test result for COVID-19, regardless of whether they have symptoms, should not attend work for a minimum of five days. In these circumstances, staff will continue to be treated as on "Special Leave – Covid Positive".

- Nine posts were advertised in July. This includes an advert for multiple staff nurse vacancies. There are three posts where individuals have been given provisional offer dates and 12 individuals with confirmed start dates. The national KPI for completion of the recruitment process from post approval to start date is 75 days and for individuals who started within May, The State Hospital average was 127. This can be attributed to delays in references being received and newly qualified nursing staff awaiting confirmation of their registration from NMC.

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

- One new employee relations cases was identified in July 2022. There were six ongoing cases. The longstanding grievance required information from MSG, which was received in June 2022 and will enable this matter to be concluded.

- Eight staff ended their employment at The State Hospital in July 2022. This brings the total number of staff who have left within financial year 2022/23 to 26 to date.

Full details can be found in the attached Appendix 1.

4 RECOMMENDATION

The Board is invited to note this report.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Links to the Attendance Management Policy and aids monitoring of 5% attendance target locally. The national target is currently 4%.
Workforce Implications	Failure to achieve 5% target will impact ability to efficiently resource organisation.
Financial Implications	Failure to achieve 5% target results in additional spend to ensure continued safe staffing levels
Route to Board Which groups were involved in contributing to the paper and recommendations.	Corporate Management Team Staff Governance Committee Partnership Forum, HR and Wellbeing Group
Risk Assessment (Outline any significant risks and associated mitigation)	Fully outlined and considered in the report
Assessment of Impact on Stakeholder Experience	Failure to achieve the 5% target will impact on stakeholder experience
Equality Impact Assessment	Not required for this report as monitoring summary report.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	There are no identified impacts.
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One X There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications , full DPIA included.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Workforce Report – August 2022

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

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

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

SSTS absence rates are calculated based on the hours lost within the month divided by the available working hours in the particular month.
SWISS absence rates are calculated based on the hours lost within the month divided by 1/12th of the annual available hours.

Absence and Sickness Absence - All Staff

Month
July, 2022

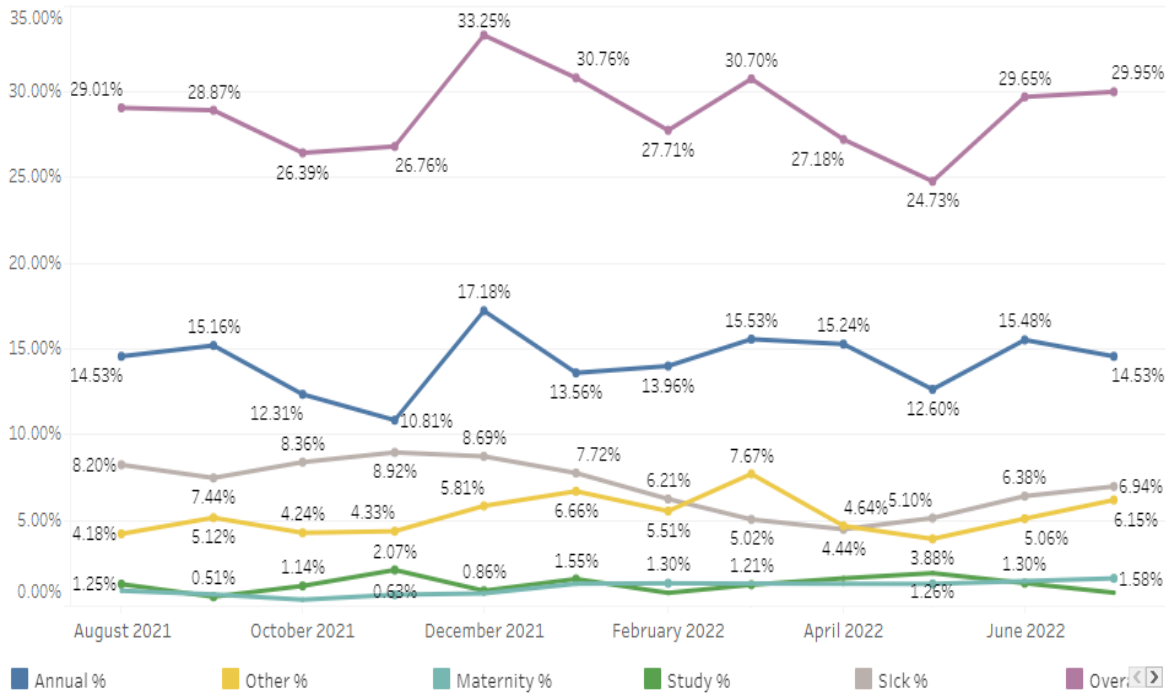
Rosters
(All)

Absence and Sickness Absence

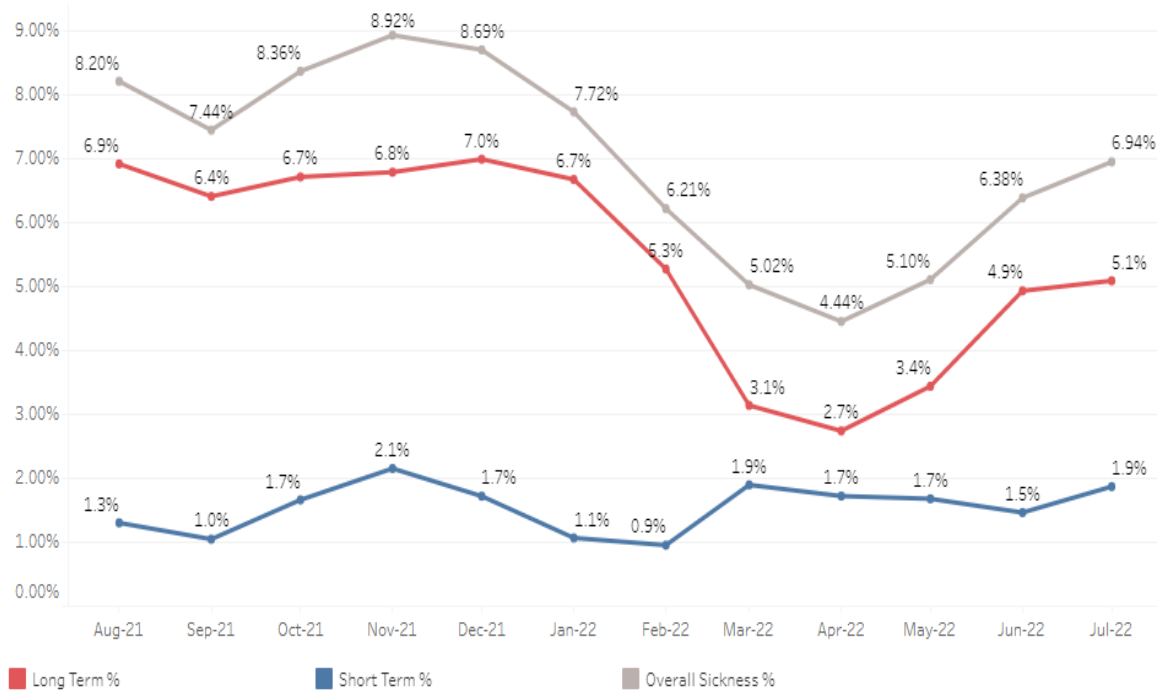
July 2022

Overall Absence	Overall WTE Lost	Overall Hours Lost	Sickness Absence	Sickness WTE Lost	Sickness Hours Lost	Long Term Sick	Short Term Sick
29.95%	172.8	28,702	6.94%	40.06	6,652	5.08%	1.86%
Rolling 12 Month	Rolling 12 Month	Rolling 12 Month	Rolling 12 Month	Rolling 12 Month	Rolling 12 month	Rolling 12 Month	Rolling 12 Month
26.17%	169.3	331,073	6.34%	41.02	80,215	4.94%	1.40%

Overall Absence 12 Month Rolling To: July 2022



Sickness Absence 12 Month Rolling To: July 2022



Absence and Sickness Absence - Hub Nursing Staff

Month
July, 2022

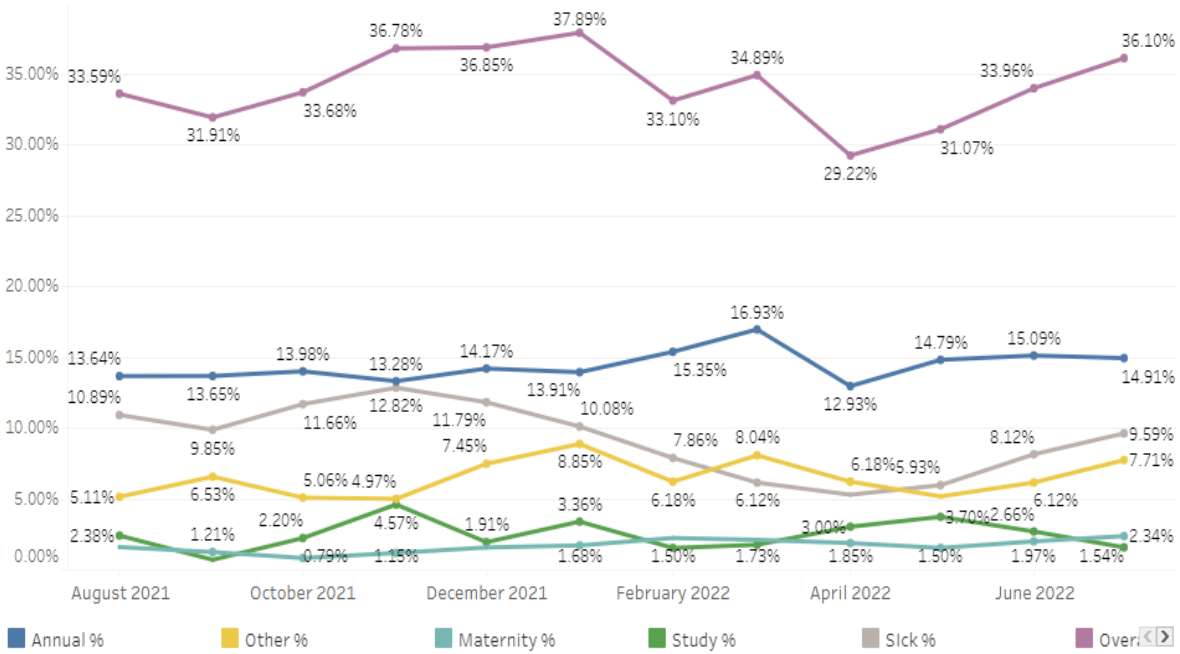
Rosters
(Multiple values)

Absence and Sickness Absence

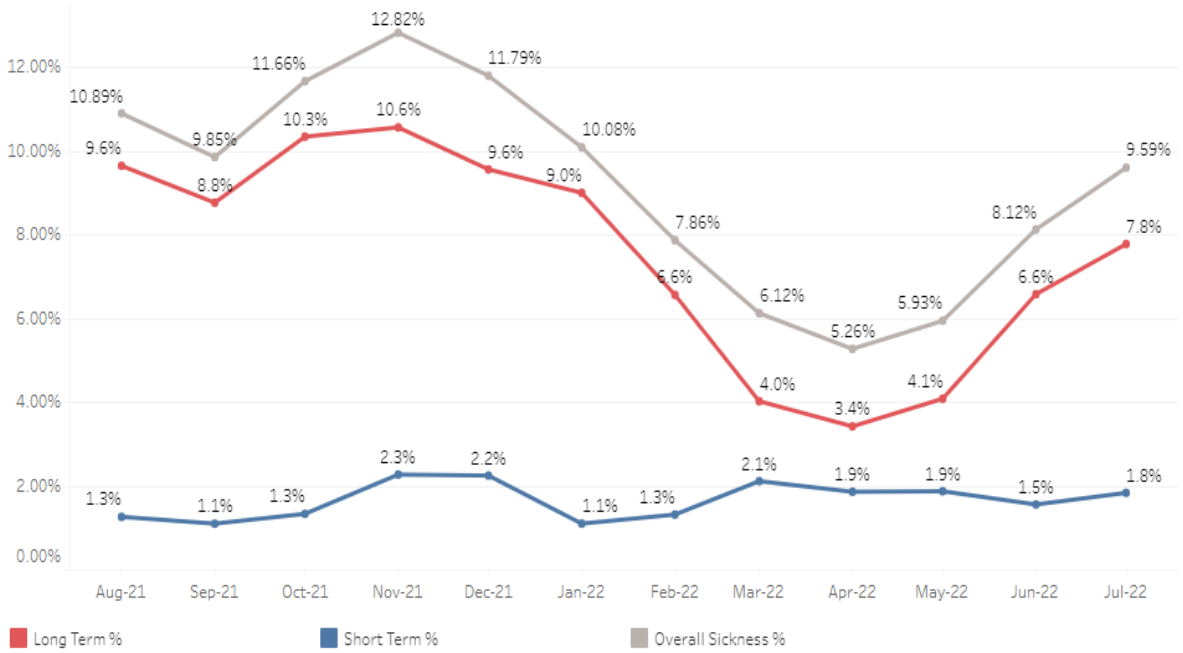
July 2022

Overall Absence	Overall WTE Lost	Overall Hours Lost	Sickness Absence	Sickness WTE Lost	Sickness Hours Lost	Long Term Sick	Short Term Sick
36.10%	92.55	15,370	9.59%	24.60	4,085	7.77%	1.82%
Rolling 12 Month	Rolling 12 Month	Rolling 12 Month	Rolling 12 Month	Rolling 12 Month	Rolling 12 month	Rolling 12 Month	Rolling 12 Month
29.99%	88.19	172,443	8.06%	23.71	46,368	6.61%	1.45%

Overall Absence 12 Month Rolling To: July 2022



Sickness Absence 12 Month Rolling To: July 2022



Reasons for Absence, Trigger points and Compliance

Month
July, 2022

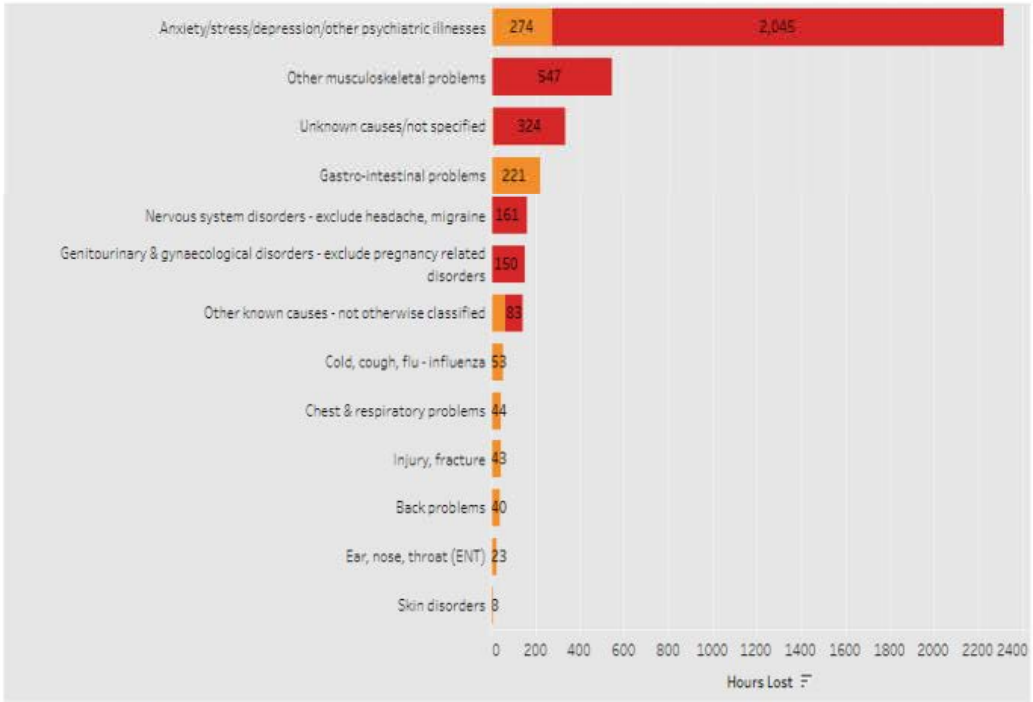
Rosters
(Multiple values)

Reasons for Absence, Trigger points and Compliance

July 2022

Staff Off Sick	Returning Staff	OH Referral Made	RTW < 2 Days	RTW > 2 Days	No RTW Held
49	35	0	1	8	22

Absence Reasons - July, 2022



Highest Absence % - July 2022

SH - Hub Iona - Iona Ward 3	20.78%
SH - Hub Lewis - Lewis Ward 2	14.77%
SH - Hub Lewis - Lewis Ward 3	12.69%
SH - Hub Arran - Arran Ward 2	11.61%
SH - Hub Lewis - Lewis Ward 1	11.40%

Lowest Absence % - July 2022

SH - Hub Iona - Iona Ward 1	9.30%
SH - Hub Iona - Iona Ward 2	6.72%
SH - Hub Mull - Mull Ward 1	6.00%
SH - Hub Arran - Arran Ward 1	5.57%
SH - Hub Mull - Mull Ward 2	3.27%

Staff Reaching Trigger Points in July 2022

4+ Episodes	8+ Working Days	29+ Consecutive Days
6	10	13

Sickness Absence Comparison – Nationally Reported Figures (In Month)

1st June 2022 - 30th June 2022	Total Hours Lost [3]	Total Contracted Hours [4]	Rate [5]	May 22 Rate [6]	Rate Difference [7]	WTE Hours Available as % Hours Worked [8]	Cash Equivalent as % Paybill [9]
Scotland	1,405,661.27	25,311,718.13	5.55	5.59	-0.04	60.5	166,341.77
NHS Ayrshire & Arran	75,843.37	1,507,003.48	5.03	5.05	-0.02	1.9	5,468.48
NHS Borders	22,223.49	442,416.04	5.02	5.05	-0.03	0.8	2,462.81
NHS National Services Scotland [10]	24,445.64	536,485.48	4.56	4.65	-0.09	3.0	9,220.65
NHS 24	16,337.76	225,447.28	7.25	7.85	-0.60	8.3	19,595.01
NHS Education For Scotland	4,396.97	299,885.11	1.47	1.42	0.05	-0.8	-861.91
Healthcare Improvement Scotland	2,085.99	87,587.76	2.38	2.96	-0.58	3.1	4,407.70
Public Health Scotland [10]	4,071.19	183,331.61	2.22	3.20	-0.98	11.0	x
Scottish Ambulance Service	82,318.51	1,008,228.94	8.16	8.38	-0.21	13.2	26,365.13
The State Hospital	5,934.97	94,565.65	6.28	4.73	1.55	-9.0	-35,501.46
National Waiting Times Centre	15,305.52	316,904.33	4.83	4.69	0.14	-2.8	-5,803.38
NHS Fife	72,146.56	1,292,631.19	5.58	5.32	0.26	-20.9	-58,175.70
NHS Greater Glasgow & Clyde	354,468.60	5,992,307.63	5.92	6.07	-0.16	57.8	174,286.71
NHS Highland	73,681.74	1,418,479.03	5.19	5.11	0.09	-7.7	-19,622.02
NHS Lanarkshire	126,049.59	1,950,985.46	6.46	6.44	0.02	-2.6	-7,087.10
NHS Grampian	105,010.53	2,280,661.13	4.60	4.59	0.02	-2.6	-7,354.38
NHS Orkney	4,774.59	99,812.51	4.78	5.15	-0.37	2.3	6,084.38
NHS Lothian	201,294.98	3,789,412.91	5.31	5.29	0.02	-5.2	-13,364.62
NHS Tayside	107,393.99	1,948,004.82	5.51	5.64	-0.13	15.7	47,190.69
NHS Forth Valley	59,742.68	958,525.88	6.23	6.49	-0.26	15.3	45,580.70
NHS Western Isles	8,936.58	142,045.33	6.29	5.69	0.60	-5.2	-15,893.67
NHS Dumfries & Galloway	34,146.46	624,802.96	5.47	5.20	0.26	-10.2	-29,851.11
NHS Shetland	5,051.57	112,193.59	4.50	4.34	0.16	-1.1	-2,635.57

Sickness Absence Comparison – Nationally Reported Figures (Rolling Year)

1st July 2021 - 30th June 2022	Total Hours Lost [3]	Total Contracted Hours [4]	Rate [5]	Previous Year Rate [6]	Rate Difference (2022 v 2021) [7]	WTE Hours Available as % Hours Worked [8]	Cash Equivalent as % Paybill [9]
Scotland	17,835,277.20	303,740,617.56	5.87	4.85	1.02	-1,584.8	-52,200,017.50
NHS Ayrshire & Arran	969,232.54	18,084,041.80	5.36	4.37	0.99	-91.6	-3,112,559.18
NHS Borders	284,827.31	5,308,992.53	5.36	4.69	0.68	-18.4	-682,740.63
NHS National Services Scotland [10]	303,544.70	6,437,825.71	4.72	3.17	1.54	-50.9	-1,857,036.45
NHS 24	233,734.47	2,705,367.40	8.64	7.21	1.43	-19.8	-557,291.32
NHS Education For Scotland	61,137.76	3,598,621.27	1.70	1.20	0.49	-9.1	-113,007.25
Healthcare Improvement Scotland	35,464.62	1,051,053.08	3.37	2.23	1.14	-6.2	-103,997.77
Public Health Scotland [10, 12]	60,750.48	2,199,979.35	2.76	2.05	0.71	-8.0	-
Scottish Ambulance Service	1,033,993.54	12,098,747.34	8.55	6.19	2.36	-146.2	-3,505,948.08
The State Hospital	73,290.86	1,134,787.85	6.46	5.68	0.78	-4.5	-213,324.05
National Waiting Times Centre	226,808.52	3,802,851.96	5.96	4.63	1.34	-26.1	-653,402.01
NHS Fife	902,436.11	15,511,574.32	5.82	4.98	0.84	-66.8	-2,229,205.34
NHS Greater Glasgow & Clyde	4,645,112.49	71,907,691.53	6.46	5.30	1.16	-426.0	-15,400,934.99
NHS Highland	908,689.77	17,021,748.33	5.34	4.80	0.54	-47.4	-1,443,933.11
NHS Lanarkshire	1,608,848.18	23,411,825.56	6.87	5.61	1.26	-151.7	-4,897,047.90
NHS Grampian	1,320,613.70	27,367,933.50	4.83	3.83	1.00	-140.3	-4,675,574.12
NHS Orkney	62,007.19	1,197,750.16	5.18	4.73	0.45	-2.8	-88,391.22
NHS Lothian	2,460,659.08	45,472,954.92	5.41	4.49	0.92	-214.4	-6,603,768.52
NHS Tayside	1,357,803.64	23,376,057.90	5.81	4.95	0.85	-102.4	-3,697,058.94
NHS Forth Valley	724,763.62	11,502,310.58	6.30	5.83	0.47	-27.5	-980,469.29
NHS Western Isles	95,849.11	1,704,543.92	5.62	5.37	0.25	-2.2	-80,567.20
NHS Dumfries & Galloway	404,183.24	7,497,635.47	5.39	5.01	0.39	-14.8	-521,608.40
NHS Shetland	61,526.29	1,346,323.08	4.57	2.80	1.77	-12.2	-351,141.69

Covid Absence

Month
July, 2022

Rosters
(Multiple values)

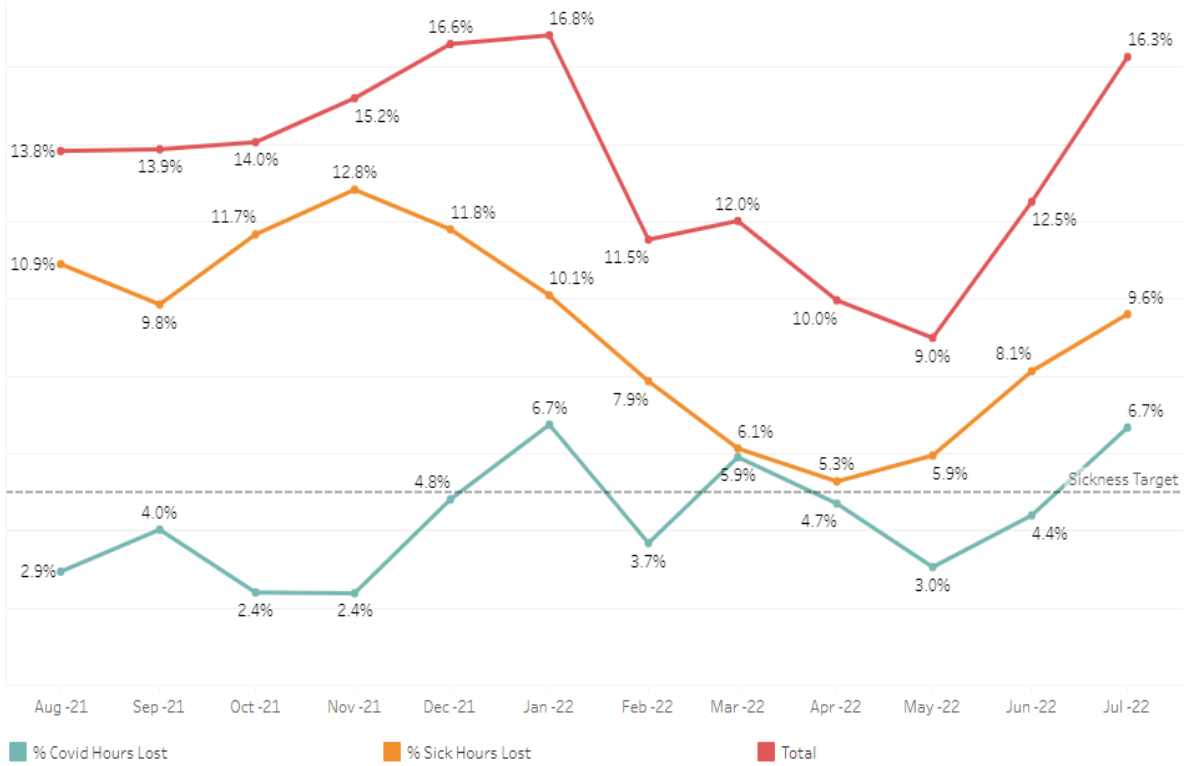
Covid Absence

July 2022

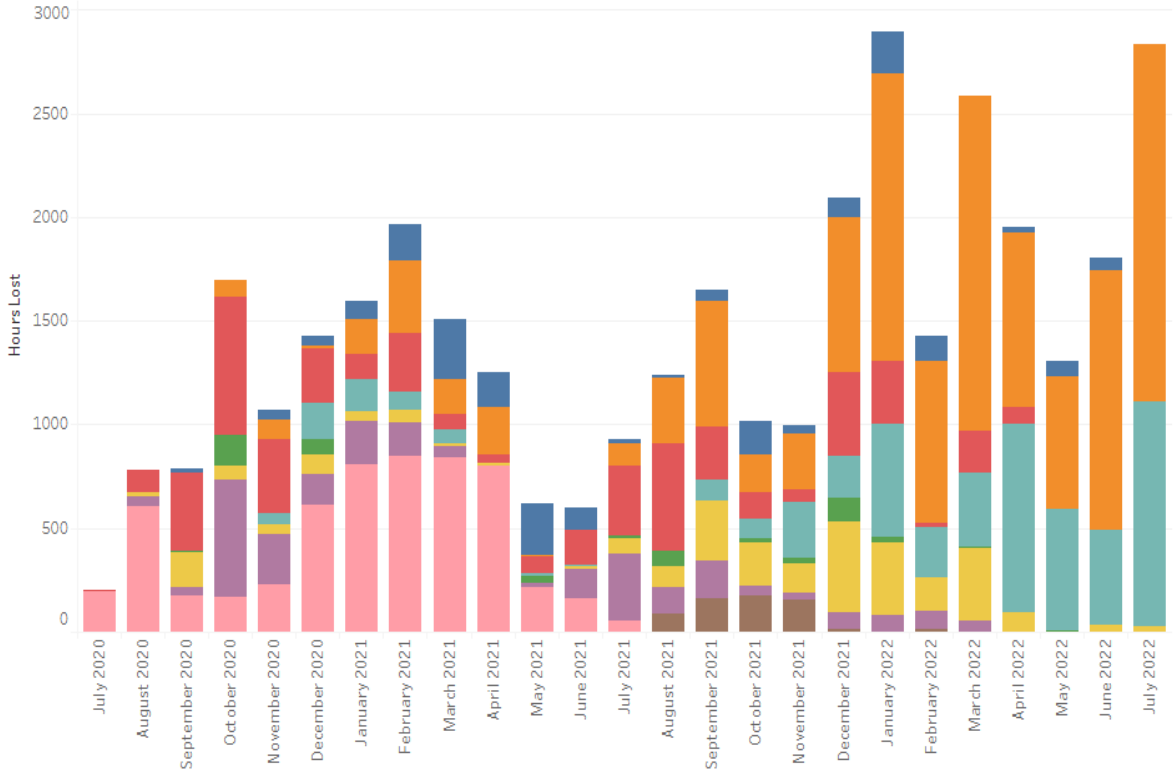
Covid + Absence	Covid + Hours Lost	Covid + WTE	Long Covid + Cases
6.66%	2,835	17.07	6

Absence Reason
Coronavirus
Coronavirus ? Covid 19 Positive
Coronavirus ? Household Related ? Self Isolating
Coronavirus ? Long Covid
Coronavirus ? Quarantine
Coronavirus ? Self displaying sympt

% Absence (Covid and SIck Leave)



WTE Lost to Special Leave

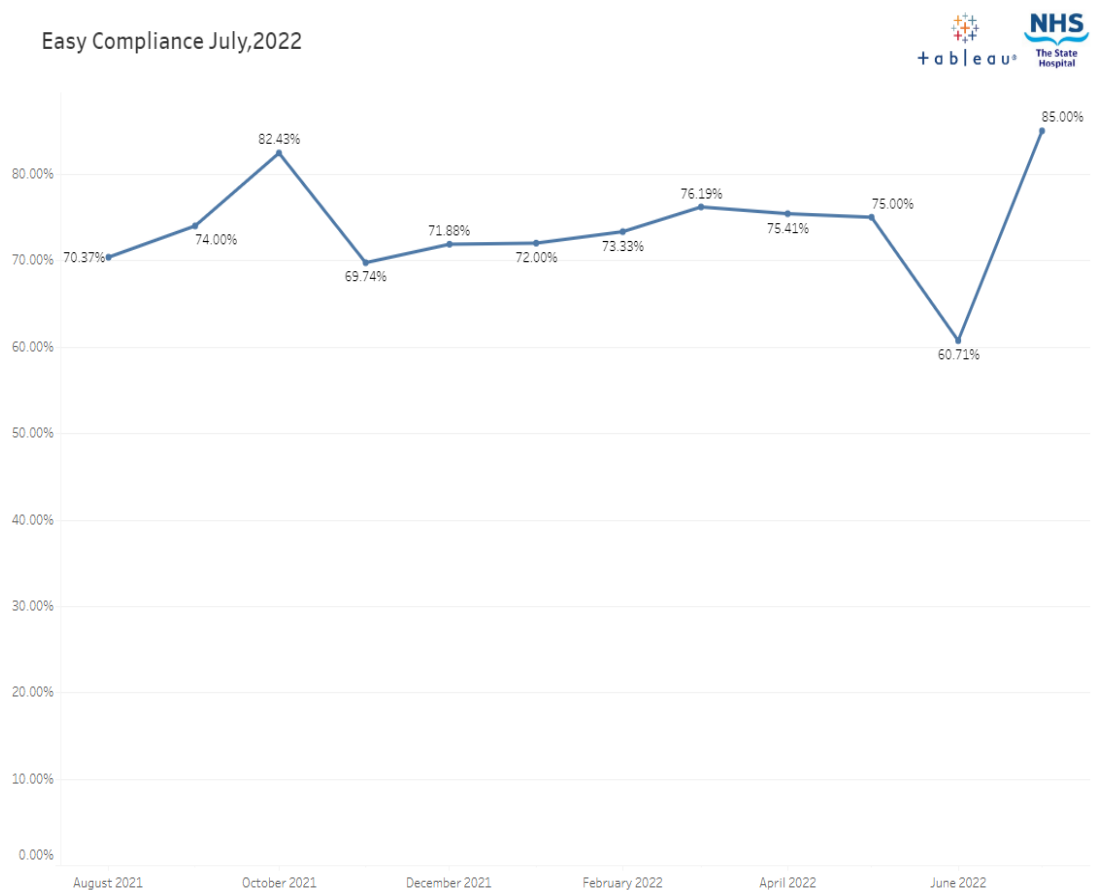


Occupational Health - EASY Compliance

Date Parameter

July, 2022

		Total Staff	Sickness Total	Referred To Easy	% Referred
2021	August	685.0	54.0	38.0	70.37%
	September	686.0	50.0	37.0	74.00%
	October	684.0	74.0	61.0	82.43%
	November	684.0	76.0	53.0	69.74%
	December	683.0	64.0	46.0	71.88%
2022	January	682.0	50.0	36.0	72.00%
	February	682.0	30.0	22.0	73.33%
	March	684.0	63.0	48.0	76.19%
	April	675.0	61.0	46.0	75.41%
	May	676.0	76.0	57.0	75.00%
	June	669.0	56.0	34.0	60.71%
	July	678.0	60.0	51.0	85.00%



Occupational Health – Appointment Information

Management Referrals

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Number received	15	8	9									
Average days – received to 1st Apt	8.3	5.9	3.0									
***Average days – Received to report sent**	11.1	6.5	7									

*KPI is 15 working days from referral to report issued

Self Referrals

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
1st attended	1	4	2									

Attendance by Clinician

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
OHP	7	9	5									
OHA	16	25	19									
Physiotherapist	36	29	9									

Recruitment – July 2022

Posts in Recruitment Process

Job Family	Calendar YTD		Current Month	
	No of Adverts	No of Positions	No of Adverts	No of Positions
Administrative Services	10	10	2	2
Allied Health Professions	4	4	3	3
Executive Level	1	1	0	0
Medical and Dental	2	2	1	1
Nursing and Midwifery	21	51	2	7
Other Therapeutic	6	6	1	1
Support Services	13	18	1	1
Total	57	92	9	14

Unconditional Offers Issued with Start Date

Job Title	Start Date
Staff Nurse x 10	03/10/2022
Senior Charge Nurse	22/08/2022
Occupational Therapist	01/08/2022

Provisional Offers Issued with Start Date

Job Title	Start Date
Human Resources Assistant	19/09/2022
Practitioner (Health) Psychologist	10/10/2022
eHealth Project Support and Intranet Content Officer	08/08/2022

National KPI (days)

Job Approval to Live	Advert live to Closing Date	Closing Date to Shortlisting Complete	Shortlisting Complete to Invite to Interview	Invite to Interview to Interview	Interview to interview complete	Interview complete to Conditional Offer	Conditional Offer to Pre-Checks complete	Pre-Checks Complete to Contract Issued	Contract Issued to Start Date	Approved to Contract Issued	Approval to Start Date
2	10	5	3	7	2	2	20	2	20	55	75

TSH – Month Average for Start date in Month

Job Approval to Live	Advert live to Closing Date	Closing Date to Shortlisting Complete	Shortlisting Complete to Invite to Interview	Invite to Interview to Interview	Interview to interview complete	Interview complete to Conditional Offer	Conditional Offer to Pre-Checks complete	Pre-Checks Complete to Contract Issued	Contract Issued to Start Date	Approved to Contract Issued	Approval to Start Date
1	17	6	6	10	7	6	37	7	38	92	127

Responsibility Key:

- HR
- Recruiting Manager
- Outwith TSH

Annual Leave, Overtime and Excess

Month
July, 2022

Rosters
(Multiple values)

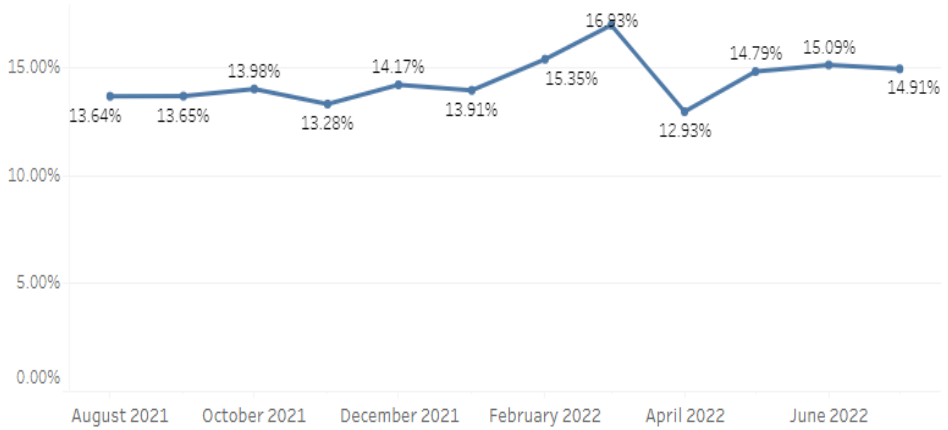
Annual Leave, Overtime and Excess

July 2022

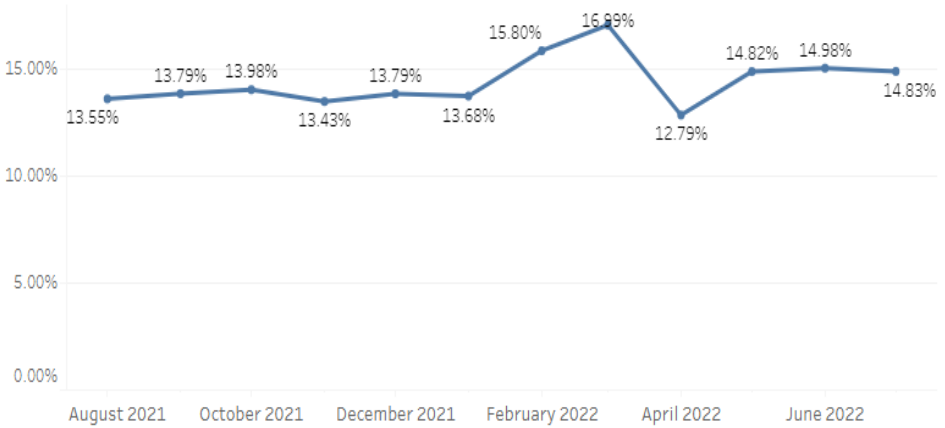
Hours Used

To Meet Clinical Demand	44,195
No Reason Selected	8,381
Linked To Absence	8,243
Coronavirus	2,628
Escort Duties	2,228
Special A patient	986
Other	552
Hospital cover	522
To Meet Workload Demand	477
Unknown - due to absence deletion	351
Linked to Absence - Bank Allocated	334
To Meet Managerial Requirements	313
To Adjust Skill Mix	146
Constant Observations	135
Coronavirus Test and Protect	83
Routine Additional Hours	45
Rota Gap	39
Coronavirus Vaccination	34
Mand training ? Manag of Aggression	12
Ambulance Service Extended Duty	11
Mandatory Training	7
Mand Training - Nursing Skills	5
Late cancellation	4
Immunisation Programme	1
Grand Total	69,733

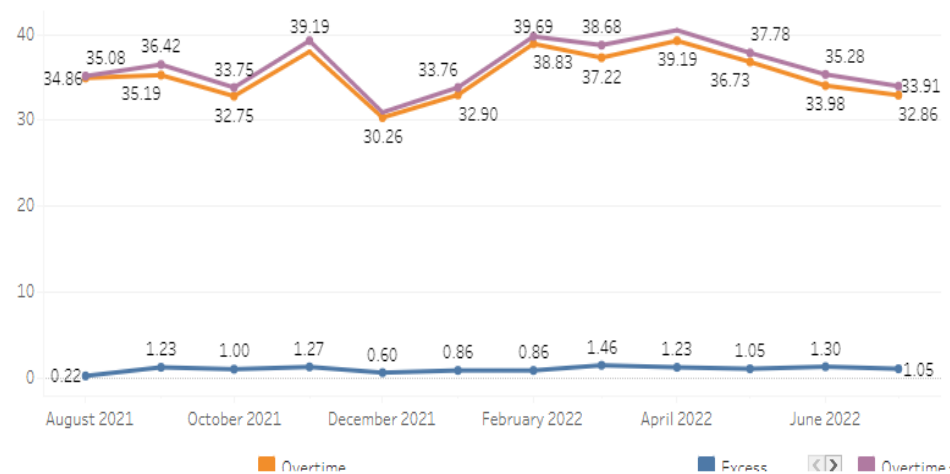
Annual Leave - Hospital



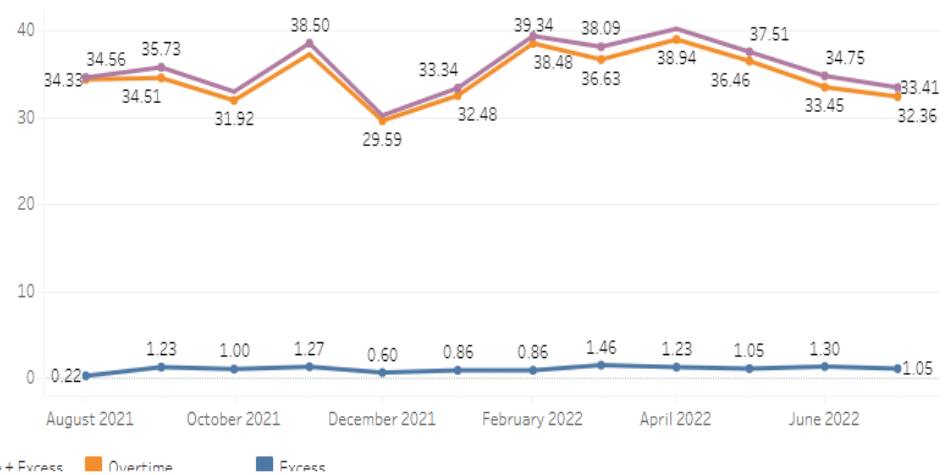
Annual Leave - Wards Only



Supplementary Hours As WTE - Hospital



Supplementary Hours As WTE - Wards Only



ER Case Management – July 2022

ER Casework

New ER Cases 2022/23												
	April	May	June	July	August	September	October	November	December	January	February	March
Capability- informal	0	0	1	0								
Capability - formal	0	0	0	0								
Conduct - informal	0	0	2	0								
Conduct - formal	1	0	0	1								
Bullying & Harassment - informal	0	0	0	0								
Bullying & Harassment - formal	0	1	1	0								
Grievance- informal	0	0	1	0								
Grievance - formal	0	0	0	0								
Whistleblowing	0	0	0	0								
Total	1	1	5	1	0	0	0	0	0	0	0	0

ER Casework – timescales

Ongoing ER Case Work					
	<1 month	1-3 months	3-6 months	6+ months	Total
Capability - formal	0	0	0	0	0
Conduct - formal	1	0	1	0	2
Bullying & Harassment - formal	0	2	1	0	3
Grievance - formal	0	0	0	*1	1
Whistleblowing	0	0	0	0	0

*Ongoing Grievance – guidance now received from STAC, will proceed to conclusion

Attendance Management

Active Monitoring	Feb	Mar	Apr	May	June	July	Grand Total
2022							
Stage One	2	6	16	8	3	3	38
Stage Two	1			1			2
Grand Total	**3**	**6**	**16**	**9**	**3**	**3**	**40**

Staff actively being monitored from effective date of monitoring

Workforce Establishment Figures – July 2022

NURSING DIRECTORATE (Wards)

Band	Establishment	Actual	Variance
Band 7	12.00	11.00	1.00
Band 6	30.00	26.00	4.00
Band 5	133.40	115.20	18.20
Band 4	14.00	14.00	0.00
Band 3	103.60	99.40	4.20
Supplementary staff	0.00	12.80	-12.80
Total	293.00	279.40	14.60

FINANCE DIRECTORATE

Band	Establishment	Actual	Variance
Band 8C	1.00	1.00	0.00
Band 8B	2.00	2.00	0.00
Band 8A	1.60	1.60	0.00
Band 7	4.60	4.60	0.00
Band 6	7.00	6.85	0.15
Band 5	3.00	3.00	0.00
Band 4	4.00	3.00	1.00
Band 3	8.56	9.36	-0.80
Total	31.76	31.41	0.35

CHIEF EXECUTIVE

Band	Establishment	Actual	Variance
SM 6	1.00	1.00	0.00
EM D	0.75	0.75	0.00
EM C	2.00	2.00	0.00
E 4	1.00	1.00	0.00
BAND 8C	1.00	1.00	0.00
BAND 8A	1.00	1.00	0.00
BAND 7	1.00	1.00	0.00
BAND 5	3.00	3.00	0.00
BAND 4	0.60	0.60	0.00
A & C	6.00	5.00	1.00
Total	**17.35**	**16.35**	**1.00**

NURSING DIRECTORATE (Other)

Band	Establishment	Actual	Variance
Band 8D	2.00	2.00	0.00
Band 8C	4.00	3.70	0.30
Band 8B	3.93	3.93	0.00
Band 8A	10.01	9.01	1.00
Band 7	12.58	11.78	0.80
Band 6	19.00	15.80	3.20
Band 5	23.20	21.93	1.27
Band 4	27.18	23.25	3.93
Band 3	15.41	14.79	0.62
Total	117.31	106.19	11.12

HR Directorate

Band	Establishment	Actual	Variance
Band 8A	2.90	2.50	0.40
Band 7	1.00	1.00	0.00
Band 6	1.50	3.50	-2.00
Band 5	5.30	2.75	2.55
Band 4	3.00	3.00	0.00
Band 3	1.49	1.00	0.49
Total	15.19	13.75	1.44

TOTAL COMBINED VACANCIES BY GRADE

Band	Establishment	Actual	Variance
Band 8D	2.00	2.00	0.00
Band 8C	7.90	7.60	0.30
Band 8B	8.93	8.93	0.00
Band 8A	18.01	16.61	1.40
Band 7	36.68	37.13	-0.45
Band 6	65.62	60.27	5.35
Band 5	175.40	153.38	22.02
Band 4	59.49	50.19	9.30
Band 3	172.52	168.61	3.91
Band 2	49.76	46.50	3.26
SM 6	1.00	1.00	0.00
EM D	0.75	0.75	0.00
EM C	2.00	2.00	0.00
E 4	1.00	1.00	0.00
Med Consult	8.70	8.70	0.00
Med Spec Dr	3.00	3.00	0.00

SECURITY DIRECTORATE

Band	Establishment	Actual	Variance
Band 8C	2.40	2.40	0.00
Band 8B	2.00	2.00	0.00
Band 7	5.50	5.50	0.00
Band 6	6.12	6.12	0.00
Band 5	7.00	7.00	0.00
Band 4	7.94	6.94	1.00
Band 3	43.46	43.06	0.40
Band 2	49.76	46.50	3.26
Total	124.18	119.52	4.66

MEDICAL DIRECTORATE

Band	Establishment	Actual	Variance
Band 8C	0.50	0.50	0.00
Band 8B	1.00	1.00	0.00
Band 8A	2.50	2.50	0.00
Band 6	2.00	2.00	0.00
Band 5	0.50	0.50	0.00
Band 4	3.37	3.37	0.00
Med Consult	8.70	8.70	0.00
Med Spec Dr	3.00	3.00	0.00
Total	21.57	21.57	0.00

Workforce Turnover

Date Parameter
July, 2022

Workforce Turnover July,2022

Month Turnover %	Month WTE	Month Number of Staff	Financial Year Turnover %	Financial Year WTE	Financial Year Number of Staff
0.85%	4.93	8	3.13%	18.2	26

Reason for Leaving - July,2022

End of FTC	2
New Employment with NHS Scotland	2
Other	2
Vol. Resignation - Other	1
Vol. Resignation - Promotion	1
Grand Total	8

Leavers Length of Service - July,2022

Null	1
0-1 Year	4
1-3 Years	3
3-5 Years	1
Grand Total	9

Leavers Division - July,2022

Human Resources (Div)	1
Nursing & AHP (Div)	6
Security (Div)	1
Grand Total	8

Reason for Leaving - Financial Year

End of FTC	3
New Employment with NHS Scotland	8
Other	11
Retirement - Age	1
Retirement Other	1
Vol. Resignation - Other	1
Vol. Resignation - Promotion	1
Grand Total	26

Leavers Length of Service - Financial Year

0-1 Year	8
1-3 Years	8
3-5 Years	3
5-10 Years	2
10 + Years	5
Grand Total	26

Leavers Division - Financial Year

Chief Executive (Div)	1
Human Resources (Div)	2
Medical (Div)	1
Nursing & AHP (Div)	18
Security (Div)	4
Grand Total	26

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 18
Sponsoring Director:	Director of Workforce
Author(s):	Head of HR
Title of Report:	Whistleblowing Update
Purpose of Report:	For Noting

1 SITUATION

As part of the Whistleblowing Standard, a quarterly update is being provided to the Board on the current situation with any outstanding Whistleblowing Investigations.

2 BACKGROUND

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

3 ASSESSMENT

The State Hospital fully launched the Whistleblowing Standards and the National Policy. A key requirement of the revised standards is notification of case incidence to the Board and Staff Governance Committee.

This is Quarter 1 update for 1st April 2022 to 30th June 2022. No Whistleblowing cases were raised during this quarter.

An action plan has been developed to further improve understanding, awareness and process in relation to the Whistleblowing Standards. The action plan is attached as Appendix 1.

The Board has invited the INWO to attend a board seminar in September 2022, as part of a development session.

4 RECOMMENDATION

The Board 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.	Staff Governance Committee
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.

Whistleblowing Action Plan

	Measure	Action	Progress	Lead	Closed
1.	All staff who are likely to receive Whistleblowing concerns such as Managers and Confidential Contacts should complete both modules of the TURAS training programme in addition to familiarising themselves with the details of the National Whistleblowing Standards, April 2021.	Agreement required that TURAS Whistleblowing Module is mandatory for all & Manager's module is mandatory for all managers Comms to be developed advising staff of policy and training	Approximately 60% of the workforce have completed an introductory module. Further work is required to promote this and increase completion levels Comms to be developed and issued	LD AB	
2.	Confidential Contacts should be recruited and fully trained	Identify current contacts and advertise names The individuals should not be involved in ER casework Display confidential contact names on intranet with clear guidance on their remit	TSH currently has one confidential whistleblowing contact, an individual within the HR team. Consideration is currently being given to changing this role to Speak Up Ambassador and identifying an individual/individuals to take on this role, as well as other individuals within the organisation who would carry out the role of Speak Up Advocate. Consideration is also being given to a shared resource across boards to ensure confidentiality Advertising campaign to be progressed to recruit advocates	LD/AB AB	
3.	The identity and roles of the Non-Executive Whistleblowing Champion and the Director with specific responsibility for Whistleblowing should be	Recruit non-executive whistleblowing champion	Work is ongoing nationally to recruit to this post. As an interim position, all non-executive directors are available to discuss any whistleblowing concerns.	Scottish Government	

	promoted more widely throughout The State Hospital				
4.	A Whistleblowing Liaison Officer should be designated with specific responsibility for the introduction of the Standards across the organisation, in addition to the recording, reporting and monitoring of cases.	Individual(s) to be identified who will work with Non-Executive Champion. This role should sit outwith HR and separate to individuals that concerns are raised with The WLO works with the Non-Executive Champion to establish if a concern falls under whistleblowing, and then arranges the admin/correspondence with the individual.	ER activity tracker is set up to record all stage 1 and stage 2 whistleblowing cases. The WLO works with the Non-Executive Champion to establish if a concern falls under whistleblowing, and then arranges the admin/correspondence with the individual. Once this individual is identified, they will record this information and provide to HR on an monthly basis, as well as providing quarterly updates to Staff Governance	AB TBA	
5.	An internal Operating Procedure should be developed and implemented which would provide clarity regarding how a Whistleblowing complaint will be dealt with from initial receipt until the closure of a case, the sharing of lessons learned and service improvements made as a result of a concern being raised. The internal Operating Procedure should also outline a process for distinguishing between a Whistleblowing complaint and other HR concerns such as Bullying & Harassment and Grievances and should address issues such as anonymity, confidentiality and ongoing feedback and communication	Internal SOP for HR/managers working with process to be developed, including template letters Page on intranet to be developed including contact details, how to raise concerns and summary of key points of Whistleblowing Standard	SOP/Guidance Document is currently in development and will be approved via Partnership Forum Once additional staffing resource has been recruited to the Comms team, the page will be developed	AB AB	

	whilst a case is being investigated				
6.	Sources of support for both Whistleblowers and others who may be implicated or involved in complaints, such as witnesses, should be established.	Support document to be developed	Support document developed within Wellbeing Service which will be available for all staff	LD	
7.	A Communication Plan aimed at raising awareness of the Standards should be developed and implemented.	Develop action plan with regular communications reminding staff about this.	Comms to be generate to advertise training, standards, contacts National Speak Up Week (3-7 October) to be utilised to create awareness	AB/Comms TBA	
8.	A culture where complaints and concerns are encouraged and welcomed by management should be developed		Regular comms to be issued	AB/Comms	

THE STATE HOSPITALS BOARD FOR SCOTLAND
STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held on Thursday 19 May 2022 at 9.45am via MS Teams. **SG(M) 22/02**

Chair:	
Non-Executive Director	Pam Radage
Present:	
Non-Executive Director	Stuart Currie
Non-Executive Director	Cathy Fallon
In attendance:	
Head of HR	Audrey Bevan
Training & Development Team	Lynn Clarke
Director of Workforce	Linda Davidson
Chief Executive	Gary Jenkins
Head of Planning & Performance	Monica Merson
Board Chair	Brian Moore
Board Secretary	Margaret Smith

1 APOLOGIES FOR ABSENCE AND INTRODUCTORY REMARKS

Ms Radage welcomed everyone to the meeting, noting formal apologies from Mr Allan Connor, Employee Director. It was also noted that Ms Dunlop could not be in attendance but that Ms Clarke had joined the meeting in her place. It was also noted that Mr Alan Blackwood, Staff Side Representative could not be in attendance.

2 CONFLICTS OF INTEREST

There were no conflicts of interest noted.

3 MINUTES OF THE PREVIOUS MEETING HELD ON 18 NOVEMBER 2021

The Committee approved the Minutes of the previous meeting held on 17 February 2022 as an accurate record of the meeting.

4 ACTION POINTS AND MATTERS ARISING FROM THE PREVIOUS MEETING

The Committee noted the action list, and the progress made in this respect. Ms Davidson provided an update in respect of the work being progressed to help provide further support to staff in relation to sickness absence. This was focused on detailed analysis of patterns of absence and the additional learning that could be taken from this. Further reporting would be brought back to this Committee by way of the standing item for attendance management.

STANDING ITEMS

5 ATTENDANCE MANAGEMENT REPORT

The Committee received the report which summarised the positon to 31 March 2022. Ms Davidson provided an overview of the report, and emphasised the improved position on sickness absence. She was able to provide an updated figure for April 2022, at 4.55%. This represented the lowest absence rate for the hospital compared across the past six years. Picking up on her update in respect to the analytical work being progressed around this data, she advised that this would help to keep focus on how best to support staff, including how this could be delivered through the Occupational Health Service. As part of this, the Head of HR was developing new ways of reporting workforce data through business tableau to provide contemporaneous data. An example of this work was included within the report. As part of her update, Ms Davidson also highlighted the decrease in compliance for EASY, and the actions taken to discover why this was the case.

Ms Radage thanked Ms Davidson for her summary, and opened the discussion. Mr Currie noted that whilst it may not always be directly relevant to compare attendance management data for The State Hospital(TSH) with territorial boards; that the national comparator was still useful. He noted the difficulty of identifying the most helpful actions to take to support staff, especially for long-term absences. He added that the tableau dashboard was a helpful addition to reporting. Ms Davidson provided further background on the work focused on long term absences, including links made with the Disability Forum.

Ms Fallon agreed that the changes to the report were helpful, and sought clarification on how training was being reported in comparison to the separate reporting on today's agenda on Statutory and Mandatory training. Ms Davidson advised that this reporting was in relation to dedicated training on how to manage attendance to support line managers. Mr Jenkins noted that there had been specific focus in the past three-month period on the delivery of Prevention and Management of Violence (PMVA) and Soft Restraint Kit (SRK) Training for frontline staff with significant progress made on this. There would now be wider focus on all areas of training delivery.

Mr Jenkins also added that following discussion at the recent Corporate Management Team (CMT) Development Day, a dynamic outreach approach was being taken in respect of providing wellbeing support to all staff. This entailed a targeted approach to make sure all staff could access services, including frontline staff.

Mr Currie also noted the rates of Covid-19 infection reported, and Mr Jenkins agreed that this reflected the increased rates of community transmission, and that given the expectation that covid rates may peak again in cycles, the CMT were reviewing the organisation's approach in respect of this and how to live with Covid-19 in the future. This would ensure that robust processes were embedded. He also followed up the point on support for staff returning after long-term absence with opportunities for staff for possible redeployment being actively explored.

Ms Radage summarised the discussion for the Committee, and the encouraging picture that reporting presented. She noted the good work being taken forward by the Workforce Directorate as well as the lessons being taken from across NHS Scotland.

The Committee noted the report.

6 HUMAN RESOURCES PERFORMANCE – EMPLOYEE RELATIONS ACTIVITY

The Committee received the Employee Relations Activity Report to 30 April 2022. Ms Davidson provided a summary of the key points of the report. Ms Radage thanked Ms Davidson for her summary and opened the discussion.

Mr Currie commented that taking a comparator to other NHS Boards, the number of cases raised through HR policies (e.g. Bullying and Harassment Policy) appeared low. He noted the large number of cases at stage 1, and the way the trigger point for this was met. In response, Ms Davidson advised that it was essential to ensure line managers were trained to recognise the trigger points and that this was being progressed by the HR team.

Ms Bevan noted that in terms of ER activity this report only recorded formal cases, and it was agreed that informal cases should also be reported in the future.

Action – Ms Davidson/ Ms Bevan

In respect of the low rates of cases being raised through HR policy, Ms Fallon underlined the importance of making sure staff had confidence in the process. Ms Davidson noted the training and support offered to line managers as well as the positives links made by HR contacts with teams across the organisation. She added that this was being developed alongside the positive relationship that the HR team had with partnership colleagues. Ms Radage agreed with the importance of this and that managers should encourage staff to come forward to raise concerns, and take an inclusive approach. Mr Jenkins also advised that CMT had led a recent exercise on reconsidering the Sturrock and Strang reports published in 2019, prior to the pandemic, to consider organisational culture and how to move forward. This was rolled out by Directors across all teams to provide a feedback loop for all staff and to help build confidence.

The committee noted the report.

7 PERSONAL DEVELOPMENT PLAN REPORT

The Committee received the Personal Development Planning & Review (PDPR) report which reported to the end of April 2022. Ms Davidson provided a summary, noting that the rate of compliance had increases slightly to 79.2%. Ms Radage thanked Ms Davidson for her report and opened the discussion.

Ms Fallon asked if the Covid-19 pandemic was continuing to impact the rate of compliance, and noted that it would be useful to see a comparator figure to rates of compliance prior to 2020. This was agreed as a helpful addition to reporting.

Action – Ms Davidson

Ms Radage asked if it would be possible to separate out the figure for employees newly started in the organisation to give a more accurate figure for compliance, and it was agreed that Ms Davidson would take this forward.

Action – Ms Davidson

The committee noted the report.

8 WHISTLEBLOWING QUARTERLY REPORT

The Committee received the Whistleblowing report for the final quarter of 2021/22, and Ms Davidson summarised the position especially around the action plan for learning and improvement which would be reported back to this Committee.

Mr Moore provided an update on recruitment to the role of Non-Executive Whistleblowing Champion, through Public Appointments. Further advice on timescales was currently awaited. He also noted the need to publish an Annual Report for 2021/22 by the end of June 2022. The

Committee noted that a development session had been organised for the Board with the Independent National Whistleblowing Officer (INWO) service for September 2022. This would be especially helpful to gain insight and learning on the particular challenges for a small NHS Board. This session along with the appointment of a Non-Executive Whistleblowing Champion would help to inform the way that whistleblowing standards were being implemented within TSH, including directorate leadership. Ms Radage and Mr Currie agreed that it would be beneficial to change this from being led from within HR given that the HR team may have a separate role in taking forward actions. It was agreed that a comparison should be made with other smaller NHS Boards to see how the standards were implemented there. Further, this should consider the possibility of collaborative working with another NHS Board to resource investigations and give assurance on impartiality in the delivery of these.

Action – Ms Davidson

The committee noted the report and update provided.

ITEMS FOR DISCUSSION

9 STAFF GOVERNANCE COMMITTEE ANNUAL REPORT 2021/22

The Committee received the draft Annual Report for the year 2021/22 and Members discussed the content in terms of representing the work of the Committee during this period.

Mr Currie thought the report did present this work well, and also added that it had been remarkably positive that the Committee work had been able to continue throughout such a challenging time due to the pandemic situation. The report should also be taken to demonstrate the strong partnership working being evidenced. Mr Moore also noted the need for the Committee to reflect the changes in culture within the organisation, and the focus on building staff confidence in bringing concerns.

Ms Fallon noted the good work in achieving a Healthy Working Lives Gold Award, and also asked if the Committee could review how it measured its own performance. Ms Smith advised that she could prepare and circulate a self-assessment tool for members to help with that, and it was agreed that this would be helpful. This action should also be added to the Corporate Governance Improvement Action Plan.

Action – Ms Smith

The Committee asked that the report be updated with the suggested changes.

Action – Ms Davidson

10 STATUTORY AND MANDATORY TRAINING COMPLIANCE REPORT

The Committee received the report which provided an update in respect of compliance levels for statutory and mandatory training to 31 March 2022.

Ms Davidson provided a summary of the report, highlighting the progress made for PMVA and SRK training. Mr Jenkins added his thanks to Ms Clarke and her team for the excellent progress made in this respect. Ms Clarke also outlined planning in place to continue to focus on this area.

The Committee were content with the approach taken, and noted the report.

11 STAFF AND VOLUNTEER WELLBEING STRATEGY/ACTION PLANS 2022-2024

The Committee received a report in this respect to provide an update on the progress made and to outline the related actions plans. This item will become a standing item for each meeting of this Committee, as well as an update being provided to the Board directly twice a year. Ms Radage noted that this strategy was now actively being implemented and opened the discussion.

Ms Fallon asked about how accessible the Staff Wellbeing Centre resources and clubs were for all staff, and Ms Davidson noted that although the Centre was well attended, it had been recognised that front-line staff in particular may find direct access more difficult due to the nature of their roles. Therefore, mini-hubs were being set up across the site alongside outreach work into teams and departments. This work was being developed and the Committee would be kept updated in this regard as part of regular reporting.

Mr Currie noted the need to take forward initiatives that would be the most impactful and demonstrate the best use of resources. Ms Davidson advised that the HR and Wellbeing Group were actively developing ideas with staff groups.

Ms Fallon also asked about how to set Key Performance Indicators (KPIs) to measure performance, and Ms Davidson referenced benchmarking to other Boards in this regard to establish meaningful KPIs.

Ms Radage summarised the discussion for the Committee, and underlined the importance of prioritising wellbeing now becoming part of usual business, rather than a one–off initiative.

The Committee noted the report.

12 FITNESS TO PRACTICE REPORT

The Committee received a report which confirmed the the process for monitoring professional registration status for all staff for whom professional registration is a statutory requirement for employment. The report provided assurance to the Committee that all members of staff hold current professional registration as appropriate. This report had previously been submitted to the Clinical Governance Committee.

The Committee were content to note the report.

ITEMS FOR INFORMATION

13 APPROVED MINUTES FROM PARTNERSHIP FORUM

The Committee received and noted the approved minutes from the meeting that took place on 22 March 2022.

14 APPROVED MINUTES FROM HR AND WELLBEING GROUP FROM

The Committee received the approved minutes from the meeting that took place on 8 March 2022.

Ms Fallon asked if a report could be requested form the newly appointed Staff Care Specialist, on her findings and any progress to date. This was agreed and should be scheduled for a meeting of the Committee this year.

Action – Ms Davidson

Ms Fallon also asked for assurance around changing facilities for ward staff and Ms Davidson advised that this had been a local challenge and actions had been taken to increase locker availability as required.

15 ANY OTHER BUSINESS

There were no other items of competent business for the Committee to consider.

16 DATE AND TIME OF NEXT MEETING

The next meeting will take place on **Thursday 18 August 2022 at 9.45am via MS Teams**.

The meeting ended at 11:25am

Paper No. 22/74

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 20
Sponsoring Director:	Chief Executive
Author(s):	Board Secretary
Title of Report:	Corporate Governance Improvement Action Plan
Purpose of Report:	For Decision

1 SITUATION

This report provides an update on The State Hospital (TSH) Corporate Governance Improvement Actions Plan to support the key corporate governance priorities as part of the NHS Scotland Blueprint for Good Governance.

This workstream has necessarily been paused at times as part of The State Hospital's resilience response, during the pandemic experience of the past two years. However, work is progressing across a range of workstreams encapsulated in the plan, and a summary is set out herein.

This improvement plan is based on the findings of a Board self-assessment conducted in 2018, and there is an expectation that national guidance will be provided on taking forward further assessment to help the Board evaluate its key priorities. The plan should remain dynamic and some new items have been added to it, including key areas highlighted by the Minister for Mental Wellbeing and Social care at the Ministerial review that took place on 5 April 2022.

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.

Further consideration can be given to the following:

Item 1	Effective rostering within the nursing directorate
Item 2	Added following Ministerial Review – Patients Physical Health
Item 3	Added following Ministerial Review – NI patients
Item 4	Review of the performance metrics framework
Item 5	Self-assessments for committees
Item 6	Communications Strategy
Item 7	Encourage public/carers/ staff to attend board meetings
Item 8	External locations for (in person) Board meetings

3 ASSESSMENT

Item 1 – Effective rostering within the nursing directorate:

Safe staffing legislation and associated monitoring tools for NHS Boards to use for self-assessment and reporting remain paused to date.

The Director of Nursing and Operations continues to lead work on effective nurse staffing and rostering, leading a Short Life Working Group which is being taken forward in partnership with staff-side colleagues. The 5/7 shift pattern continues to be reviewed, particularly around best practice for shift handovers alongside the existing rota pattern. Progress has been made with the Supplementary Staffing Register (SSR) with the ending of the offer of fixed-term contracts for staff returning to work following retirement. Offers have been made for staff to join the SSR, and the opportunity to do so has been welcomed to date given the additional flexibility this can give. Feedback has included staff stating that they may be willing to remain on the register for a longer period of time due to this additional flexibility.

The Board is asked to note these developments and the positive impact this may have on the recruitment offer that TSH can make to attract nursing staff to the organisation. This was noted at the Ministerial Annual Review on 5 April 2022, and will remain on this action plan as a key area of development.

Item 2 - Supporting Healthy Choices

The Minister highlighted this as a key area of improvement for patients' physical health as part of the Ministerial Annual review in April 2022. The Board is asked if it would like to use this mechanism to help track progress in this respect, with dedicated reporting included in today's agenda.

Item 3 - Northern Ireland funding

The Minister highlighted this as a key area for clarification following liaison with NHS National Services.

A meeting took place between the Director of Finance and EHealth, and Tracey McCaig (Director of Finance – NI DoH Strategic Planning and Performance Group and Public Health Agency) in relation to charging for patients from Northern Ireland.

She was understanding of what we are looking to raise with them, and the reasons behind this, and will have discussions with her own colleagues regarding the background of NI policy and knowledge of social care placings.

She is not aware of any paperwork in place historically re the current arrangement between TSH and NI, but thinks there may be something in their legislation, so is going to look into this before the next meeting on September.

Item 4 – Review of the performance metrics framework:

The Board has received newly formatted reporting in the past year, as well as participating in a dedicated development session on 3 May 2022 led by the Board Development team at NHS Education for Scotland. This enabled wider consideration of how to best use data reporting to inform effective governance.

The Head of Planning and Performance has confirmed that work progresses to make amendments to reporting to the Board as a result. The Board is invited to note that quarterly performance review meetings have been introduced led by the Chief Executive with each Director. This will include performance against the Annual Operating Plan, review of the directorate workforce and financial position, and any emerging issues.

The NES Board Development Team have asked the Board to complete a further self- assessment survey on progress to date, and the Board is asked to feedback at this meeting with respect to Board and Committee meetings that have taken place in the past quarter, so that the Board Secretary can respond.

This includes suggestions to take forward:

- Use of Board Development Turas Learn
- Development of a Board Assurance Framework document
- Refreshed Corporate Risk Register
- Assurances sought from Committee Chairs for their Committee
- Improvement of data charts in reporting
- Made changes to Board and Committee papers (aligning data and narrative)
- Considered system level assurance (with partner assurance requirements)

The Board Development Team have asked the Board to consider what barriers remain in place and what further support may be required e.g. from NES Board Development/ Turas resources or further training and development opportunities.

The Board is asked to consider its position and discuss what further actions may be required for reporting to both the Board and its Committees to further improve assurance reporting.

Item 5 - Self-Assessment for Committees

The Staff Governance Committee asked for a self-assessment tool to help measure its effectiveness. This will be taken forward by the Board Secretary, and it is suggested that the Clinical Governance Committee is provided with this. The Audit Committee already completes this annually, and this will be taken forward again this year.

Item 6 - Communications Strategy

The Board has been focused on promoting the excellence of care provided within TSH, and helping to support greater public understanding of forensic mental health care. TSH has promoted this strategy through release of a range of short films featuring key staff from clinical disciplines, describing the care delivered to our patients, and these were promoted through the use of social media. In June 2022, the Board agreed a strategy for further service transformation, with further recruitment being made to this area. It should also be noted that the need for website upgrade was highlighted at the Ministerial Annual Review on 5 April 2022, and this has been progressed speedily.

The Board has requested dedicated progress reporting in this area at every second meeting, with the next update due in October 2022. The Board is asked to consider closing this item on this action plan, given the structured nature of reporting now in place.

Items 7 and 8 - Public Board Meetings

Prior to the pandemic, the Board had been considering how to encourage wider attendance at its meeting, including the public, and this was linked to holding meetings outwith the hospital site. There has followed a period of meetings being held on a digital platform, due to restrictions and community infection. This brought an unexpected potential benefit as this format may help to support greater public accessibility, especially as a National Board serving patients in both Scotland and Northern Ireland.

The Board planned to re-consider this position in 2022, taking into account the lessons learned through the pandemic rather than moving back to the previous position of holding Board (and Committee) meetings in person as was the case prior to the pandemic. Further, to take into account practice as it has been developing across the wider NHS Scotland.

The options available include a return to face to face meetings, remaining on MS Teams as a virtual platform or a hybrid system whereby access can be in person or virtually. For completeness this should be considered for both Board and Committee meetings as well as for development sessions.

Benchmarking to other Boards has been conducted through the Board Secretaries Group, and some themes are emerging. Firstly, the clear majority of committee meeting remain on MS Teams, though a few Boards are offering Committee Chairs discretion to take these forward in person should they identify additional value in doing so.

The majority of public NHS Board sessions remain virtual, although some Boards have already or are planning to move to use a hybrid version. The functionality of this, especially for equality of access to the meeting for all participants is being tested and is under active discussion as this new way of working is being used. There are a variety of approaches, and early indication that success may depend on the balance of numbers attending in person as opposed to virtually. The fewer attending virtually was found easier, and some Boards have offered this to those who cannot travel or may be self-isolating. A Meeting Owl device is the most preferred way of supporting this functionality. The eHealth team at TSH have confirmed that additional equipment should not be required as the existing technology installed in the boardroom at TSH will already support this. At the same time, upwards of 20 people can be involved in a public session, and consideration would need to be given to an increased number meeting within the boardroom.

A move back to in person meetings has been paused or delayed for those Boards who have wished to move back to this, with some Boards seeking larger facilities to hold the meetings. The recent cycle of community infection has seen a further delay in taking this forward.

An alternative to hybrid meetings has been suggested – in alternating in person and virtual meetings on a cycle, thought the difficulty with that may be timing in terms of period of community upsurges.

There has been a theme of Boards agreeing that virtual meetings seem to better support public attendances, especially for national boards. Members of the public join as observer only guests to MS Teams. There continues to be little uptake of recording or live streaming public sessions though this is the practice in two Boards. TSH does not generally experience much public interest in joining the public sessions.

For development sessions, there is an increased appetite among Boards to try and progress these for in person meetings given the more informal nature of these meetings. Similar barriers have been found – in the need to secure off-site accommodation rather than existing meeting settings; as well as sessions having to be paused or cancelled due to the recent increase in community infections.

Summary:

The options available to the Board have been outlined, and these are presented in the context of the continuing risk of cyclical increases in Covid-19 infections in the community.

It would be in keeping with practice across NHS Scotland for Committee meetings to continue virtually until Spring 2023, wherein the position can be reviewed.

Most Boards continue to offer virtual meetings either in whole or in part as a hybrid model. At TSH this can be tested for functionality within the TSH boardroom. If the Board prefers to move to in person meetings, then consideration could be given to an off-site location to support this. Planning for 2023 meetings could support alternating virtual and in person meetings.

The next Board Development Session – already arranged with attendance form the SPSO Whistleblowing team will take place via MS Teams. Internal auditors RSM are arranging an in person session on risk in October 2022. The following development session in November could be arranged in person, possibly at a suitable off-site location.

4 RECOMMENDATION

The Board is asked to note the updates in relation to each item, and to provide a view on:

- Performance reporting
- Self-assessments for all committees
- Close communications action as reporting included in workplan
- Discuss and provide guidance for supporting Board, Committee and Development Sessions.

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 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 - IMPROVEMENT PLAN **Appendix A**

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION	1	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 Board Update**	**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. **Update December 2021:** Safe Staffing legislation/reporting paused. Reporting on staffing impacts in nursing embedded into fora (Clinical Governance Committee/ OMT/ Partnership Forum. Rostering masterclass delivered to SCNs with support from national safe staffing team. Agreed to test a nationally agreed safe staffing readiness self-assessment template, which will be available to us in December 2021 Implementation of a 'safe to start' real time staffing assessment and are reporting our nurse staffing levels daily on a risk rated basis Working in partnership to agree a rostering protocol and test of change on 5/7 shift pattern. CMT agreed bank and supplementary staffing options for future implementation, following work progressed in partnership. **Update April 2022:** Safe staffing legislation remains paused, with progress expected during 2022. Self-Assessment further rollout planned also paused to date. 5/7 shift pattern – work progressed on staff feedback particularly around impacts on shaft

						handovers and to service delivery / impacts on patient experience currently underway. Bank - Recruiting underway to Nursing Bank among existing staff group with interviews for first cohort planned, and SLWG to take forward to monitor development and impacts and potential to grow thereafter. **Update August 2022:** Safe staffing legislation & self-assessment remains paused. Engagement with the national team regarding e-rostering and exploring options regarding project management support for this work. Work progressed on shift patterns, especially proposals for supporting handovers. Nurse Bank re-flagged as Supplementary Staffing register(SSR). This is being actively progressed with ending of fixed term interviews for nursing staff within the nursing pool, and offer of joining SSR. This renewed offer has been positively received to date. SLWG continues to have oversight of this work.
	2	Patient Physical Health	Medical Director	Board	New	The Board is asked to consider adding this to the plan - this area was highlighted as part of formal feedback following the Ministerial Annual Review in April 2022

HOLDING TO ACCOUNT	3	NI Patients	Director of Finance and eHealth	Board	New	The Board is asked to consider adding this to the plan - this area was highlighted as part of formal feedback following the Ministerial Annual Review in April 2022
	4	Review performance framework and assurance information systems to support review of performance.	Head of Corporate Planning	CMT	New: **January 2022**	**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. P**uMP 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. Further update to Board in due course. **Update December 2021:** Board Development Session on Active Governance scheduled for 13 January 2022, and Board will consider this action further following that. **Update April 2022:** Session delayed due to extreme pressures during January – now scheduled for 3 May 2022. **Update August 2022:** Following the Board Development session on Active Governance, the Quarterly and Annual Performance Reports have been revised with slight amendments made. Development of the Performance Management Framework within TSH has continued and an agreement reached at CMT Development day to introduce 1/4ly Directorate Performance Management meetings with Directors. These meetings will provide the opportunity for a constructive deep dive to understand how each Directorate is performing against our Annual Operating Plan, the current operating context and new and emerging issues. This will also include a review of the workforce and financial position. **For Discussion**: Board is asked to provide feedback on performance reporting following current quarterly committee meeting and to this Board meeting.

	5	Self- Assessment tool for Staff Governance Committee	Board Secretary	Board	November 2022	**Update August 2022**: Staff Governance Committee asked for a self-assessment tool to be shared, to help them consider effectiveness. This already exists for Audit Committee. **Board:** suggest this is rolled out to both Staff Governance Committee and Clinical Governance Committee.
ENGAGING STAKEHOLDERS	6	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. **Update December 2021:** Presentation by Head of Communications to Board. **Update April 2022:** Roll out of Presentations highlighting work of TSH during March 2022, released on YouTube and promoted through social media platforms. Re-start of progress on communications options appraisal exercise following paused due to incident command, and Board reporting in April 22. **Update August 2022:** Board agreed to service transformation workstream in June 2022, with work progressed on website development, as well as recruitment

						of two further positions in communications team. Board will receive dedicated progress reporting at every second Board meeting going forward, and this is built into workplan. Board to consider closing this item on this plan given stand up of regular and dedicated reporting.
	7	Encourage carers / volunteers /staff / local population to attend public Board Meetings through additional promotion and links with local community.	Board Secretary	Board	**New: Review April 2022**	**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 further in September Development Session **Update December 2021:** Board received presentation in development session to review the options and consider within context of continuing impacts of Covid-19. Decision to necessarily pause until Spring 2022. In meantime encouragement given through CMT to staff to attend as observers in digital meetings when possible. **Update: April 2022:**

						Board noted will consider move towards change to how to manage meetings based on previous presentation to board on exploring options including hybrid meetings, and to compare to other NHS Boards. To consider the timescale for any change. **Update August 2022:** **Board Discussion:** Range of options and benchmarking to current practice in other Boards presented to this meeting to allow the Board to consider its way forward – including virtual/hybrid/ in –person or combination of options. This is for Board and Committees meetings as well as development sessions.
	8	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 further in September Development Session **Update December 2021:** detailed consideration by Board in context of Covid-19 in development session, on hold to spring 2022. **Update April 2022:** Discussion as per item 12 above – consider planning for this in future. **Update August 2022:** Board Discussion as item 12.
	9	Annual Review - Public Meeting to be held outside of the hospital to	Board Secretary	Board	Paused awaiting	**Update: December 2019:** Plan to be progressed as part of Annual Review. The review in 2020 was redesigned due to Covid-19.

		help engage public engagement and attendance.			national guidance	Awaiting national guidance for the current year. **Update December 2021:** Confirmation of virtual Annual Review for 2020/21, took place 5 April. This will depend on national guidance for 2021/22 review arrangements. **Update August 2022:** Awaiting guidance from Scottish Government on format of Annual review 2021/22. Minister for Mental Wellbeing and Social Care visited informally on 10 August, and toured the hospital meeting patients and staff.

Record of closed actions:

BLUEPRINT FUNCTION		ACTION	LEAD	ASSURANCE SYSTEM	TIMESCALE	PROGRESS
SETTING THE DIRECTION		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.
		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		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**
		Ensure implementation of attendance management policy through support from HR to line managers	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

		help identify and act upon patterns of absence. Continued implementation of the action plan developed through the Attendance Management Improvement Task Group (AMITG).				Meeting. Improvement activity now directed by the HR and Wellbeing Group.
		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	**Completed:** TSH readiness for planned implementation of phase 2 for April 2022. 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.
		Blueprint Improvement Plan to be placed on Board Workplan for review at each Board Meeting.	Chair	Board	June 2019	**Completed**
ASSESSING RISK		Further development of risk management with focus on risk register to ensure this is clearly defined with set of	Director Security, Resilience and Estates	Audit Committee / Board	New: June 2021	**Completed:** Work progressed to review the Corporate Risk register and link to development of local registers throughout TSH. Regular reporting of Corporate Risk Register to Board and tracked

		mitigating measures against each risk which also have a focus on improvement actions.				through monthly reporting at CMT and quarterly at OMT. Local Risk tracked and link made to CRR.
		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.
INFLUENCING CULTURE		Define culture in The State Hospital in terms of key strengths and weaknesses - take forward through development sessions	CEO	Board	New: August 2021	**Completed:** **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.
		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.
		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.**
		Senior Management visibility through regular front line staff engagement meetings with CEO / Directors' Group - plan a calendar of	CEO	CMT	New: **Review April 2022**	**Update: December 2019** wider engagement across TSH – progressed in conjunction with response to Sturrock and Clinical Model Review. **Update: December 2020**

		events to ensure regular engagement.				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 **Update December 2021:** Directors schedule on site is produced weekly ensuring on site presence rather than digital links. Directors lead on engagement with teams to ensure visibility. Hospital events not being taken forward face to face so remainder of action ON HOLD. **Update April 2022:** Structured engagement more firmly embedded through development of planning leadership and key workstreams – for Remobilisation Planning, Clinical Model Implementation. Board to consider if new management structure aligned to CMT, is now supporting means and route for engagement, and that reporting will come to the Board in these areas through its workplan. **Board agreed this position in relation to structured engagement/reporting and that this action should be closed on the plan. Completed.**
		Senior Team / RMO presence at key events in hospital calendar e.g.	CEO / Medical Director	CMT	New: **Review April 2022**	**Update: December 2019** Coordination of central diary of events to help facilitate attendance.

		patient learning awards/ sportsman dinner. 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. **Update December 2021:** Hospital events not being taken forward face to face. Digital platform for Staff Awards. Remainder of action ON HOLD. **Update April 2022:** Ability to take forward on site events is under remit of CMT given the need to coordinate across site in line with national recovery. **Board agreed that this is embedded and can be included as part of CMT workplan and closed as action for this plan. Completed.**
		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**
		Plan a schedule of Non-Executive Director informal visits across TSH to help promote the values and behaviours of the organisation.	Chair	Board	New: **Update to Board December 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. **Update December 2021:** PPG link and meeting schedule /Patent Safety Walkrounds schedule established (depending on any future restrictions). Link to Staff awards available to Non Execs. **Update April 2022**: Schedule now in place and commenced in February 2022. **Board agreed programme in place and can be closed as part of this plan. Completed.**

Updated 12.08.22 - M Smith

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 21
Sponsoring Director:	Finance and eHealth Director
Author(s):	Deputy Director of Finance
Title of Report:	Financial Position as at 30 June 2022
Purpose of Report:	For Noting

1 SITUATION

The Board is asked to consider the Revenue and Capital Resources spending plans, and monitor financial outturn. This report provides information on the financial performance, which is also issued quarterly to Scottish Government (SG) along with the statutory financial reporting template.

2 BACKGROUND

2.1 TSH

SG were ordinarily provided with an Annual Operating Plan (OP) and 3-year financial forecast template. The Operating Plans for 2020/21 and 2021/22 were paused due to Covid and replaced with the Board Remobilisation Plan (BRP), however we will now once again be submitting an Annual Operating Plan for 2022/23 in July 2022.

SG notified all Boards of there being no Covid-specific funding available ongoing into 2022/23 at the levels of the last two years and, while this position will remain under review, there are a number of processes now being put in place with individual budget-holders so that the pressures of Covid-related costs which will continue to be incurred will to be met within the specific Directorates as we return to “business as normal” in 2022/23.

There are delays (attributable to Covid) in the Perimeter Project which are being monitored by the Project Board and for which any delay costs will be quantified for consideration (in 2022/23).

The draft base budgets have been established (pending notification of the confirmed AFC Pay Circular for 2022/23) and these forecast a breakeven year end position, set on achieving £0.811m efficiency savings, as referred to in the table in section 4.

This is subject to change once we receive the pay circulars but to manage this prudently we are also maintaining an element of contingent reserve until the final pay award levels are known from SG.

2.2 SG Communication

On 14th July, the NHSScotland Chief Operating Officer and Director of Finance wrote to all Chief Executives and Directors of Finance highlighting Service Priorities and the "considerable financial challenge" for 2022/23, 2023/24 and beyond. Priorities for 2022/23 were noted as:

- Planned care – reduction in waiting times
- Cancer care – enhanced diagnosis and treatment
- Unscheduled care – taking forward the new "Urgent and Unscheduled Care Collaborative" – funding to be confimed
- Extended flu and Covid vaccinations
- Reduced drug deaths

The letter referred to the 2022/23 Agenda for Change pay offer, with Boards to assume that funding will be provided based on the additional costs associated, and allocations to be confirmed following conclusion of pay negotiations.

It was also noted that Boards are to focus on reducing remaining Covid costs, with the anticipation of no further COVID consequentials in 2022-23 or in future years and any recurring costs to be met through confirmed recurring allocations where now in place (e.g. sustainable vaccination workforce) or from existing baseline budgets. (Funding is expected towards the Test and Protect programme).

3 ASSESSMENT

3.1 Revenue Resource Limit Outturn

The annual budget of £40.696m is primarily the forecast Scottish Government Revenue Resource Limit core and non-core allocations, and anticipated additional allocations.

The Board is reporting an underspend of £0.097m to June 2022, with revenue forecast trajectory variance set at £0.062m.

PAIAW ("Payment as if at work") funding continues to be held as a reserve for the current year. This is a significant element for the Board because of our high levels of overtime and high Nursing vacancies.

Some pressure potentially remains re prior years' PAIAW still outstanding – claimants being in the hand of CLO (some of whom have recently been paid.) This was accrued at March 2022.

Additional at March 2022, some costs of the project works started in 2021/22 re the eRostering project, M365 licences, and related pressures have been accrued to fund an element of anticipated costs in 2022/23.

3.2 Key financial pressures / potential benefits.

Revenue (RRL): -
Covid-19
As noted above, because of the late advice from SG that Covid would no longer be funded there are some hanging cost pressures which will need to be managed within Directorates, which will be regularly monitored.

Clinical Model review update
There is risk noted that the updated Clinical Model review's financial position is expected to differ in structure from that which was originally considered and evaluated pre-Covid – current indications being that while this is not expected to give additional costs above current levels, originally anticipated savings will not be realised.

Energy and inflation increases
The rising costs of energy supplies and the knock-on effect on other supply chain deliverables will be closely monitored in 2022/23.

Extra PH for Platinum Jubilee
It is noted that there is the cost of one day's additional holiday in 2022/23.

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

Directorate	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	22,173	5,660	5,682	(22)	402.10	412.37
Security And Facilities	6,520	1,642	1,634	8	121.62	116.43
Medical	2,923	731	673	58	18.55	20.22
Chief Exec	1,979	495	494	0	21.96	21.19
Human Resources Directorate	962	240	239	2	14.65	15.21
Finance	2,586	647	713	(66)	29.43	31.61
Cap Charges	2,641	660	664	(3)	0.00	
Misc Income	(600)	(150)	(317)	167	0.00	0.00
Central Reserves	1,513	30	77	(47)	0.00	0.00
	40,696	**9,956**	**9,859**	**97**	**608.31**	**617.03**

Nursing – currently mainly affected by Ward Nursing overtime pressure, there is anticipation that leavers replaced by new starts in year will contribute to the underachieved savings.

Security & Facilities – Biomass and gas overspends noted, with a focus forward on monitoring energy costs in a pressured market.

Medical – Benefits are noted from some additional income received and a small element of research underspend.

CE – Breakeven position noted.

HR – Vacancy benefits have to date countered staff cost pressures.

Finance – eHealth notes new staff cost pressures for which we are awaiting confirmation of strategic funding expected, which is currently indicated should be in line with prior years.

Capital Charges –The budget is currently carried forward from previous year, awaiting SG confirmation of the required change to the allocation (core to non-core adjustment). £2.620m is the most recent estimate, and once confirmed this will be presented in the first quarterly template return to SG.

Miscellaneous Income (MI) – The budget recognises income billed for exceptional circumstance patients. This anticipated new income has reduced required savings.

Central reserves – Most significant are inflation for pay awards held centrally awaiting circular; PAIAW costs reserve; and Apprenticeship Levy reserve.

Anticipated RRL confirmations are awaited, for example as noted above for expected additional "bundled" funding such as for annual eHealth strategic costs.

4 ASSESSMENT – SAVINGS

The following table summarises the savings set by Directorate.

Cumulative Savings	Savings - Annual Target	Achieved to date / post base adj'ts	(Still to be achieved) / over achieved
Directorate	**£'k**	**£'k**	**£'k**
Chief Executive	(41)	0	(41)
Finance	(42)	5	(37)
Nursing & AHP's	(347)	70	(277)
Human Resources	(29)	0	(29)
Medical	(68)	0	(68)
Security & Facilities	(115)	40	(75)
Unidentified (phased ytd) - so all 'achieved'	(169)	0	(169)
Total	**(811)**	**115**	**(696)**

While an improved level of recurring saving remains a national / audit focus, it should be noted that of the Hospital's budget only 15% of costs are non-pay related while by comparison, many territorial boards have a non-pay cost element of around 65% and other National boards have non-pay costs ranging from around 80% (NSS, NES) to 30/40%.; while certain boards also treat vacancy savings, or a proportion thereof, as recurring savings.

Savings are phased evenly over the year (twelfths). Draft budgets have unidentified savings currently set at £0.169m.

National Boards Contribution

The eight National Boards (formerly Special Boards) continue to work towards joint efficiencies and collaborative working. The recurring level of contribution to the collective £15m savings challenge which the Board agreed and approved for 2021/22 remained at £0.220m, and this is also currently forecast for 2022/23.

5 CAPITAL RESOURCE LIMIT

The recurring capital allocation anticipated from Scottish Government for 2022/23 is £0.269m. Additionally, we are expecting carry forward of unspent 2021/22 allocated project funding for Key Safes & MSRs – this will be added when we receive such – with confirmation anticipated in our August Allocation schedule.

With regard to the Perimeter Security Project allocation, there are elements of unforeseen delays in the project – likely to be Autumn 2022 – requiring carry forward of unspent monies from 2021/22.

CAPITAL CRL 2022/2023 AS AT JUNE 2022	ANNUAL PLAN £'k	Anticipated £'k	YTD PLAN £'k	YTD SPEND £'k	under/ (over) £'k
PERIMETER SECURITY					
STANLEY SECURITY SOLUTIONS LTD			159	159	0
THOMSON GRAY LTD			47	47	0
TSH STAFFING APR - MAR'22			51	51	0
DJ GOODE			-2	-2	0
PERIMETER SECURITY TOTAL (Yr 2 of 2)	905		256	256	0
CAPITAL					
IM&T	30		0	0	0
OTHER	179		0	0	0
MSR refurbishment		400	0	0	0
Family Centre gardens	60		0	0	0
Key-safes refurbishment		100	0	0	0
CAPITAL	269	500	0	0	0
Total CRL	1,174	500	256	256	0

6 RECOMMENDATION

Revenue

Year to date position is £0.097m underspend, with breakeven anticipated for the year-end.

Capital

CRL June 2022 received £0.269m. Fuller details will be provided later. However, anticipated that our capital allocation will be fully utilised in-year.

The Board is 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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 22
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Programme Director / Head of Estates and Facilities
Title of Report:	Perimeter Security and Enhanced Internal Security Systems Project
Purpose of Report:	For Noting

1. SITUATION

This report to the Board summarises the current status of the Perimeter Security and Enhanced Internal Security Systems project. Board members are asked to note the overall project update, the financial assessment and current issues under consideration by the Project Oversight Board.

2. BACKGROUND

The Governance for the project is provided by a Project Oversight Board (POB) co-chaired by the Chief Executive and the Director of Security, Estates and Facilities.

The Project Oversight Board meets monthly. The POB last met on 18th August 2022 and is scheduled to meet again on 15th October 2022.

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

3. ASSESSMENT

a) General Project Update:

Quality targets are being met, project costs are projected to overspend by a small amount (See Finance – Project Cost at point 3c & 3d below) and project timescales have been reviewed and adjusted (See "Project Timescale" at point 3b below). A strategic overview of progress during the period from February 2020 to date is below:

- Construction Phase – 45% completed (7 work faces in progress, 18 to be commenced)
- Testing and Commissioning – not yet commenced
- Detailed Design Packages – 100% completed
- Construction Health and Safety documentation – 65% completed (14 to be commenced)

b) Project Timescales & Quality Issues:

Programme revision 40 has been submitted and is currently under review. This projects a completion date of 24th November 2022, exceeding the contract completion date by approximately 7 months.

Of the total delay, TSH has been responsible for approximately 12 weeks; around a third of this was due to the impact of COVID, with the remainder due to addition of the Running Track CCTV coverage, the Perimeter Redesign and changes related to the IP Network.

Stanley have been responsible for approximately 47 weeks of the delay. This is due to an over ambitious programme and consistently overambitious reviews of the programme coupled with difficulties in managing sub-contractors.

All quality targets are being met.

c) Finance – Project cost

The project is proceeding according to the current projected cost plan.

The key project outline is:

Project Start Date:	April 2020
Planned Completion Date:	Nov. 2022
Contract Completion Date:	April 2022
Main Contractor:	Stanley Security Solutions Limited
Lead Advisor:	ThomsonGray
Programme Director:	Doug Irwin
Total Project Cost Projection (inc. VAT):	£10,529,255
Total costs to date (Inc. VAT) at 14th August 2022:	£ 9,632,048

The cash flow schedule planned for the months to come is confirmed on a rolling basis in order to ensure that the Hospital's cash flow forecast is aligned and that our 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 13th August 2022 is below the amount forecast by Stanley that would be reflective of their planned schedule of works. As the current packages of works are significant and amounts are due on completion of each package there is a continuing mismatch between work on site and payments made. The last three months have been further complicated by penalties in excess of works completed and amounts due resulting in a nil valuation.

50% of the 5% retention is due to be paid at completion, with the remaining 50% to be paid at the end of the defects and liability period of 2 years.

A Rounded breakdown of actual spend to date at end of March 2022 is below.

Stanley	£ 6.836m (5% retention applied)
Thomson Gray	£ 0.762m
Doig & Smith	£ 0.008m
HVM Design	£ 0.017m
VAT	£ 1.524m
Staff Costs	£ 0.485m
	£ 9.632m

d) CCTV – Local Engagement

As part of the upgrade of security systems the CCTV element of the project requires TSH to engage with the local community surrounding the hospital. This requirement has arisen as a result of Stanley being unable to source cameras fitted with Dynamic Privacy Zones (DPZ) for the perimeter area of the hospital. DPZ technology allows for the pixilation of any property surrounding the hospital where if the perimeter cameras were utilised the image would be able to identify individuals.

This work commenced on 19 July 2022 with attendance at Carnwath Community Council where the Director of Security gave an oversight of the requirement to engage with local communities as a result of the DPZ issue as well as the plan to engage with elected representatives and properties surrounding the hospital.

On 10 August 2022 Councillors Alex Allison and Ian McAllan attended the hospital where they received a briefing and were given a demonstration of the cameras in the control room. Both councillors provided very positive feedback on the security systems' and the plan for engagement with surrounding properties. Mhairi McAllan, Constituency MSP is due to visit on 9 September 2022.

Following this, engagement with the surrounding properties will commence and a briefing document will be published on TSH website when the CCTV systems go live.

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.

THE STATE HOSPITALS BOARD FOR SCOTLAND

Date of Meeting:	25 August 2022
Agenda Reference:	Item No: 23
Sponsoring Director:	Chief Executive
Author(s):	Complaints and Legal Claims Officer/Board Secretary
Title of Report:	Complaints Annual Report 2021/22
Purpose of Report:	For Noting

1 SITUATION

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

The State Hospitals Board for Scotland receives reporting on feedback in a number of ways, including individual stories from patients and carers. This report will provide the Board with a summary of activity within complaints handling activity for the year 1 April 2021 to 31 March 2022.

2 BACKGROUND

The NHS Model Complaints Handling Procedure (CHP) supports a person centred approach to complaint handling across NHS Scotland, ensuring people using NHS services have confidence in the complaints services provided. The process is designed to encourage NHS Boards to listen to, and learn from, complaints in order to help to improve services for patients.

In The State Hospital (TSH) the Board Secretary to act as Complaints Manager for the organisation, supported by the Complaints and Legal Claims Officer. The Complaints Officer role delivers the service, and is responsible for connecting directly with patients and carers to provide an approachable point of contact and to ensure that the service can be easily accessed.

Independent advice is also available through the Patient Advisory Service (PAS) with their representatives being available on site to enable access and support for patients. The Complaints Officer liaises closely with PAS and this helps both to engage patients in the process, as well as providing an additional conduit for feedback for the complaints team.

3 ASSESSMENT

The CHP introduced a standard approach to managing complaints across NHS Scotland, which complies with the Scottish Public Services Ombudsman (SPSO) and meets the requirements of the Patient Rights (Scotland) Act 2011. The two-stage model enables complaints to be handled by way of early resolution (Stage 1) within 5 working days; or for issues that are more complex, by Investigation (Stage 2) within 20 working days.

The 5-day local resolution stage continues to encourage speedy resolution of issues and is welcomed by both patients and staff. The Complaints Team is focussed on building and maintaining relationships with patients and front line staff, and most complaints continue to be resolved at the early resolution stage. This is a key focus and the Complaints Officer maintains an onsite presence, regularly meeting directly with patients, subject to infection control measures in place.

Complainants who remain unhappy with the outcome of their complaint at Stage 2 have the right to ask the SPSO for an independent external review of their complaint.

Complaints Received

The hospital received 65 new complaints this year showing an increase of 35% on the previous year. The table below shows the number of complaints received, the average number of patients, and the number of complainants over the last three years.

Number of Complaints Received	2019/20	2020/21	2021/22
Total Number Received	52	42	**65**
Average number of patients throughout the year	106	111	**114**
Number of Complainants	21	24	**33**

Due to the nature of the environment as a long-term health care setting, it is expected that patients will make more than one complaint during their time with us. 15 stakeholder made more than one complaint this year, compared to eight in 2020/21 and seven in 2019/20.

Complaints Closed

A total of 54 complaints were closed this year. And of these 42 complaints (78%) were resolved at Stage 1.

The table below shows the number of complaints closed at each stage this year and the previous two years. Complaints received but subsequently withdrawn are not reported nationally and therefore not included in this report. They continue to be reported through governance groups for monitoring purposes.

Complaints Closed	2019/20	2020/21	2021/22	% of all closed
At Stage 1 (Early Resolution)	30	31	**42**	**78%**
At Stage 2 (Investigation)	7	7	**6**	**11%**
After Escalation to Stage 2 (Investigation)	6	5	**6**	**11%**
Total	43	43	**54**	**100%**

Complaint Outcomes

Complaints closed are categorised as either being upheld, not upheld or partially upheld.

Outcomes continue to be sense checked through the Complaints Manager, and random audits are carried out on complaints files. This helps to review both the quality of responses provided as well as recognising that the culture of an organisation may impact on the way that it responds to complaints. The need for transparency and openness, as well as an ability to acknowledge and apologise for those times when service delivery has fallen short

of the accepted standard, is essential. At the same time, this will only be successful when staff feel supported through the process and can take learning from it.

The tables below provide performance data relating to the outcomes of complaints closed during 2020/21, which is then split into each stage of the process.

All Complaint Outcomes	2019/20	2020/21	2021/22	As % of all Outcomes
Upheld	8 (19%)	8 (19%)	**28**	**52%**
Not Upheld	29 (67%)	25 (58%)	**18**	**33%**
Partially Upheld	6 (14%)	10 (23%)	**8**	**15%**
Total	43	43	**54**	**100%**

Outcomes at each Stage

Stage 1 - Early Resolution	2019/20	2020/21	2021/22	As% of all S1
Upheld	7 (23%)	7 (23%)	**23**	**55%**
Not Upheld	19 (64%)	18 (58%)	**12**	**28%**
Partially Upheld	4 (13%)	6 (19%)	**7**	**27%**
Total	30	31	**42**	**100%**

Stage 2 - Investigation	2019/20	2020/21	2021/22	As % of all S2
Upheld	1 (8%)	1 (8%)	**5**	**42%**
Not Upheld	10 (77%)	7 (59%)	**6**	**50%**
Partially Upheld	2 (15%)	4 (33%)	**1**	**8%**
Total	13	12	**12**	**100%**

Response Times

TSH continues to adhere to the CHP targets timescales for resolving complaints locally within 5 working days and completing investigations within 20 working days.

The table below shows the average number of days taken to respond to complaints this year and in previous years.

Average Number of Days	2019/20	2020/21	2021/22
To resolve at Stage 1	3	4	**3.5**
To respond to a complaint at Stage 2	18	20	**17**
To respond to a complaint after escalation to Stage 2	20	17	**16**

The tables below show our performance in responding to complaints at each stage within the CHP target response times. Whilst extensions to the response times should be an exception, the Complaints Team is focused on ensuring that the response fully addresses all of the issues raised. Therefore, on occasion an extension has been required to allow a more comprehensive response to be provided. The SPSO has confirmed that there is no prescriptive approach about who should authorise an extension – only that decisions should be proportionate and made at a senior level. The Complaints Manager takes this responsibility within TSH.

Complaints Closed within the target timescales	2019/20	2020/21	2021/22
Closed at **Stage 1** within **5** working day target	29	27	**38**
as % of the total number closed at Stage 1	97%	87%	**90%**
Closed at **Stage 2** within **20** working day target	8	10	**11**
as % of the total number closed at Stage 2	62%	83%	**92%**

Complaints that required an extension to the timescales	2019/20	2020/21	2021/22
Closed at Stage 1 after the **5** working day target	1	4	**4**
as % of the total number of Stage 1 closed	3%	13%	**10%**
Closed at Stage 2 after the **20** working day target	5	2	**1**
as % of the total number of Stage 2 closed this year	38%	17%	**8%**

This year has seen a decrease in response times at both stages. However, given the ongoing challenges of covid-19, staff have done remarkably well this year in responding to the majority of complaints within national target response times.

Focus on Quality

An internal quality assurance process has been established to ensure compliance with the requirements of the CHP. As detailed within this report, performance timescales and recording of outcomes are quality checked by the Complaints Manager.

Stage 2 investigation responses are also checked by the Complaints Manager to ensure the quality of the response and that it answers all of the concerns raised. The Director(s) responsible for the service(s) involved is asked to review and approve the content, before a proposed draft is provided to the Chief Executive for finalisation. This process is aimed at ensuring directorate accountability, as well as bringing focus on learning opportunities and identifying trends in respect of the issues raised.

During this year an audit of the complaints service was undertaken by RSM UK Risk Assurance Services. The audit looked at compliance and adherence to the CHP, the evidence within the complaint file and the quality of the response that was sent to the complainant. The outcome of the audit concluded that the Board could take substantial assurance that the controls upon which the organisation relies to manage the complaints service are suitably designed, consistently applied and operating effectively.

Learning from Complaints

When any aspect of a complaint is upheld or partially upheld, we look to identify if improvements can be made with preventing a reoccurrence.

The majority of complaints received (78%) were resolved at Stage 1 during this year. Most of these were resolved on an individual basis locally with the staff who provide the service, and did not involve implementing improvements or changes to policies, services or ways or working across the hospital. However, an apology is always offered to the complainant where appropriate and a reminder issued to staff to reflect on behaviours or adherence to policies / procedures.

Themes Emerging

- **32%** of complaints raised related to staff availability and the impact this had on patients, especially in relation to accessing activity. Staff resourcing remained a challenge throughout the year linked to cyclical increases in community infection levels of Covid-19. There were a number of covid outbreaks experienced in the hospital throughout the year. Recruitment has been key priority for the hospital with recruitment campaigns successfully attracting nursing staff.

  Patents were concerned that they spent more time in their rooms and about the potential impact this could have on their mental wellbeing. Five related to activity placement closures and another that staffing resources had prevented a rehabilitation outing taking place. The majority of these complaints were upheld (15 equalling 88%), one was partially upheld and one was not upheld.

- **15%** of complaints raised related to clinical treatment, with grounds access restrictions being the most common issue raised. Three complaints related to care plan involvement or diagnosis.

- **12%** of issues raised related to communication issues. This included patients not feeling listened to, staff not providing full answers to enquiries, misunderstandings between staff and patients/carers and misunderstandings between staff from different departments. Five of the complaints related to communication between Security and Ward staff regarding patient access to protein bars, and these were upheld and revised governance put in place to prevent this from happening again.

- **12%** of issues raised related to Staff Attitude / Behaviour / Conduct. Two related to alleged assault and two to threatening/intimidating behaviours. Following investigation, none of these complaints were upheld. Two complaints related to staff being rude, one was not upheld and the other was partially upheld. The other complaint related to a staff member speaking on behalf of a patient during a GP consultation, and this concern was upheld.

Some complaints do result in changes in practice and examples of this are provided in the table below.

Issues Raised	Findings	Output
Patient with special dietary requirements received ingredients in their meal that they are unable to tolerate.	New chef had not been made aware of the requirements.	A robust system for checking special diet meals was put in place to ensure all special diet meals are now checked by two staff prior to leaving the kitchen.
Patients grounds access time was cut short due to the need for another patient to access the grounds to return to their ward.	In line with policy patients who are disassociated from each other are not permitted in the grounds at the same time.	Wards agreed to liaise with each other regarding patient timetables to ensure equitable access to activities and fresh air for both patients.
Benches in the central grounds area were turned to face in the opposite direction meaning the patients feet would rest in the grass, which is problematic given our wet climate.	The benches were turned to encourage patients who did not wish to participate in outdoor activities to do so as spectators. However, it was accepted that some patients may wish to utilise the benches for other purposes.	Some of the benches were restored to their original position to allow patient to enjoy the outdoor area and surrounding views.

Culture, Staff Awareness, Training and Development

Responding to Covid-19 has meant that TSH has undergone significant reconfiguration in how care and services have been delivered to protect the health of both patients and staff. During this time, TSH has continued to provide a full complaints service to patients and carers.

Staff respond well to the early resolution stage of the process, and are provided with ongoing guidance and support, which is key to its continuing effectiveness. All complaints received were included in the daily reporting structure to senior managers to ensure that any issues being raised were taken into account. The focus is on taking learning from complaints and opportunities for quality improvement in service delivery.

All staff are required to complete the national e-learning Feedback and Complaints online training modules. The compliance rate was 84% at the end of March. In addition to the online modules, a complaints awareness session formed part of the induction programme for all new staff. Due to the ongoing pandemic staff inductions were put on hold. It is hoped that these will resume soon. Meantime, student nurses continue to receive an awareness session on complaints as part of their induction programme.

The main issues arising and learning taken from complaints are communicated through Staff Bulletins which contain a link to the quarterly report published on the staff intranet.

Complaints Process Experience

Although making a complaint may be the result of a difficult experience, it is the aim of the Complaints Team to ensure that all complainants have a positive experience when contacting the service.

To ensure we can capture learning from this, a form is available to help to seek feedback from everyone who uses the complaints service. It is acknowledged that this process does not elicit many responses. As a long-term health care setting we expect to receive more than one complaint from the same person. It remains a challenge therefore encouraging complainants to complete the feedback forms on each occasion.

Seven forms were returned this year compared to three in 2020/21. Six of the forms included involvement of the Person Centred Improvement Team (PCIT) who engaged with patients to encourage them to provide feedback. Responses were mainly positive. However, some highlighted that patients can be worried about making a complaint. This feedback has helped the Complaints Officer focus on providing additional reassurance to patients that the complaints process is a supportive mechanism through which they can voice any concerns. This is supported through regular attendance through the Patients Partnership Group, and through liaison with the Patient Advisory Service (PAS).

Scottish Public Services Ombudsman (SPSO)

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

During this year one complaint was escalated to the SPSO for consideration. This related to staff shortages and ward closures, and the impact this was having on the patient.

Following a review of the file the SPSO were satisfied that the action taken by the Board had been reasonable in the circumstances. They noted that the Board had apologised for the impact the situation had on the patient and had outlined the steps being taken to improve staffing levels and how staff were deployed on the wards. The SPSO decided not to take the complaint forward for investigation as there was nothing further they considered could be investigated in this instance.

Alternative Dispute Resolution

TSH also supports the use of alternative dispute resolution e.g. mediation to conclude cases which are unable to be resolved locally. NHS Scotland has established links with Scottish Mediation in this regard. One complaint this year received support from the Scottish Mediation Service resulting in a successful outcome.

Patient Advocacy Service (PAS)

PAS is based on site and has also been able to regularly support patients to resolve issues through early resolution. They also provide support and guidance to patients who wish to escalate their complaint. PAS continue to provide a valuable service in supporting those who wish to make a complaint but may feel they do not wish to do so directly. During the year PAS supported 42 complaints representing 65% of all complaints received.

The Complaints Team works closely with PAS, meeting regularly, to share best practice in complaints handling and to discuss learning emerging from complaints. These relationships further strengthen the advocacy route through which patients and carers can raise concerns.

Accountability and Governance

The Chief Executive is accountable for the delivery of the CHP within TSH, including supporting a culture of transparency and openness in complaint investigation. This supports the organisation's ability to listen and respond to concerns raised, as well as to take learning from complaints. Responsibility for the complaints sits within the Corporate Services Team led by the Board Secretary who acts as Complaints Manager for TSH.

The Board has oversight of complaints and will receive annual reporting. This follows quarterly reporting to the Clinical Governance Committee, which monitors the issues raised, findings, outcomes and any learning identified. Quarterly reporting is also routed through the Organisational Management Team (OMT) which is comprised of service leads.

The Operational Model Monitoring Group also received reporting on complaints throughout the year as part of a focus on listening to the experience of patients; and to ensure that changes were closely monitored and patient views shared with service leads to support a person-centred approach. Work will be progressed to ensure that this link continues through the Hospital Leadership Team structure, and feedback can be offered to the Activity Oversight Group.

Service Development

There is continued focus on delivery the aims of the CHP in terms of each of the Key Performance Indicators, as well as a focus on quality and making a contribution to service improvement. In addition to other established patient engagement work streams the CHP is another route through which stakeholder voices can be heard, and the organisation can measure its performance on the delivery of its key aims.

To do so, it is recognised that there is a need for refreshed training across staff groups. Directorates had been asked to identify staff groups who would benefit from this, and two areas of focus were highlighted. Firstly, to deliver training to staff who may be involved in complaints investigations at a local level, focussed on the CHP. Secondly, training for staff who have a front line role around how to manage difficult conversations when concerns may be raised (before the initiation of a complaint). Delivery of this has continued to be delayed due to the ongoing pandemic and the impact of this on staff resourcing. However, all departments and staff who have been asked to respond to a complaint receive support directly from the Complaints Officer and Complaints Manager.

Development of the service also requires recognition of the need for resilience. Training has been provided within the Corporate Services Team this year to help build knowledge and resilience in this area. This included the opportunity of external complaints training as well as shadowing the Complaints Officer/ Manager internally.

4 RECOMMENDATION

The Board is invited to:

1. Note assurance on delivery of the CHP within TSH, especially the focus on quality improvement and learning from complaints.
2. Note evolving practice in this area and learning which has contributed to service development
3. Advise of any change in reporting structure or additional reporting required for future reporting.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	The CHP introduced a standard approach to managing complaints across NHS Scotland which complies with the Scottish Public Services Ombudsman (SPSO) and meets all the requirements of the Patient Rights (Scotland) Act 2011. Reporting measures performance and delivery within TSH.
Workforce Implications	There are no associated workforce implications.
Financial Implications	There are no associated financial implications.
Route to Board	Requested by Board through workplan as part of annual reporting requirements.
Risk Assessment (Outline any significant risks and associated mitigation)	There are reputational risks associated with not meeting the MCHP target response times, as well as the risk of systemic failure to respond to concerns raised.
Assessment of Impact on Stakeholder Experience	Reporting captures stakeholder views and how these are responded to by the organisation for service improvements.
Equality Impact Assessment	Not required.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do)	Not applicable
Data Protection Impact Assessment (DPIA) See IG 16	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:	25 August 2022
Agenda Reference:	Item No: 24
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 2022/2023
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 2022. 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 care continues to be delivered as outlined in the Interim Clinical Operational Policy (ICOP). This was introduced in March 2020 to ensure infection prevention and control measures are prioritized and is currently on version 23. 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.

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

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 nine KPI's which have reached and / or exceeded their target this quarter.

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

- Patients have their care and treatment plans reviewed at 6 monthly intervals.
- Patients will have a healthier BMI.
- Patients will commence psychological therapies <18 weeks from referral date.

Performance Indicator	Target	RAG Q2 21/22	RAG Q3 21/22	RAG Q4 21/22	RAG Q1 22/23	Actual	Comment
Patients have their care and treatment plans reviewed at 6 monthly intervals	100%	A	A	A	A	92.43%	This indicator remains in the amber zone for quarter 1.
Patients will be engaged in psychological treatment	85%	G	G	G	G	83.23%	This indicator remains green for this quarter.
Patients will be engaged in off-hub activity centers	90%	-	-	-	-	-	This indicator was closed in June 2020 to accommodate engagement in off-hub activities during the pandemic.
Patients will be engaged in off-hub activity centers during COVID-19	90%	G	G	G	G	96%	This figure includes drop-in sessions, which took place in hubs, grounds and the Skye Centre.
Patients will undertake an annual physical health review	90%	-	-	-	G	100%	100% compliance. Green compliance for this amended KPI.
Patients will undertake 150 minutes of exercise each week	60%	-	-	-	G	64%	Green zone for the first quarter of this KPI's data collection.
Patients will have a healthier BMI	25%	R	R	R	R	10%	The percentage of patients with a healthier BMI has remained the same.
Sickness absence rate (National HEAT standard is 4%)	** 5%	R	R	A	G	5.03%	April's figure was 4.10%, May's figure was 4.73% and June's figure was 6.28%.
Staff have an approved PDR	*80%	G	G	G	G	81.3%	This indicator has been within the green zone since March 2019.
Patients transferred/discharged using CPA	100%	G	G	G	G	100%	6 patients were transferred during this quarter all using CPA.
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	A	A	A	92.85%	5 instances of patients waiting beyond the specified wait time during Q1.
Patients have their clinical risk assessment reviewed annually.	100%	G	G	A	G	96.73%	As at 30 June 2022, there were 112 patients in the hospital. Twelve were new admissions and five patients had an out of date risk assessment.
Attendance at CPA Reviews (Refer to Appendix 1)							

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

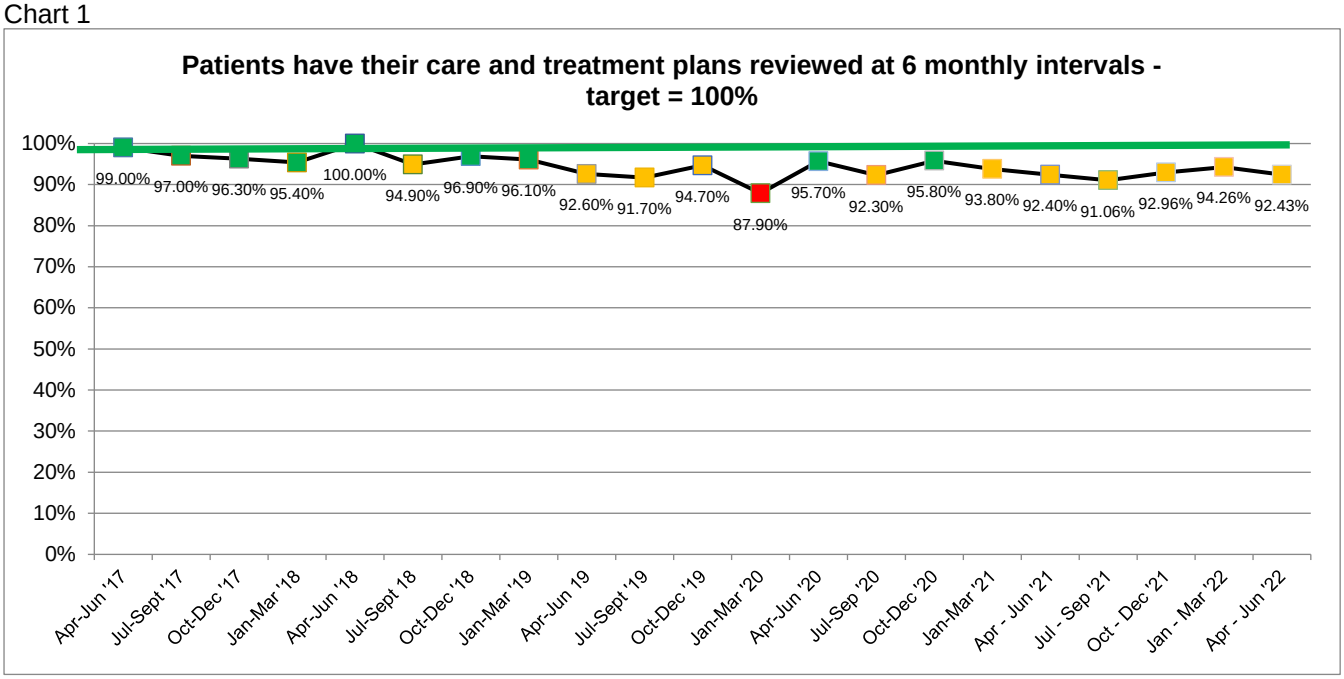
Target: 100%

Data for current quarter: 92.43%

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 admission, 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.

Chart 1



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In April the compliance was 96.1%, May was 92.2% and June was 89% giving a quarterly compliance of 92.43%, which is a slight decrease from last quarter's figure. This indicator remains with the amber zone.

On 30 June 2022, there were 112 patients in the hospital. Twelve of these patients were in the admission phase. Eleven CPA documents had not been reviewed within the 6-month period, or within the agreed admission phase. Five of these CPAs have been held with no documents being uploaded to RiO within allocated timescales and the remaining 6 were out with 6 months of the previous CPA being held or an admission CPA held over 4 month after the date admitted.

Work has continued to be undertaken to ensure continuous improvement in this KPI. The Health Records Manager has provided rolling monthly updates to all relevant individuals as requested and support is continually offered to all secretaries regarding the uploading of these documents onto RiO within the allocated timescales. 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

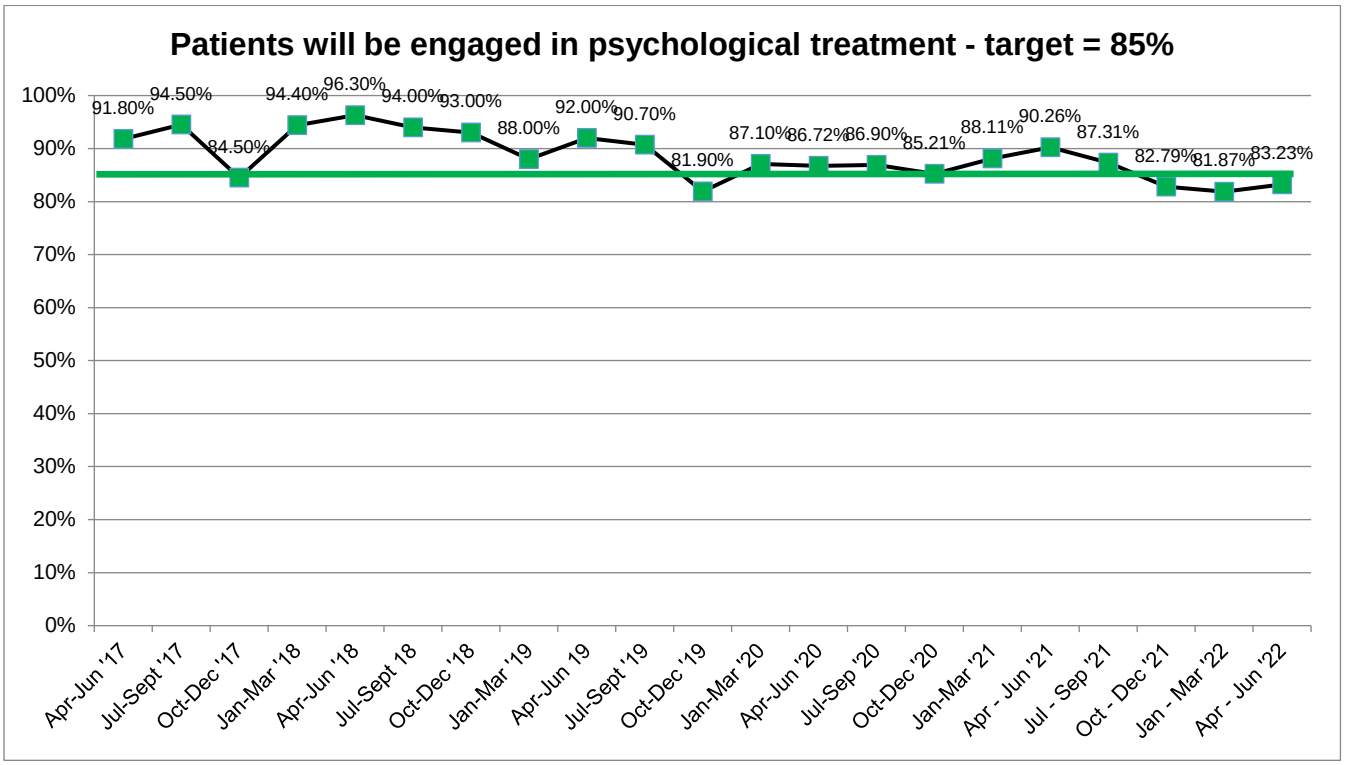
Target: 85%

Data for current quarter: 83.23%

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.

Chart 2



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In April the compliance was 82.05%, May was 84.48% and June was 83.18% giving a quarterly compliance of 83.23%, which is a slight increase from last quarter's figure. This indicator remains with the green zone.

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

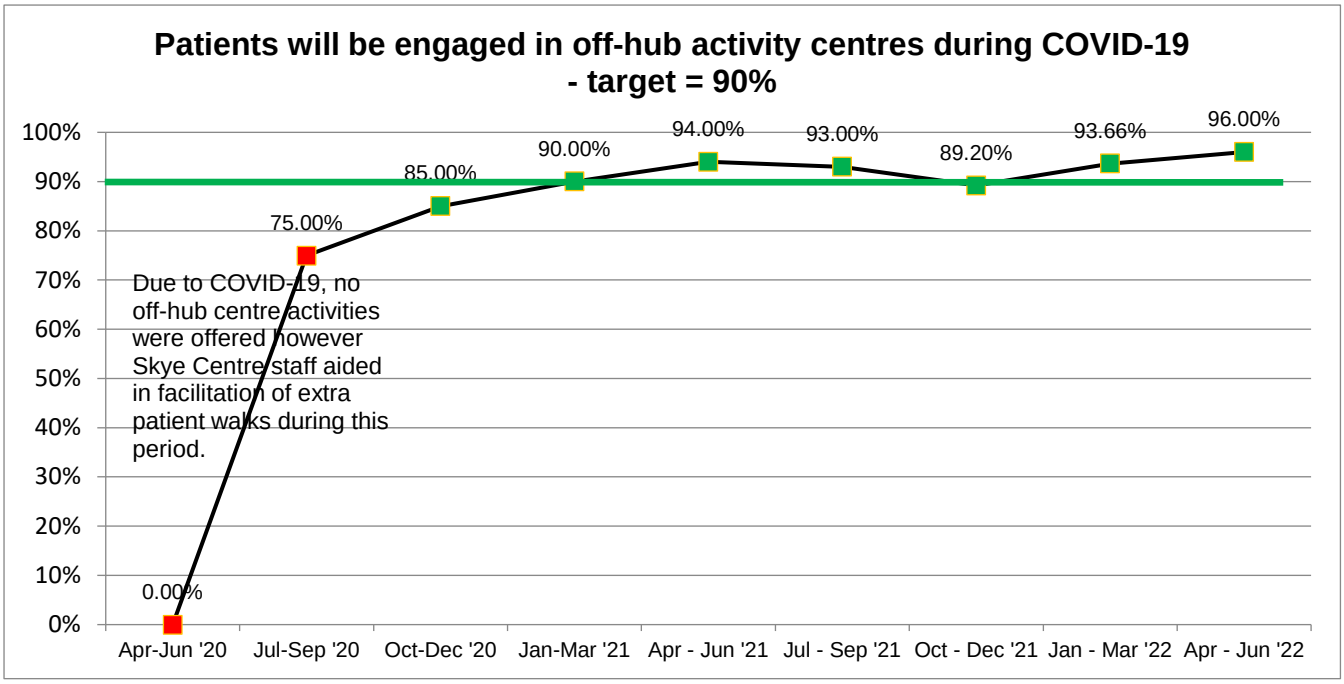
Target: 90%

Data for current quarter: 96%

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).

Chart 3



This indicator includes data gathered pertaining to scheduled activity in addition to all off-ward drop-in activity rates at the Skye Centre from July 2020 onwards. This includes Grounds Access as this is recorded via the drop-in function on RiO.

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 Undertake an Annual Physical Health Overview

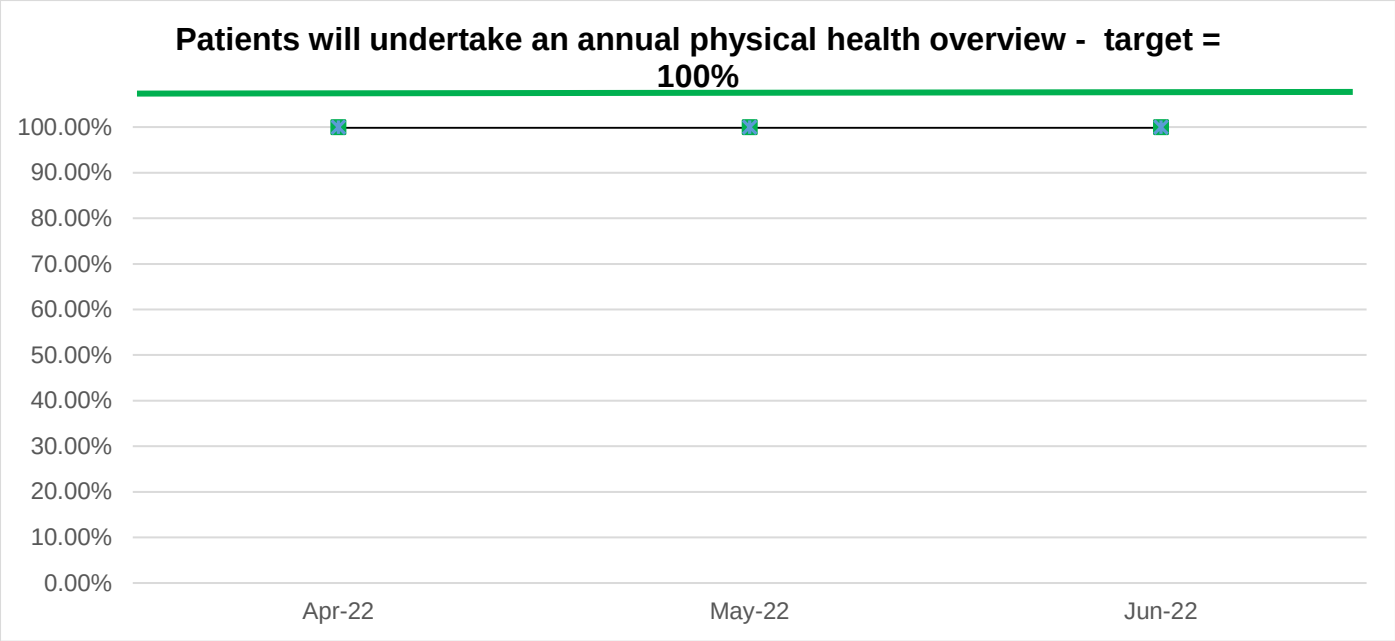
Target: 100%

Data for current quarter: 100%

Performance Zone: Green

This indicator is linked to the National Health and Social Care Standards produced by Healthcare Improvement Scotland (HIS). The indicator measures the uptake of the annual physical health review. The target has been increased to 100% from the 90% target before to recognize that the Annual Physical Health Overviews should be carried out for every patient every year.

Chart 4



As at 1 April 2022, this KPI was amended to incorporate the uptake of an annual physical health review by all of our patients, rather than the previous data collection of an offering of a review. This KPI now charts the completion of an annual physical health overview by the Practice Nurse. The Practice Nurse then refers appropriate patients on for face to face review by the GP. The GP conducts these consultations to complete the physical assessment of the annual health review. The backlog of patients who were due annual health reviews in 2021/22 has now been cleared, using a triage approach to ensure that patients who most required a consultation were prioritised.

During Q1, 100% of patients who were eligible for an annual physical health review were reviewed by the Practice Nurse. Out of these 20, 18 were reviewed in addition by the GP. Two patients did not attend their face-to-face consultations; this was due to one patient suffering from poor mental health and the other patient being COVID-19 positive. Both of these reviews have been rescheduled.

No 5: Patients will be Undertake 150 Minutes of Exercise Each Week

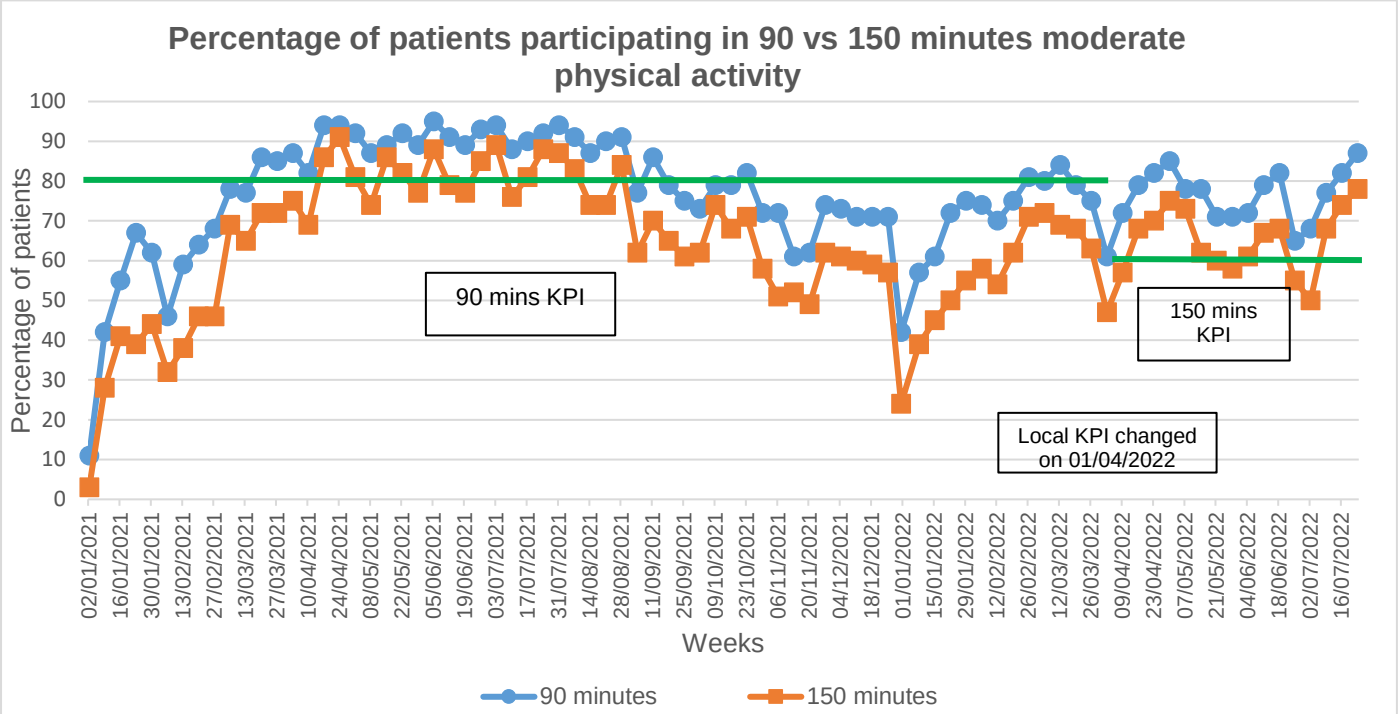
Target: 60%

Data for current quarter: 64%

Performance Zone: Green

This links with national activity standards for Scotland. This measures the number of patients who undertake 150 minutes of exercise each week.

Chart 5



At the Board meeting in June 2022, the Board agreed to change the corporate Key Performance Indicator from 80% of patients will achieve 90 minutes of moderate physical activity per week to 60% of patients will achieve 150 minutes of moderate physical activity per week following guidance released by the WHO and reviewed by the PHSG. This change will be effective form 1st April 2022 and will be reviewed after 4 quarters data to assess whether the target should be increased to 70% for 2023/24.

The chart above shows the percentage of patients that have achieved the previous 90 minutes KPI versus the new 150 minutes KPI. This is recorded when patients participate for more than 10 minutes of moderate activity and does not include patients being escorted / or using grounds access to and from the Skye Centre (unless it has been agreed by the patient's keyworker).

Since the change of KPI on 1 April 2022, the target was achieved on 9 out of 13 weeks. An outbreak of Covid-19 within Mull hub influenced a reduction in physical activity uptake during the last 3-week period in May 2022 whilst a further outbreak within Arran and Lewis affected uptake during the last week in June 2022. Work is ongoing to increase staff understanding of what activities can still take place during such periods. This indicator sits with the green zone for this quarter. The previous 2 years Q1 KPI for physical activity have also sat within the green zone.

No 6: Patients will have a Healthy BMI

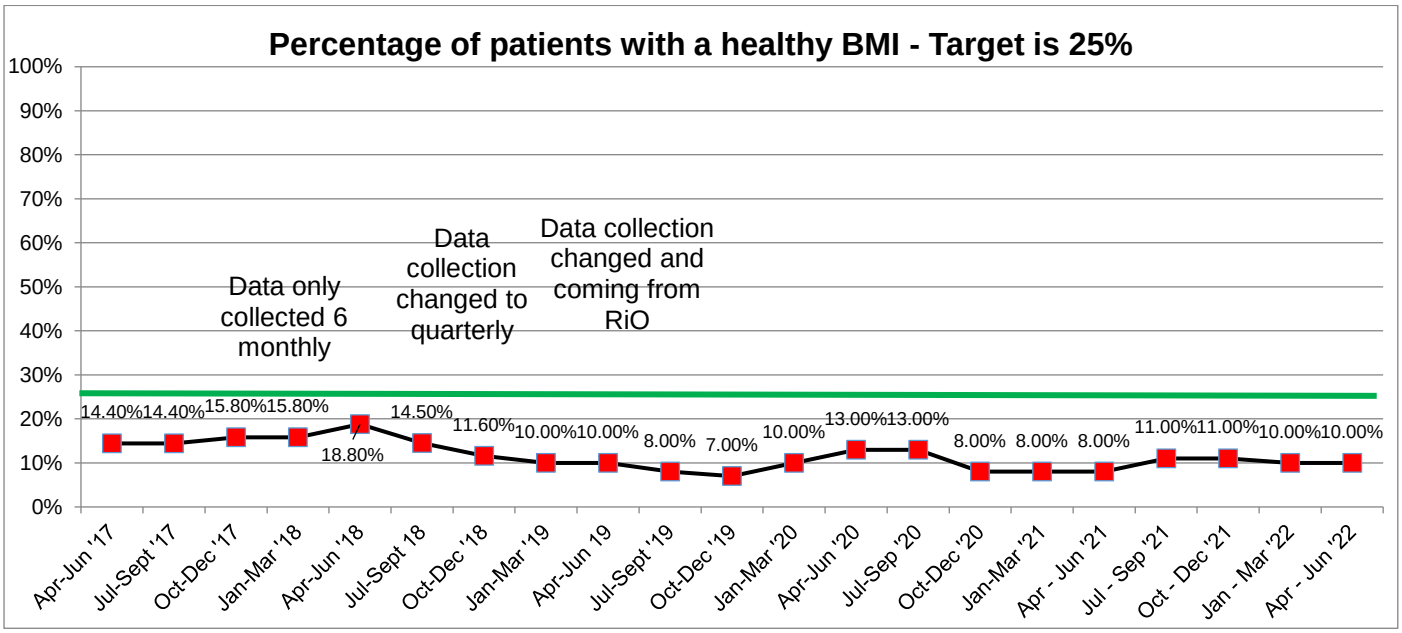
Target: 25%

Data for current quarter: 10%

Performance Zone: Red

This correlates towards the national target from the care standards as well as a corporate objective of TSH. This is an aspirational target and a local priority due to the obesity issue of our patient group.

Chart 6



The RiO reports show that 10% of patients have a healthy BMI; this has remained the same figure from the previous 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.

During this quarter, there was 21 instances where a patient had gained enough weight to move up a weight category and 15 patients who reduced in weight enough to move them down a weight category. Three patients refused to have their weight taken during this quarter and there were 17 instances during this quarter where a patient's weight was not recorded. In quarter 1, there was 8 admissions and 10 discharges; one who fell within the normal range; four who fell within the overweight range, 3 within the Obese 1 category, 2 within the Obese 2 category.

The PHSG have requested monthly monitoring reports to review the data and going forward, the Supporting Healthy Choices Group (SHCG) remits to change the culture in TSH for maximising physical activity and promoting healthier lifestyles; including dietary changes where appropriate. Options to consider how groups and ward-based weight loss interventions may be delivered have been included within the plan of work. The 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.

Table 1

Weight Range BMI	**Q1 Apr-Jun 2022 N=107**	**Q4 Jan-Mar 2022 N=98**	**Q3 Oct-Dec 2021 N=107**	**Q2 Jul-Sep 2021 N=115**
<18.5 Underweight	1%	1%	0%	0%
18.5-24.9 Healthy	10%	10%	11%	11%
25-29.9 Overweight	28%	26%	30%	33%
30-34.9 Obese (Class 1)	34%	31%	32%	33%
35-.39.9 Obese (Class 2)	16%	18%	19%	15%
>40 Obese (Class 3)	4%	5%	4%	4%

*N.B. The N number equates to how many patients we hold BMI data for during the last month of the 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%)

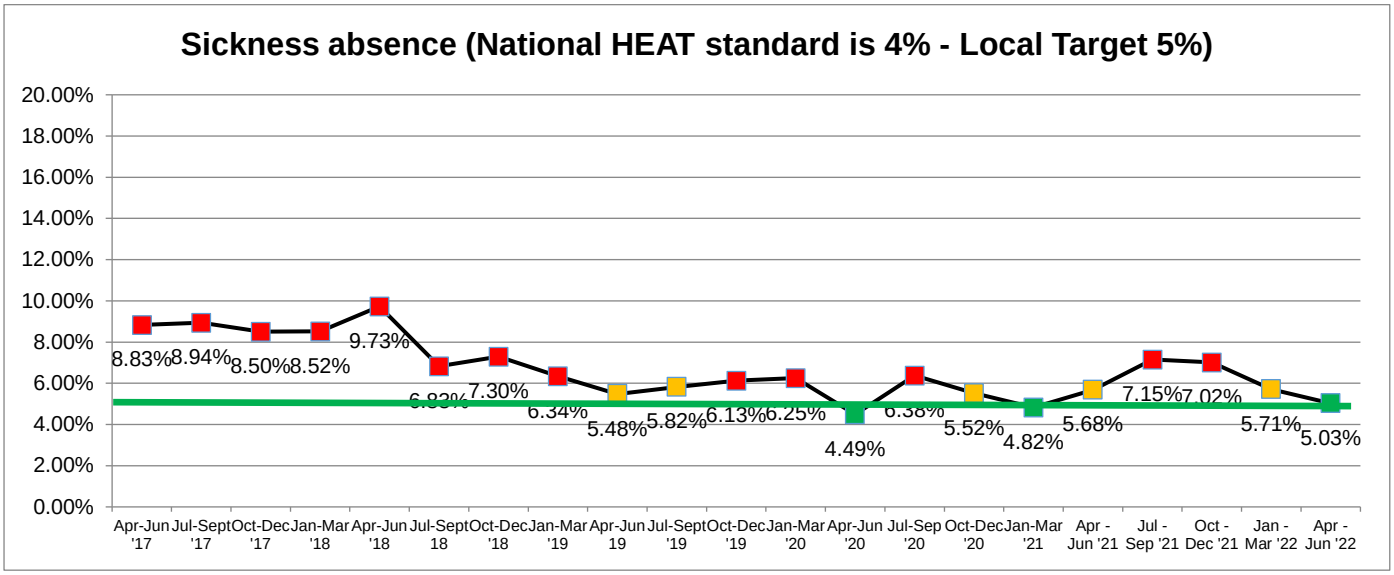
Target: 5%

Data for current quarter: 5.03%

Performance Zone: Green

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. The State Hospital uses the data provided from SWISS for this KPI to align with all NHS Scotland Boards to ensure valid comparisons across Scotland can be achieved. The figures provided via SWISS data slightly differ from SSTS figures; this is due to the SWISS contractual hours being averaged over the 12-month period and the figures from SSTS are based on the contractual hours available within that month.

Chart 7



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

Table 2

Month	Total Hours Lost	Total Hours Lost (%)
April 2022	3069.8	3.24%
May 2022	1851.53	1.89%
June 2022	3196.94	3.38%

No 8: Staff have an Approved PDR

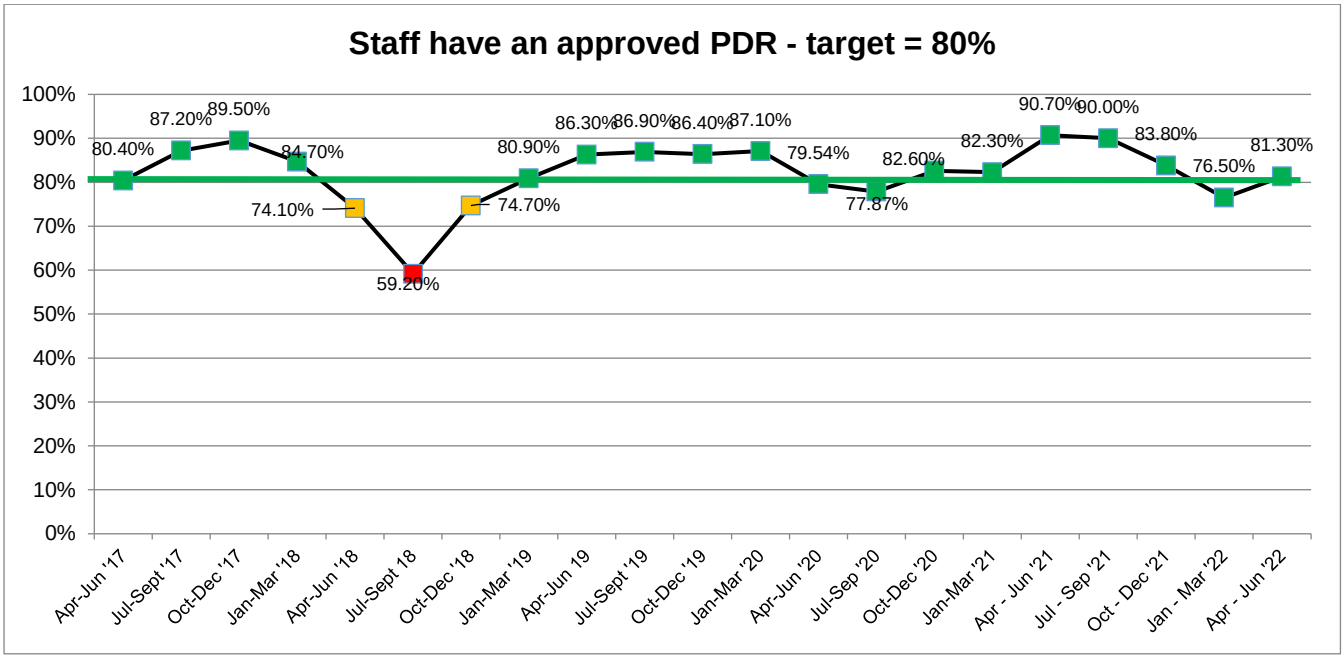
Target: 80%

Data for current quarter: 81.30%

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.

Chart 8



This data is reviewed monthly with the quarterly KPI taking an average across the three months in the quarter. In April the compliance was 79.2%, May was 81.1% and June was 83.6% giving a quarterly compliance of 81.3%, which is a slight increase from last quarter's figure. This indicator remains with the green zone.

No 9: Patients are Transferred/Discharged using CPA

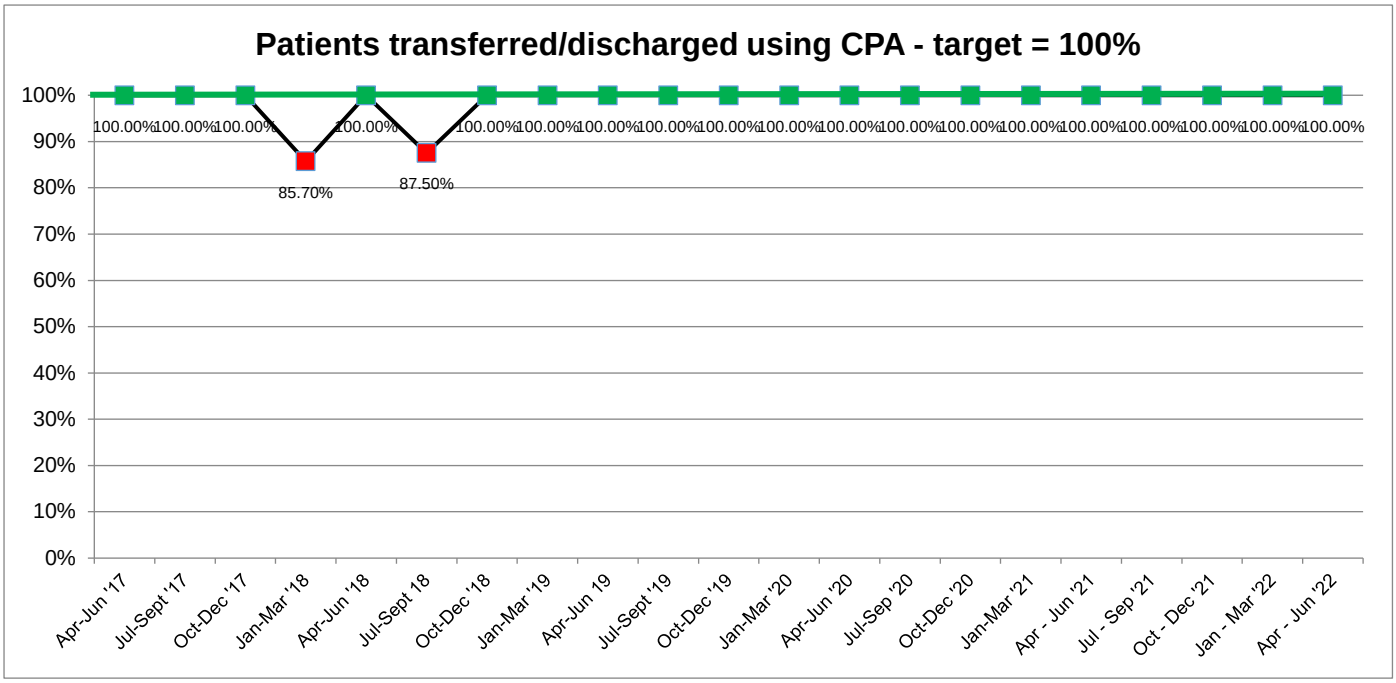
Target: 100%

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.

Chart 9



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

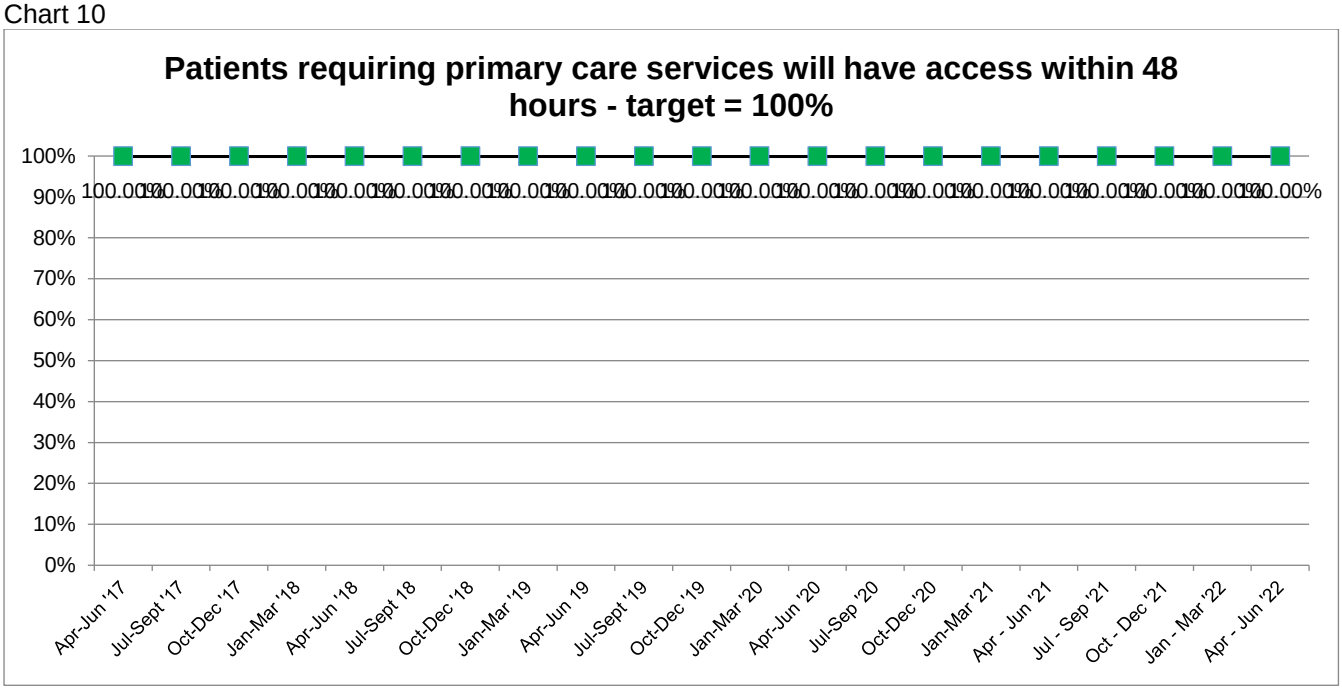
Target: 100%

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.

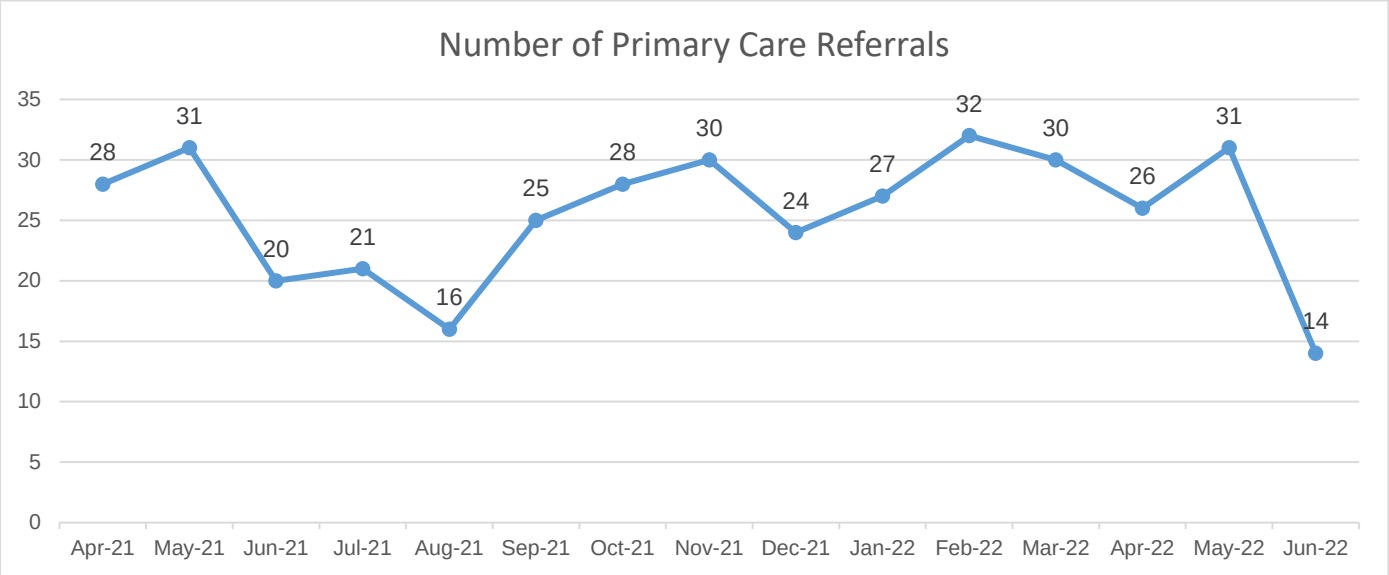
Chart 10



All referrals made to the Health Centre have been actioned within 48 hours. The referrals are triaged when received and onward referral to the most appropriate specialist. These have been actioned by a range of practitioners, including the GP who attends for 2 sessions per week and the Practice Nurse.

The chart below provides a monthly update on the number of referrals received by the Health Center. This provides the Board with data to demonstrate the scale of referrals being received and actioned. The average number of referrals received in 2021/22 was 26 per month, the chart shows monthly random variation. This charts the number of referrals, there could be numerous referrals for 1 patient.

Chart 11



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

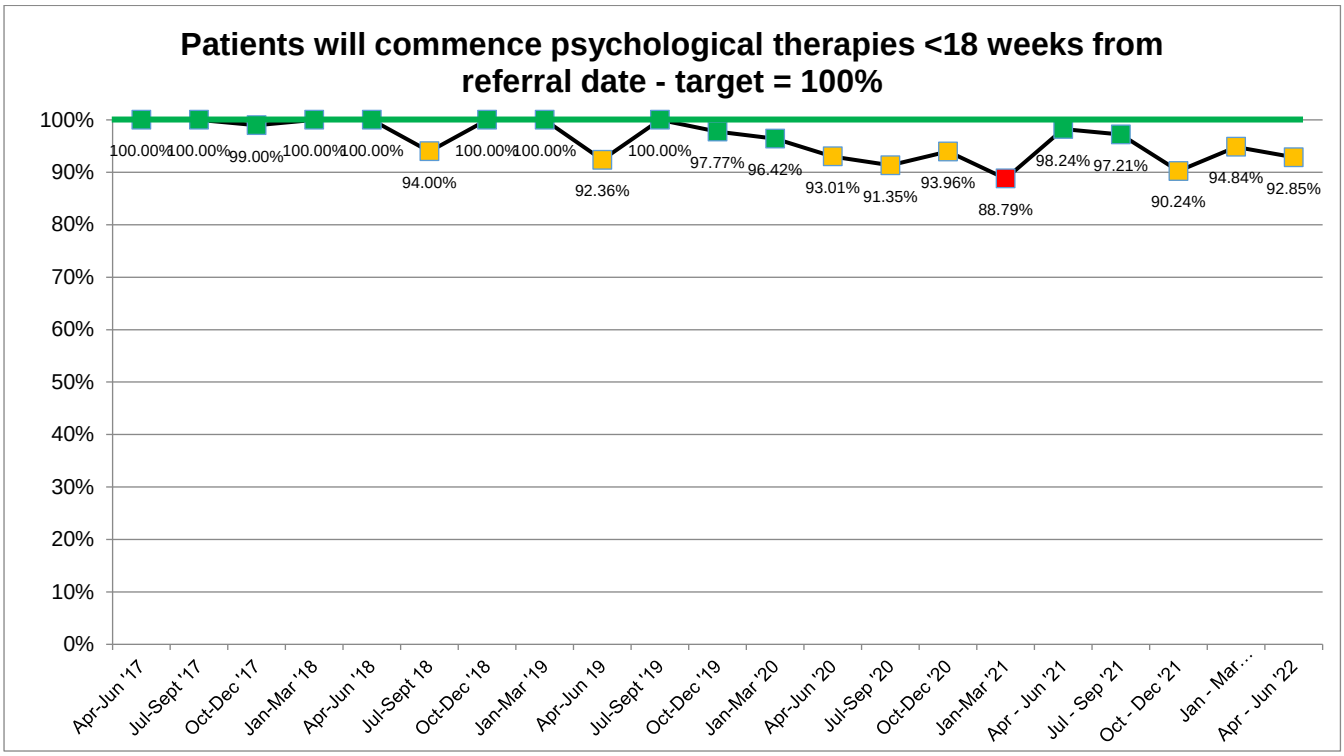
Target: 100%

Data for current quarter: 92.85%

Performance Zone: Amber

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.

Chart 12



The calculation for this KPI was revisited due to an inconsistency in the figures and all data points have been updated. The data required for this calculation are the number of patients waiting to engage in a psychological intervention to which they were referred who has not already completed another psychological intervention whilst waiting.

During Q1, four patients waited beyond the expected referral timeframe to commence their psychological therapies. Of these four:

- One patient was counted within April and May as their intervention began in June.
- One patient was counted in May and June as they are still awaiting their intervention. This patient is currently involved in a therapy which is being delivered by a different service however this is an intensive therapy.
- One patient was counted in May as they reached their 18-week target in May; this patient has since started their intervention in June.

All patients who are waiting for a therapy should still have regular contact with their psychology team and during their pre-CPA interviews.

No 13: Patients have their Clinical Risk Assessment Reviewed Annually

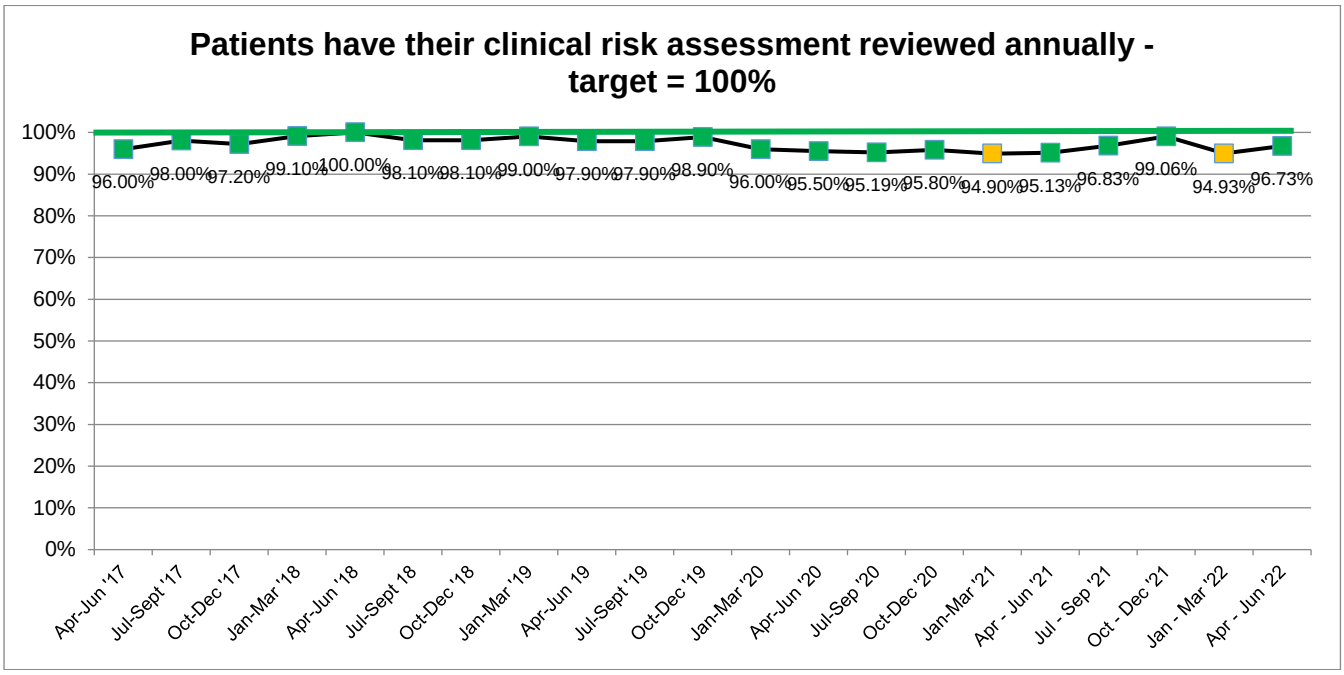
Target: 100%

Data for current quarter: 96.73%

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.

Chart 13



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.

Chart 14

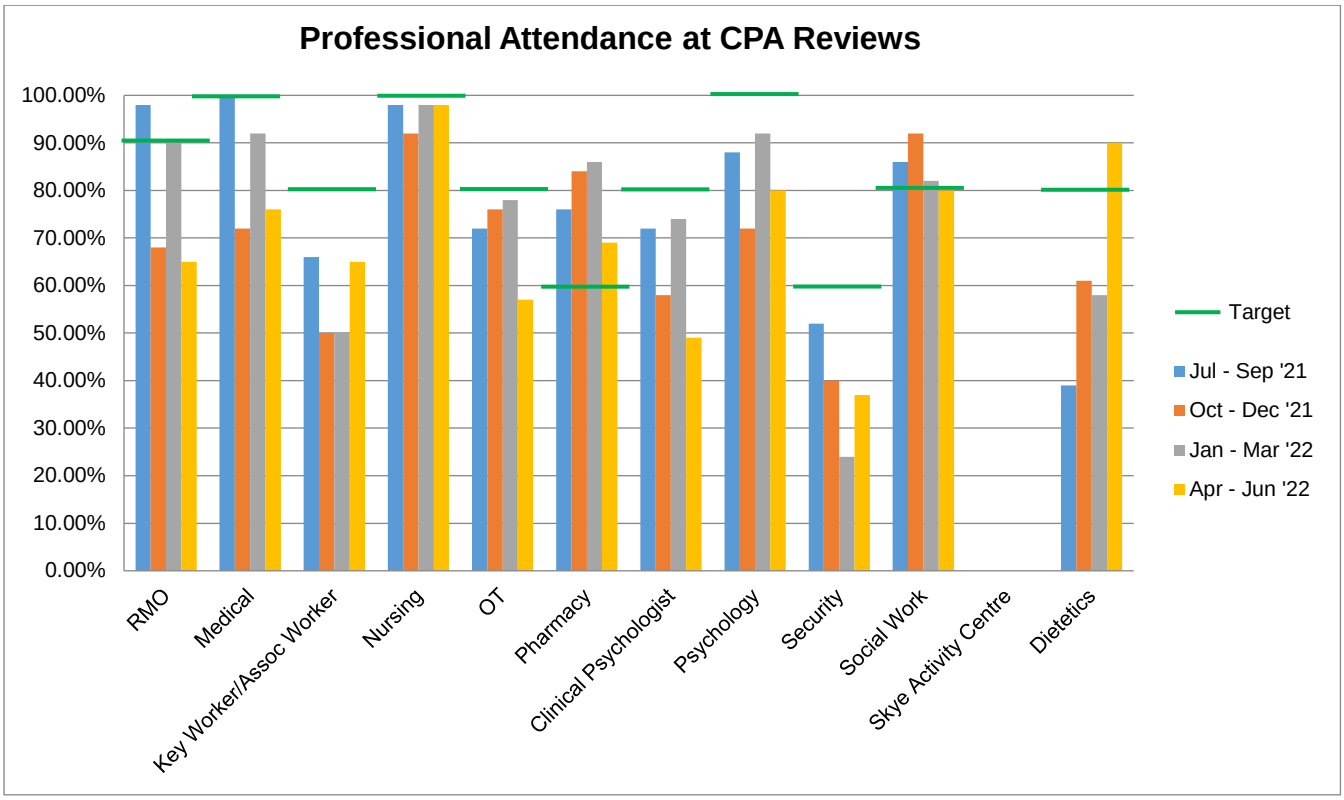


Table 3

Profession	Apr 22 n=13	May 22 n=21	Jun 22 n=17
RMO	69%	71%	53%
Medical	85%	81%	65%
KW/AW	62%	57%	77%
Nursing	100%	95%	100%
OT	77%	71%	24%
Pharmacy	69%	71%	65%
Psychologist	46%	52%	47%
Psychology	85%	71%	88%
Security	23%	33%	53%
Social Work	69%	86%	82%
Skye Centre	0%	0%	0%
Dietetics	80%	100%	75%

The targets for attendance are set to reflect what is reasonable to expect from each discipline and have been in place for over 5 years. Attendance at case reviews was recorded as both physical and virtual attendance.

RMO – attendance for this profession has declined to 65% in Q1. This indicator moves into the red zone for this quarter. There were 12 instances where the VAT form was not completed and 4 instances where the Junior Doctor chaired the meeting in their absence.

Medical – this profession moves in the red zone for this quarter, with a decrease from 92% to 76% in Q1. There were 12 instances where the VAT form was not completed.

Key Worker/Associate Worker – attendance figures increased to 65% for this quarter. On the 17 occasions where a key worker / associate worker was unable to attend the CPA, a nursing representative attended in their place.

Nursing – during Q1, nursing attendance remained at 98%; this profession moves into the green zone. On one occasion, no nursing staff were available to attend the patient's review.

OT – attendance has decreased during Q1 to 57% from 78%. OT has therefore moved into the red zone for this quarter. This can be mainly attributed to staff vacancies within this department.

Pharmacy – attendance for this quarter has declined from 86% to 69%. This profession remains within the green zone.

Clinical Psychologists – this profession's attendance has declined in Q1 to 49%. This indicator moves from the amber zone into the red zone. Five instances where the VAT form was not completed and a combination of annual leave, no reason, staff sick leave and staff vacancy made up this percentage.

Psychology – this professions attendance has decreased in Q1 to 80%. This profession moves into the red zone. On 16 occasions where the Psychologist was unable to attend, a Psychology representative attended in their place.

Security - attendance from security has increased in this quarter from 24% to 37%. Security remains in the red zone for this quarter. Six instances were due to annual leave, 11 instances were due to staff off duty, 6 instances of staff new to ward and a combination of VAT not completed, other commitments, staff sick leave and training contributed to this figure.

Social Work – attendance has slightly decreased in Q1 to 80% from 82%. This profession remains in the green zone.

Dietetics – during Q1, attendance from dietetics has increased to 90% from 58% in Q4 of 21/22. This profession has agreed a target of 80% thus this profession is within the green zone for this quarter.

4. RECOMMENDATION

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

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Monitoring of Key Performance Indicator Performance in the TSH Local Delivery Plan (2017-2020), the Operational Plan and the Remobilisation Plan submitted to Scottish Government in September, to cover the period September 20 – March 21.
Workforce Implications	No workforce implications - for information only.
Financial Implications	No financial implications - for information only.
Route to Board Which groups were involved in contributing to the paper and recommendations?	Corporate Management Team
Risk Assessment (Outline any significant risks and associated mitigation)	There is a dependency on the Business Intelligence project. While we can identify other ways of obtaining and analysing data there will be continue to be limitations on the timeliness and granularity of the information reported.
Assessment of Impact on Stakeholder Experience	The gaps in KPI data which make it difficult to assess.
Equality Impact Assessment	No implications identified.
Fairer Scotland Duty (The Fairer Scotland Duty came into force in Scotland in April 2018. It places a legal responsibility on particular public bodies in Scotland to consider how they can reduce inequalities when planning what they do).	n/a
Data Protection Impact Assessment (DPIA) See IG 16.	Tick One √ There are no privacy implications. □ There are privacy implications, but full DPIA not needed □ There are privacy implications, full DPIA included.

Appendix 1

Item	Code	Principles	Performance Indicator	Profession (Lead)	Target	RAG Q4	RAG Q1	Overall attendance Apr – Jun 2022 (n=51)	Overall attendance Jan – Mar 2022 (n=50)	Overall attendance Oct – Dec 2021 (n=50)	Overall attendance Jul – Sep 2021 (n=50)
15	T	2, 6, 7, 9	Attendance by all clinical staff at case reviews	RMO **(LT)**	90%	G	R	65%	90%	68%	98%
				Medical **(LT)**	100%	A	R	76%	92%	72%	100%
				Key Worker/Assoc Worker **(KM)**	80%	R	R	65%	50%	50%	66%
				Nursing **(KM)**	100%	G	G	98%	98%	92%	98%
				OT**(MR)**	80%	G	R	57%	78%	76%	72%
				Pharmacy **(LT)**	60%	G	G	69%	86%	84%	76%
				Clinical Psychologist **(JM)**	80%	A	R	49%	74%	58%	72%
				Psychology **(JM)**	100%	A	R	80%	92%	72%	88%
				Security **(DW)**	60%	R	R	37%	24%	40%	52%
				Social Work **(KB)**	80%	G	G	80%	82%	92%	86%
				Skye Activity Centre **(KM)** (only attend annual reviews)	tbc			0%	0%	0%	0%
				Dietetics **(KM)** (only attend annual reviews)	80%	R	G	90% (n=19)	58% (n=28)	61%	39% (n=19)

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:	25 August 2022
Agenda Reference:	Item No: 25
Sponsoring Director:	Director of Security, Resilience and Estates
Author(s):	Director of Security, Resilience and Estates
Title of Report:	Sustainable Centralised Visiting modification plan
Purpose:	For Noting

1 SITUATION

As part of The State Hospital's (TSH) response to the Covid-19 pandemic, the interim centralised visiting model was implemented in July 2020, using the Family Centre to support prevention and control of infection. The Family Centre was designed to provide a balance between security and child protection and facilitates visits for patients and family with prior approval by the clinical team. Following positive feedback on the interim model a request was made to the Corporate Management Team (CMT) to purpose the centre as the main visiting area for the hospital with visiting for patients with more complex needs continuing to be facilitated within the ward environment.

2 BACKGROUND

Visiting has historically taken place within the ward environment, facilitated by nursing staff. Considerable feedback has been shared by stakeholders indicating that this environment is not always conducive for visits. There have also been numerous requests for access to outdoor space for visiting when weather permits. Additionally, Scottish Government Person Centred Visiting guidance calls for a more tailored approach to meeting individual needs, advocating the need to ensure that visiting environments are fit for purpose and embrace the concept of 'open visiting', which enables family and friends to be more involved in the delivery of care, including spending mealtimes together.

Following the request to CMT to re-purpose the Family Centre, a risk assessment highlighted that additional security control measures would be required to ensure that centre was fit for purpose and all relevant risks had been highlighted and appropriate control measure were in place in line with the hospital's Risk Management Strategy.

The CMT commissioned a short life working group remitted to identify and assess any long term risk in using the Family Centre,as well as maintaining and improving security and defining costings for implementation. The group consisted of:

Responsible Medical Officer (Lead)
Head of Estates and Facilities
Head of Security
Head of Risk and Resilience
Estates Officer
Person Centred Improvement Lead

3 ASSESSMENT

Initial assessment identified adaptations with an estimated cost of £100k, however following a Fire Risk Assessment the security proposal was adapted resulting in a new plan with reduced costs.

A capital budget has already been allocated to upgrade the Family Centre garden, supporting wider use of the outdoor environment for visiting. This presents an opportunity for visitors and patients to benefit from fresh air as part of the visiting experience, responding to well documented feedback in relation to this gap in access. This work also allows for an opportunity to review access/egress of both patients and carers.

There are a number of security enhancements that require to be implemented to support the new access/egress and management of the area during visits including additional electronic locking mechanisms and CCTV.

The cost of the remedial work to be undertaken at this time is in the region of £70k; and the Estates Department is progressing a more detailed costing plan. It is important to underline that a defined timeline for implementation cannot be determined at this stage due to supply issues outwith the control of TSH. However, regular reporting will be brought to the Board, to provide assurance on progress, and full details on adaptations, timelines and costings as well as any further potential delays to implementation.

4 RECOMMENDATION

The Board are invited to note progress.

MONITORING FORM

How does the proposal support current Policy / Strategy / LDP / Corporate Objectives	Supports delivery of person-centred service delivery objectives.
Workforce Implications	
Financial Implications	Additional budget required for capital costs.
Which groups were involved in contributing to the paper and recommendations.	SLWG, Board requested
Risk Assessment (Outline any significant risks and associated mitigation)	
Assessment of Impact on Stakeholder Experience	Responds to stakeholder feedback reporting improved visiting experience within the Family Centre.
Equality Impact Assessment	Not required. Family Centre more accessible for those with mobility issues.
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 implications.
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